Person-Centered Psychopathology of Schizophrenia: Building on Karl Jaspers’ Understanding of Patient’s Attitude Toward His Illness

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In this article, building on and extending Jaspers’ concept of the “patient's attitude toward his illness” we draw attention to the active role that the person, as a self-interpreting agent engaged in a world shared with other persons, has in interacting with his/her basic disorder and in the shaping of psychopathological syndromes. This person-centered approach helps us to see patients as meaning-making entities rather than passive individuals and their attempt at self-understanding as not necessarily pathological and potentially adaptive. We describe 3 contemporary resources for a person-centered psychopathology: dialectical psychopathology, contemporary approaches to the meanings-causes debate, and value-based practice. Each of these provides a theoretical framework and practical resources for understanding the diversity of schizophrenic phenotypes, including symptom presentation, course, and outcome as a consequence of the different ways people with schizophrenia seek to make sense of the basic changes in self and world experiences. A person-centered approach, in building on patients' individual values and experiences as key aspects of their self-understanding of their psychosis, supports recovery and development of self-management skills.

Key words: Jaspers/person-centered psychopathology/schizophrenia/self-management/service user empowerment/value-based practice

Introduction

The recent growth of neuroscientific paradigms in psychiatry has led to renewed challenges for clinicians and researchers in combining objective knowledge of brain functioning with the subjective experiences of schizophrenia. Similar challenges in the early years of the 20th century, during psychiatry’s “first biological phase,” led Karl Jaspers to insist on the importance of meanings as well as causes in psychopathology. But the same point has been made in a contemporary context. This is because psychiatry is essentially about people, not (just) brains, and hence has to be concerned with (1) the patients’ subjective experiences as well as neurobiological dysfunctions, (2) the personal meanings of psychoses for the individuals concerned as well as their causes, and (3) personal, individual features of psychotic disorders as well as impersonal diagnostic criteria. This is important practically as the basis, we will argue in this article, for a person-centered approach to the management of psychosis that supports recovery and development of self-management skills.

A rich tradition of psychopathological research has been built on the foundations laid by Jaspers. Yet there is a new tradition that Jaspers’ legacy enriches: the rise in all areas of medicine of person-centered approaches based on an understanding of and responsiveness to the individual experience of illness. The experience of persons with schizophrenia embraces 3 distinct domains: the patients’ phenomenal world (ie, all forms of subjective experience, including subtle abnormalities in sensory and body perception, motor action, thinking, and speech), their sense of prerelative self (the distinctive disorders of their implicit sense of agency, coherence, unity, and immersion in the world), and, least researched and yet crucial to a person-centered psychopathology, their existential orientation and attitude toward their illness.

In this article, we describe 3 contemporary resources for a person-centered psychopathology: dialectical psychopathology, contemporary approaches to the meanings-causes debate, and value-based practice. Each of these provides a theoretical framework and practical resources for understanding an individual’s experience of his/her illness, aimed at supporting recovery and development of self-management skills. We start with a brief resumé of Jaspers’ discussion of patients’ attitude toward their illness in chapter VII of General Psychopathology.
Jaspers Account of a Patient’s Attitude Toward “His” Psychosis

Jaspers’ discussion of the patients’ attitude toward their illness develops out of his account of the early stages of schizophrenia2 (see table 1). Jaspers identifies the origin of acute onset schizophrenia in a basic alteration of experience (which he calls delusional mood) characterized thus: “The environment is somehow different—not to a gross degree—perception is unaltered in itself but there is some change which envelops everything with subtle, pervasive and strangely uncertain light.” 2(p98) Faced with these uncanny experiences, it is understandable that most people’s first reaction is what Jaspers calls “perplexity”—a state whereby the patient’s level of activity is falling and he is gradually becoming detached from external reality. But individual differences start to appear almost immediately afterward as the patient tries to make sense of these experiences. “Working through” is the phrase Jaspers uses to describe the process of self-interpretation as the patient, reflecting on his perplexity and other basic abnormal experiences, “can see himself, judge himself, and mould himself.”2(p424) Thus, we find patients for whom their experiences introduce new significance into their lives, others for whom the content of their abnormal experiences is linked with their preonset personality structure (including their values and beliefs), and yet others for whom the content of their incipient psychosis remains entirely alien and brings no added significance. Quoting Mayer-Gross,12 Jaspers lists the following “after-effects” of acute onset schizophrenia as different outcomes of the patient’s “position taking” in the face of his basic abnormal experiences: “despair, ‘renewal of life,’ ‘shutting out’ (as if nothing had happened), ‘conversion’ (the psychosis offered something fresh by means of a revelation), and ‘integration.’”2(p416) Working through his symptoms, the patient “laborsiously develops a delusional system out of his delusional experiences.”2(p416) Delusions are thus conceived as a top-down attempt to explain the aberrant experiences taking place during the initial pre-delusional stages of schizophrenia.

Table 1. Stages in Onset of Schizophrenia

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<tr>
<th>Delusional mood: the patient experiences strange, uncanny, and quasi-ineffable changes in environment, self, and others’ perception</th>
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<tr>
<td>Perplexity: the patient’s behavior appears grossly disorganized and inappropriate as his/her level of activity is falling and he/she is gradually becoming detached from external reality</td>
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<tr>
<td>Self-interpretation: the patient reacts, takes up (in Jaspers’ phrase) an attitude toward his/her abnormal experiences, and tries to give personal meaning to them</td>
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<tr>
<td>Full-blown psychosis: psychotic symptoms, eg, delusions, are the outcome of the patient’s self-interpretation of and attempts to give meaning to his/her early abnormal experiences</td>
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By way of example, Jaspers describes the case of a patient whose psychosis started with perplexing experiences of depersonalization and derealization. The patient first believed that he caused his illness: In his attempt to penetrate the other world, the patient says, “I met the natural guardians, the embodiment of my own weakness and faults.” Initially, he thought these were demons; and that because he had forced his way into the “source of life,” the “curse of the gods” had descended on him. 2(p418) Later, he thought his “demons” were split parts of his mind. Then, there came a new illumination: They were pimps and seducers. Now, he could abandon his previous self. A new life began for him. A self consisting of conventional lies and self-deceptions, exactly like those of other people, grew in him; but “behind and above it, stood a greater and more comprehensive self.” 2(p418)

Jaspers concludes his discussion of this case consistently with his emphasis on the importance of meanings as well as causes, by emphasizing that the patient’s “self-interpretations (...) originate from profound experiences and the wealth of such schizophrenic experience calls on the observer, as well as on the reflective patient, not to take all this merely as a chaotic jumble of contents.”2(p418) There are then, Jaspers continues, two kinds of knowledge required in relation to patients’ basic abnormal experiences. First, there is “objective” knowledge, which is rooted in the medical literature and which sees schizophrenia as caused by a morbid process. This is the kind of knowledge in which clinicians and researchers are proficient. Second, there is a kind of knowledge that Jaspers calls a “comprehending appropriation” of the illness, a more personal kind of understanding, “an act which is meaningful only in the midst of an in-between existence.”2(p426) The attempt to achieve a comprehending appropriation, which characterizes the patient’s attitude, is the constant search for personal meaning.

Jaspers insists that the search for personal meaning in a condition like schizophrenia, which is explained from the perspective of biomedical science as being caused by a morbid process, “does not immediately signify lack of insight into the illness.”2(p427) Many problems remain in what follows from this, namely, the task at the heart of Jaspers’ psychopathology of reconciling meanings and causes. Yet, it is precisely this task too that is at the heart of modern person-centered approaches to the management of psychosis. This is why Jaspers’ concern to combine neuroscience (concerned with causes) with phenomenological understanding (concerned with meanings) is no less vital to psychiatry now than it was during psychiatry’s first biological phase. There are, moreover, contemporary resources for combining meanings with causes that were not available to Jaspers. In the following sections, we outline 3 such resources respectively from dialectical psychopathology,
phenomenological and cognitive psychology, and value-based practice.

The Dialectical Model in Psychopathology of Psychosis

The central idea underpinning the dialectical model in psychopathology is that there is an active interplay between the person and her/his basic abnormal experiences. The dialectical model of mental disorders draws attention to the active role that the person, as a self-interpreting agent or “goal-directed being” engaged in a world shared with other persons, has in interacting with his/her basic disorder and in the shaping of psychopathological syndromes. One feature of this model is that it explains the diversity of schizophrenic phenomena as a consequence of the different ways people with schizophrenia seek to make sense of the basic changes in self- and world experiences. According to the dialectical model, consistent with a person-centered approach, each individual, with his/her unique strengths and resources as well as needs and difficulties, plays a central role not only in outcomes but also in the course and manifestations of the psychotic process. The main difference between an exclusively neurobiological and the person-centered model is that in the former, the patient is conceived as a passive victim of his/her symptoms, whereas the latter attributes to the patient an active role in shaping his/her symptoms, course, and outcome.

The origins of the dialectical model can be traced to the French alienist Pinel. Pinel is perhaps best known for his role in liberalizing the treatment of “the mad” in the Parisian hospital of Bicêtre. Equally important, though, is his seminal work, in which he lays down the cornerstone of a dynamic understanding of mental illness. The principal points of his theory are the following: (1) the partial nature of alienation—no mad person is entirely so but retains a part of selfhood that can be cognizant of his/her alienation and thus enables the person to try to cope with it; (2) the plasticity of madness—each person stamps his identity onto the “raw material” of the vulnerability from which alienation derives, with the result that each case of pathology and each form of alienation is the result of a dynamic relationship between the person and his/her vulnerability; (3) the nosodromical continuum of mental syndromes, therefore, and the variety of psychopathological syndromes, are not discrete entities but steps along a continuum, with the suffering person in different stages of his/her psychopathological course being affected by different forms of the same core type of alienation; and (4) the potential for different outcomes will also vary from person to person, depending not only on the seriousness of their vulnerability but also on the resources that the person can muster to counter it.

Bleuler’s distinction between primary and secondary symptoms is also important to the theoretical foundation of the dialectical model of schizophrenia: “We can only understand a physically determined psychosis if we distinguish the symptoms stemming directly from the illness process itself from the secondary symptoms which only begin to operate when the sick psyche reacts to some internal or external processes.” Bleuler provides the key to reconciling the idea of a common pathological ground for the diverse manifestations of schizophrenia with the idea that each patient has his/her “own” schizophrenia. These 2 apparently incompatible conceptions can be brought together if we assume that persons affected by schizophrenia respond differently to their shared basic abnormal experiences. The various forms of schizophrenia are thus a consequence of the wide variety of ways in which persons with schizophrenia contribute to shaping their basic disorder.

De Clérambault gives the following example of how individual differences help to explain the variety of clinical forms of schizophrenia: 3 different people are affected by similar abnormal bodily experiences. The first, who suffers a continuous form of anxious introspection, will develop a hypochondriacal form of delusion, which explains his abnormal bodily sensations as the symptoms of a somatic illness. The second person, who has a more “imaginative” character, will interpret analogous bodily disturbances as the outcome of some entity (e.g., the devil) possessing his/her body and changing the place of his/her organs or doing other malicious deeds. The third, who has a tendency to give external or “exogenous” explanations, will develop a persecutory delusion, believing that his/her somatic troubles derive from being poisoned by some conspirator. De Clérambault argues that the disparity in the content of delusions is more the effect of different elaborations by the person than of different basic transformations of bodily experience. Each person stamps his/her autograph onto the “raw material” of abnormal bodily sensations. Each form of delusion is the result of a relationship between the persons and their basic abnormal experiences driven by the painful tension with what Mayer-Gross called “the drive for the intelligible unity of life-construction.”

Swiss psychiatrist Wyrsch gave probably the most detailed account of the dialectical model of schizophrenia. Describing the relationship between the person and the onset of acute schizophrenia, he distinguished 4 groups of patients: patients who objectify their own suffering and conceive them as symptoms of a somatic illness; patients who are passive and incapable of any reaction; patients who engage in a fight against their pathological experiences, displaying a stubborn determination to fit such experiences “into the meaning context of their life-story;” and a last group who are exalted by the novelty of the psychotic experience, which acquires for them a cosmic meaning. “It is significant in the world order and not just for him.” These different reactions to the psychosis are “only four of the...
many ways in which the person can deal with the illness that threatens his existence." [21(p105)]

More recent contributions to the dialectical model include Mundt’s intentionality model [22] and John Strauss’ person-based approach. [15] Mundt argues that the basic abnormal experiences result from a breakdown of intentionality, with delusions, hallucinations, and other symptoms arising from attempts to compensate. Strauss makes explicit the role of the person as the key to understanding mental disorder. “The person in mental disorder is not peripheral, merely as a passive victim of a disease;” [23(p182)]

The problems about the scientific status of mental states faced by Jaspers were not confined to psychiatry. They were evident in many contexts as the various human sciences—psychology, sociology, and history—were establishing empirical methodologies against a background of materialist natural science. Jaspers drew the philosophical foundations of psychiatry have shifted since Jaspers’ time in the context of broader shifts in the scientific culture. [31] Crucially, the cognitive paradigm, linked to the information-processing paradigm, breaks down the dichotomy between semantic and causal connections, insofar as meaningful/information-carrying states regulate behavior. At a theoretical level, the relationship between meanings and causes remains a matter of active debate, [32,33] and the epistemological issues that underpinned the original meaning/causality distinction remain unresolved; these include the following questions: How far is it possible to generalize over brains and what is the role of individual differences? Does knowledge of physical properties of brain states enable prediction of behavior, or does this require knowledge of the cognitive processes the brain is implementing? Does this knowledge ultimately rest on empathic understanding by another subject? But at a practical level, reconciling meanings and causes within a cognitive paradigm presents less difficulty now than it did for Jaspers.

Phenomenological and Cognitive Paradigms: Meanings as Causes?

In working through the relationship between meanings and causes, Jaspers was seeking to establish the validity of mental states as objects of knowledge within scientific psychiatry. [26-30] One way of understanding this problem is that it is about the relationship between mental states and behavior: Are mental states to be considered only as objects of scientific study—to be described and categorized—or is knowledge of mental states useful because they make a difference to what happens in the patient and in the clinician-patient relationship? The view that mental states made no difference to behavior was part of the reductionist world view that came to be known as epiphenomenalism. It is strikingly against common sense. In daily life, we normally assume that mental states cause behavior, e.g., pain causes us to wince, fear to avoid. This assumption enables us to predict the behavior of others, and to collaborate with others in joint activities. Jaspers wanted this common sense assumption to be acknowledged as having validity in psychiatry and it is essentially this assumption, that mental states cause behavior, that has been carried over into and formalized in phenomenological and cognitive paradigms. As such, it is surely valid: We cannot act as clinicians, indeed we cannot relate to other people in any shared situation and joint activity, without relying on knowledge of their mental states, how they hang together, and how they affect behavior. To go beyond this however, to say that mental states are causes in the same sense as material states was a step too far for Jaspers, given the wide chasm implied by the scientific materialism of the day: The only causes permitted were material ones.

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The problems about the scientific status of mental states faced by Jaspers were not confined to psychiatry. They were evident in many contexts as the various human sciences—psychology, sociology, and history—were establishing empirical methodologies against a background of materialist natural science. Jaspers drew directly or indirectly on many of the great contributors to arrive at what has become known as the Methodenstreit, the debate on method in the human sciences that ran through much of the 19th century. [34] Central to this debate was the distinction with which Jaspers was concerned, between meaningful and causal connections, and such related distinctions as that between understanding and explaining. Jaspers’ great innovation was to recognize the importance of incorporating both sides of these distinctions into psychiatry, thus bringing together the methods of the human sciences with those of the natural sciences. In this, Jaspers gave psychiatry the best philosophical framework possible at the time. First of all, “psychic events ’emerge’ out of each other in a way which we understand. Attacked people become angry and spring to the defense, cheated persons grow suspicious.” (…) Thus we understand psychic reactions to experience, (…) how the patient sees himself and how this mode of self-understanding becomes a factor in his psychic development.” [2(p302-303)] Thus, meaningful mental states act as causes of other meaningful mental states and, in the end, of human behavior. These types of “causes” are called “motivations.”

Even more importantly, Jaspers argues for another kind of meaning-causes relationship. Remember that
persons who are affected by uncanny abnormal experiences, as in the early stages of schizophrenia, respond by trying to give meaning to them. These basic abnormal experiences are at face value meaningless and not understandable (to the patient as well as to the clinician). Because they cannot be connected to any psychological factor giving rise to them, according to Jaspers, they are supposed by clinicians to be caused by an unknown psychopathological process. Thus, we have basic abnormal experiences whose meaninglessness motivates the patient to search for meaning and thus, as noted above, generates the diverse phenotypes of schizophrenia.

This is why Jaspers’ work remains so crucially relevant today. Clark and Beck, eg, argue\textsuperscript{35} that “[t]he philosophical perspective that most closely captures the core assumptions of cognitive theory and therapy is that of existential phenomenology.” Similarly, an important example of a cognitive model of schizophrenia\textsuperscript{36} posits appraisal processes as critical to the construction of positive symptoms out of basic cognitive/experiential anomalies—appraisals that at least in part have specific personal meanings. Such models are not antithetical to the biomedical model. People with schizophrenia vary widely in the extent to which they find medical or psychological approaches more or less meaningful and helpful.\textsuperscript{37} What is important though is that they should “have a say” in how they are treated.\textsuperscript{38} The importance of this is reflected, eg, in current National Institute for Health and Clinical Excellence guidance in the United Kingdom on the management of schizophrenia.\textsuperscript{39} All these developments thus reflect the importance of the patient’s “appropriating attitude” to their illness. Phenomenological and cognitive models in building on the person’s own understanding of their experiences offer a positive approach not only to “having a say” in how people are treated but also to developing the skills for self-management that, in restoring agency, are integral to the person-centered approach.\textsuperscript{5,40}

**Value-Based and Evidence-Based Practice**

Our third contemporary development relevant to a person-centered psychopathology of schizophrenia is value-based practice. Value-based practice is a partner to evidence-based practice. Both are responses to the growing complexity of clinical decision making. Evidence-based practice offers a process that supports clinical decision making where the evidence relevant to the decision in question is complex and/or conflicting. Value-based practice offers a complementary process (based primarily on learnable clinical skills) that supports clinical decision making where the values relevant to the decision in question are complex and/or conflicting. Building on both analytic-philosophical\textsuperscript{25,41} and empirical\textsuperscript{37} foundations, value-based practice has found application in a number of areas of training\textsuperscript{42} and service development initially in mental health\textsuperscript{33,44} and, more recently, in other areas of health care.\textsuperscript{45}

Jaspers was ambivalent about the role of values in psychopathology. Yet, the 2 kinds of knowledge he identified as being crucial in schizophrenia (objective causes and subjective understanding of meanings) directly reflect the different priorities of the clinician and the patient and hence can be understood as differences of (and potential conflicts between) values. It was precisely this and other related differences as well as similarities of values that were found by Colombo et al.\textsuperscript{37} in their study of models of disorder in schizophrenia. Clinicians are concerned primarily with psychopathological symptoms as objectively founded in underlying causal disease processes; many patients, by contrast, are engaged in an attempt to comprehend and (in Jaspers’ term) appropriate their symptoms as meaningful aspects of their existence. Jaspers writes that the patients’ constant search for “interpretation and inclusion”\textsuperscript{26,47} does not immediately signify lack of awareness of psychosis. Rather, the clinician’s and the patient’s perspectives need to be brought together in a coherent and complementary way that supports recovery.

Learnable clinical skills are important in how this is done: Recognizing the extent to which values are woven through the way mental disorders are understood is an essential first step toward managing them more effectively.\textsuperscript{41,46} Research too is vital. The study by Colombo et al.\textsuperscript{37} also showed that many patients emphasized the importance of objective (causal) knowledge in the way they understood their disorder.\textsuperscript{37} The different priorities noted by Jaspers, therefore, instead of being a source of tension, emerged from this study as a resource for care planning that (in reflecting the different perspectives of individual patients) offered a genuinely person-centered approach.

The importance of values in how a psychotic episode is understood and hence managed is illustrated by the story of Simon.\textsuperscript{47}

Simon was a black, middle-class professional in his forties. He reported a series of “revelation” experiences conveyed by delusional perceptions and thought insertion. Nosographically, Simon’s experiences, if assumed to be pathological, might suggest a diagnosis of schizophrenia. However, from Simon’s perspective, his experiences were spiritual revelations: and consistently with this they were entirely beneficial to his life. To this extent therefore he did not fulfill the DSM criterion of “social/occupational dysfunction.” Rather, his experiences and beliefs, whilst unusual in form and content, essentially enhanced his ability to function effectively: he won a difficult court case thus advancing his career as a lawyer. But this outcome depended critically on Simon’s values as reflected in that aspect of his attitude to his experiences characterized by what Jaspers called “appropriating judgment.” Consistently with the principles of dialectical psychopathology, Simon’s...
engagement with his experiences was as an active agent rather than as a patient. Framing his experiences positively rather than negatively he avoided contact with doctors and instead integrated the information he (somehow) took from them in fighting and winning his court case.

A number of factors—biological, social, as well as psychological—will be involved in whether a particular person’s psychotic experiences develop in a pathological or problem-solving way. Here, the values not only of the patient but also of others will be critical. The interpretation of Diagnostic and Statistical Manual of Mental Disorders (DSM) criterion of social/occupational dysfunction depends on balancing the way a given person’s functioning is perceived in the 3 distinct domains of interpersonal relations, work, and self-care. In Simon’s story, social/occupational dysfunction clearly failed to be satisfied (he was functioning above average at least in his work). But how would Criterion B have read had Simon turned, say, to violence with his family or friends? Or taken to fast- ing and self-flagellation? In such cases, whatever Simon’s values, the values of others will be relevant to how social/ occupational dysfunction is read. And the values of others may be highly variable: eg, in Moslem societies, a young man who becomes withdrawn and spends his time in prayer and contemplation to the neglect of his work and family may well be valued a spiritual exemplar. The difficulties here furthermore are critical to outcomes as well as diagnosis. We can only imagine how different the outcome of Simon’s story might have been had his family insisted on him seeing a psychiatrist.

Of course, many clinicians would object that most patients, especially when acutely ill, may not be able to express their values and meanings because the psychosis destroys, rather than enhances, their capacities for self-reflection, self-understanding, and position taking. But this is exactly why the person-centered approach emphasizes these features of psychosis: Enhancing the clinician’s awareness of the importance of values and meanings in psychoses may help them to help their patients to understand their illness and thus support them on their path to recovery. The importance of the skills for value-based practice are crucial in such areas as early intervention and recovery-oriented care. As noted above in relation to Simon’s story, given the highly individual nature of values, such approaches necessarily face challenges of interpretation and of balanced decision making where values conflict. This is why value-based practice is an important partner to evidence-based practice in providing a process for balanced decision making where complex and conflicting values are in play clinically. The skills of value-based practice are also important in eliciting clinically crucial values: An individual’s aspirations, eg, may be misunderstood or fail to be elicited at all in many mental health assessments and yet are often one of the keys to recovery. In the United Kingdom, correspondingly, the Department of Health of the UK government has issued good practice guidance, prepared through a joint consultation between clinicians, patients, and carers, on the central role of values in mental health assessment and the importance of a person-centered approach, reflecting the particular needs, preferences, strengths, and other values of the patient as a unique individual, is correspondingly emphasized.

It was perhaps the open and relatively fluid nature of values that explains Jaspers’ ambiguity about their place in a scientific psychopathology despite his insistence on the need for meaningful understanding as well as causal explanations. Again, however, theory and practice have both moved on since Jaspers’ day. In the early 20th century, science was understood as delivering certainty; and Jaspers’ ambitions for a science of subjective experience must therefore have seemed prejudiced by the inherently indeterminate nature of value judgments. In the early 21st century, however, the contrast between science and values in this respect is less stark, at least in clinical contexts. The very need for the processes of evidence-based practice is a reflection of the relative indeterminacy of science in the context of clinical decision making; and the need for the processes of value-based practice is a reflection of the equal and opposite necessity for bringing a degree of determinacy to the corresponding values. Far from being antithetical indeed, values provide a key link between best evidence and the unique values of the individuals involved in any given clinical decision. In the case of psychosis, value-based practice, working alongside and in partnership with evidence-based practice, provides a basis for a coherent and balanced approach to person-centered care planning that supports recovery and development of self-management skills.

Conclusions

The person-centered approach in psychiatry sees patients as active and meaning-making entities rather than as passive individuals and their attempts at self-understanding as potentially adaptive. This is important in contemporary practice at a number of levels. Crucially, it helps improve understanding of the unique personal values and beliefs by which each individual’s experiences of schizophrenia are shaped, thus enhancing insight and improving the quality of the clinician-patient relationship. It is also significant in relation to current policy priorities such as service user empowerment and the development of self-management skills. Last, and by no means least, it may help make sense of schizophrenic symptoms and neurobiological and other research findings.

The 3 contemporary developments outlined in this chapter—the dialectical model, the phenomenological and cognitive debate on meanings and causes in mental disorders, and value-based practice—each offer resources for
emerging concepts of patient-centered psychopathology, in which patients have an equal say alongside clinicians in how their mental health issues are understood and managed. The dialectical model focuses on enhancing the agency of patients, building, as phenomenological and cognitive models also build, on individual experience and understanding of mental health issues; and value-based practice links generalized best evidence with the unique values of the individuals involved in particular clinical situations.

We have explored these developments by reference to a relatively neglected aspect of Jaspers’ psychopathology, namely, his comments on the importance of what he called the patient’s appropriating attitude toward his/her illness. Some might argue that person-centered psychopathology has little relevance in an age where neuroscience promises ever-more detailed understanding of brain functioning. We should not forget though that Jaspers was writing in a period like our own of reconciling meanings and causes in psychiatry resonates as strongly for us as it did in Jaspers’ day. The theoretical problems that we have indicated in reconciling meanings and causes remain. Yet, the contemporary developments outlined here show that theoretical problems notwithstanding, we have already started to handle the resources to develop approaches to psychopathology, which, as Jaspers anticipated, are both firmly science-based but also encompass individual values and meanings, thus being genuinely person-centered.

References