THE SIGNIFICANCE OF EMPATHY FOR THE DIAGNOSIS OF SCHIZOPHRENIA AND MELANCHOLIA

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Modern glossary diagnostics presumes an objective givenness of diagnostic criteria which should be independent to a high degree of the intuitive and empathic capacities of the diagnostician. However, even in the glossary diagnostics and much more so in diagnostics independent of glossaries, the diagnostic divergencies of the diagnosticians are very much based on these capacities. This is particularly true for the diagnostics of endogenous psychoses. But what the diagnostician really assesses empathically and intuitively is often very difficult for him to describe and to communicate. This article, concerned with this task, is restricted to the diagnostics of schizophrenia and what formerly was called melancholic or endogenous depression.

I. WHAT IS EMPATHY?

The German expression *Einfühlung* for empathy has connotations different from those of the English neologism of "empathy", derived from the Greek. *Fühlen* (feeling) as well as "feeling", linguistically related to touching, sensing and groping, refers to corporeal processes in this kind of communication. *Einfühlung* moreover means a feeling of the other from inside, putting oneself in the position of the other, also not giving up the difference between oneself and the other.

To Max Scheler we owe an important and rich phenomenology of different kinds of feelings. In recent times among others Dreitzel tackled the problem of the phenomenology of feelings in the frame of psychotherapy. As to him we have to differentiate two forms of empathy: an adaptation to the feelings of another (*Nachfühlen*) and a feeling-oneself-into-the-other (*Einfühlung*). The last one in our understanding is empathy in a more strict sense. Adaptation to the feelings of the other can mean that I feel specific situation, which I have already experienced earlier in the same or a similar way, or a general situation like one of distress, of a loss, of threat, etc., which everybody already has experienced. But it can also be only the emotional state itself of the other to which I am adapting my feelings. Over against this adaptation to the feeling of another feeling-oneself-into-somebody-else is an intentional act, where the perception of the other as a person plays an important role. Here, the reflection on the perception, not only of the bodily expression of the emotion of another but also of one's own feelings provoked by the other's expression of his feeling, is important. In this context we mention only that empathy of course plays a particularly important role in non-verbal communication, as Fuchs says. In the feeling-of-oneself-into-the-other one does not only identify with the cause of the feeling of another, or with the feeling of the other, as it is the case with the mere adaptation to the feeling of another, but in a certain way also with the person of the other. Thus, with empathy in this strict sense on one hand we have to do with the capacity of emotional experiencing and of resonance to feel in oneself what the other feels, on the other hand in a cognitive-intuitive act the diagnostician takes the role of the other in the sense of G. H. Mead, takes his perspective respectively and reflects on it.

To put oneself in somebody's circumstances in order to understand his problems and his life history etc., as if one were the other, in our understanding is only an aid for the diagnostician. It is decisive also to understand the fundamental outline of another, to grasp what Sartre called the "original choice" (*choix originel*), which is expressed in all feelings, all kinds of behaviours, but also in the life history of somebody, even with all possible contradictions and permanent changes. This means to understand the other from the centre of this person. That in our relationship with the other we normally meet him as a whole, becomes particularly apparent where this, in a certain mode, is not possible, as it can happen in schizophrenics, which should be shown later on.

The identification with the other in the frame of empathy is not without problems. It may promote but also impede empathy, if by an uncontrolled projection of one's own wishes, needs and unconscious

conflicts to the other the perception of the other as another is distorted. In order to be able to really feel into the other it is necessary to take a certain distance to oneself. Only in this way is it possible to recognize one's own wishes, fantasies, and needs, to set them temporarily in brackets.

On the other hand we should not imagine an empathically understanding person as a completely empty mirror lies own point of view. Our own point of view is necessary in order to recognize all the frames of reference of a patient and to relativize these. But also the patient may relativize the frames of reference of the diagnostician or therapist. Thus, empathically to feel into the other does not only help to experience and recognize the other, but also oneself. In this way there is always a reciprocity taking place between diagnostician or therapist and patient.

Jaspers differentiated different forms of understanding, among these an understanding of feeling into the other as the real psychological understanding. Even if the mental life of another can fundamentally not be perceived directly, it can intuitively be represented (*anschaulich vergegenwärtigt*).

II. SCHIZOPHRENIA

An important restriction of understandability, however, is found, according to Jaspers, in the schizophrenic mental life, particularly in so-called experiences of "being made" (*Erlebnisse des Gemachten*, K. Schneider) (e.g. by others). "Being made" in schizophrenics can be feelings, perceptions, movements, moods, etc. The patients feel themselves like puppets. But also other phenomena of schizophrenics such as affects etc. and their whole personality can be ununderstandable.

K. Schneider reformulated Jasper's "theory of incomprehensibility" more precisely insofar as for him only the existence of a psychosis and the form of a psychotic experience, i.e. as hallucination or delusion, but not the contents of these are fundamentally incomprehensible. Müller-Suur made a further clarification in speaking of a "definite incomprehensibility" of schizophrenic experiences to delimit this from an undefined, vague incomprehensibility which can happen in ordinary life. With that the possibility is shown to determine positively the incomprehensibility of schizophrenics as we will see later on.

Blankenburg objected to Jasper's theory of incomprehensibility that in this case a subjective incapability, a not-being-able to understand is taken for a criterion of a diagnostics which claims to be objective. In

this context he points to the different notions of comprehending and comprehensibility. Incomprehensibility in this context does not mean that something is not understandable in principle, but signifies the «capability to make oneself intersubjectively understandable» (Blankenburg, p. 455). This does not signify that what somebody experiences, does or thinks could not be made understandable. To be good at understanding common sense is characteristic of the life-world and related to the intersubjectivity of somebody. The incomprehensibility of schizophrenics from this point of view consists in the incapability of schizophrenics to perceive what is understandable in itself, what goes without saying, what is obvious.

We (1994) have shown that the reason for the incapability to make oneself understandable can also be that the experiences as such of schizophrenics are of such kind that they cannot be explained by the language of every-day life, that they cannot be expressed by our ordinary language. This signifies that what the empathic diagnostician recognizes is not only something negative, an incomprehensibility, but positively another kind of being-in-the-world with certain basic structures of being, e.g. of temporality and spatiality, of being for oneself and for others, which appear modified. Thus the "definite incomprehensible" in the sense of Müller-Suur is a relatively definite form of being-in-the-world, which can be described and can in this way also be part of describable diagnostic assessments.

III. Melancholia

The ICD-10 lists only quantitative and no qualitative differences of depressive mood alteration in the frame of different affective and other psychiatric disturbances. Thus, the earlier diagnostic entity of melancholics can only be reconstructed by the co-occurrence of other symptoms like inhibition, loss of feeling of one's own worth, a somatic syndrome, etc. The DSM IV at least mentions a special quality of depressive mood alteration in melancholics, however, without defining it in detail.

In the case of a melancholic "mood" alteration the empathic diagnostician recognizes, different from other kinds of depression, particularly from sadness, an inaccessibility of this kind of "mood" with respect to its motivation. It appears to be strange, and it is difficult to take part in it. He perceives, not only like the glossaries presume, single symptoms such as mood alteration, inhibition, somatic symptoms, etc., but also a holistic alteration of the patient's relationship to himself and

to others, expressing itself more or less in all psychic acts. Whereas normally a certain common atmosphere and mood is constituted between the respective partners of an interaction, this is more or less impaired with a melancholic patient. However we behave to the patient and whatever we say to him mostly does not find the expected resonance. Inversely, it is difficult for us to react adequately to his “dejection”. Differently to a mourning person we experience a being-in-oneself (Griesinger, 1867) which separates him from us. He is incapable of taking a distance to himself, which among other things is the precondition for every self-control and thus also for the possibility of role-taking. We (1977) have spoken of an overidentification with one’s being with the expression of an “over-sincerity” (*gesteigerte Echtheit*). This over-identification is also shown by his being fixed thematically in his thinking as well as in his possibilities of experiencing. In his monotony of mood he lacks every possibility of a change of his internal attitude, or of his being in general. In his “inhibition to become” (*Werdenshemmung*) in the sense of von Gebsattel (1963), the melancholic has no relationship to future, not only in the sense of a prospection, but also of protention, that means an extension to the future (Janzarik). Future to him is just a prolongation of his present being, not a dimension of new possibilities of being. Whereas normally the past is seen in the light of future possibilities, intentions and wishes and therefore is changeable, the melancholic is unchangeably tied down to the past. A retardation and inhibition of all mental acts corresponds to this lacking relationship to future and to his attachment to the past. What is called an inhibition of drive is above all a disturbance of temporalisation from a phenomenological point of view.

A disturbance of spatialisation is concomitant with this disturbance of temporalisation. All distances between himself and the objects seem to be enlarged. To overcome them is particularly difficult to him. This concerns above all the distances of things and ways of his daily affairs. A fixed posture and restricted movements correspond to this alteration of spatialisation.

Not only his transcendence to the world but also to the concrete other is impeded. It is difficult for him to respond to the expectations, wishes and problems of others. His worrying about others contrasts to his complaints of loss of feeling and to his lacking empathy, which can be assessed objectively. Normally, feelings for others are connected with particular feelings for oneself. Therefore, with a loss of feelings for others a loss of self-feelings is concomitant in melancholics. Kaestner spoke of a general “loss of feeling for values”, an “endogenous extinction of values”.

If, in a first step of our empathic-intuitive diagnostics, we assessed a disconcerting being-in oneself in contact with the melancholic patient, in a second step this can be specified more exactly. With this being-in-oneself we have apparently neither to do with an ego-centricity in the usual meaning of the word, nor with an increased self-awareness. Characteristically the patient himself experiences an emptiness in himself. Already Freud saw this, when he wrote that in melancholia not like in mourning the world has become poor and empty but the ego itself. Moreover, the patient feels his mental state as forced on him, without the possibility of access to it, as an impediment of being himself in this kind of "mood" alteration.

All these empathic-intuitive observations and perceptions of the diagnostician do not allow us with melancholia merely to speak of an affective disturbance. If personhood is characterised by the presence of self-feelings, by the possibility of a free realization of the self and a turning towards the world and to others, by the capability of self-transcendence and therewith of a change of the self, then all these forementioned impairments may be such of personhood, i.e. a kind of hypo- or depersonalisation. Thus, the being-in-oneself of the melancholic is paradoxically without a being-oneself.

This melancholic depersonalisation has strictly to be differentiated from a neurotic depersonalisation as well as from a schizophrenic depersonalisation, the last one being characterised by K. Schneider as a loss of mineness, of one's own acts and states.

The being-in-the-world of schizophrenics and melancholic patients, inferred by empathic-intuitive acts of the diagnostician, is not only important as a diagnostic complement to a symptomatological-criteriological diagnostics, but is also of significance for the empathic guidance and psychotherapy of these patients.

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