To have a complete human science in the mental health field it is essential to give adequate attention to both the objective and the subjective data related to people with psychiatric disorders. The tendency in the past has been to ignore or discount one or the other of these data sources. Subjective data are particularly neglected, sometimes considered (only) part of the “art” of medicine since the usual methodologies of the physical sciences in themselves are not adequate to reflect the nature, elusive, and complexity of human subjective experience. The complete experience of hallucinated voices, for instance, often includes not only the voices themselves but also terrible anguish and terrifying inability to concentrate. But even such descriptors fall unnecessarily short of reflecting the data of the experience, thus leaving research, theory, and treatment with incomplete information. To represent adequately the subjective data it is essential to recognize that besides the usual discursive knowledge and methods of traditional physical science, a second kind of knowledge and method is required to reflect the depth of human experience. To accomplish this, we must employ approaches to narrative and the arts that are uniquely capable of capturing the nature of these experiences. Only by attending seriously in our research, training, theory, and practice to the unique nature of subjective data is it possible to have a true human science for our field.

Key words: subjectivity/severe psychiatric disorders/human science/discursive and experiential knowledge

This report will be somewhat different from what readers of Schizophrenia Bulletin will probably expect. The theme will be that there is a whole realm of “knowledge” about psychiatric disorders and human experience that is largely excluded from psychiatric theory and research and only sneaks into psychiatric practice and training under the somewhat dismissive label of “the art of psychiatry” or “the art of medicine.” This theme is actually part of a much larger issue that has been crucial in civilization over the centuries, at least since the struggles between Aristotle and some of his contemporaries, between attention to objective and subjective approaches to knowledge. In the 19th century, for instance, this struggle surfaced in the struggles between rationalism and romanticism. In this age-old struggle, there has always been a tendency for supporters of the approach in power to derogate the approach not in power. I will suggest in contrast that it is important not to choose between these two but rather to attempt to include both in our theories, research, practice, and training. So I will ask for your temporary “willing suspension of disbelief” in order to engage in this inquiry.

Even beginning with the title of this report, we confront a problem. The word “subjective” is actually an objectifying word, putting the topic at a respectful rationalist distance. Immediately, it impedes our entering our own experience into an effort to considering the possible roles of feelings such as hope, courage, or anguish—for instance, the role of intuition, or the role of determination and willpower; this latter, for instance, as reflected in the statement of one patient with schizophrenia, “I looked around me at the other patients on the ward and said to myself, ‘I can do better than this’ and so I started to pull myself together.”

Before we go further, one more caveat. Ever since Will Carpenter and I published our article using reliable methods to show that people with schizophrenia can improve,1 I have become all too familiar with certain common responses, the “we know it’s not possible (or is not important)” response and the “We knew it already” (or in some instances “we do it already”) response, even when the juxtaposition of these super negative and super positive statements revealed that they were mutually incompatible. In the discussion period following one presentation, for instance, one person in the audience said, “But we knew this (that people with schizophrenia can improve) already.” Directly after him, another said “Well this is impossible, we know that people with schizophrenia never improve.” I was tempted to suggest...
that the two holders of knowledge discuss this with each other, but my sense of decorum won out. So I beg you once again, just take a look at the following report and see what you think.

What is the aspect of subjectivity we will explore here? One example would be the feeling experience of a patient who hears voices or feels the Federal Bureau of Investigation (FBI) is after him. In our work in the International Pilot Study of Schizophrenia participating early on in the renewed trend in psychiatry toward operational definitions of signs, symptoms, and diagnostic categories, we developed questions of demonstrated reliability to be used in structured interviews to assess the objective aspects of subjectivity. In this report, I would like to focus on that other aspect, that is to give attention to what the feeling aspect of experience is like and the implications of that aspect of experience for our field.

I will start to try to clarify this difference between objective and experiential aspects of subjectivity by describing an example that does not come from the mental health domain. A while back, I was working on a project with a colleague who was going through a divorce. Because I try to be a generally nice guy, I understood I thought what that experience must be like and tried to take up the slack of some of the work in our project that he was supposed to be doing. At one point, however, the work became overwhelming and so I told him that I understood what he was going through and how difficult that must be, but he simply had to apply himself more to our project because it was getting dangerously behind schedule.

A few years later, I was going through a divorce of my own, and although it was a “civilized” process, I often felt totally overwhelmed by the degree to which it took me over, preoccupied me and all aspects of my life. I suddenly realized that I had previously had absolutely no idea of what my colleague must have been going through.

And now a mental health example of the difference between objective and experiential aspects of subjectivity. I have over the years carried out research interviews and treated literally hundreds of people who had the experience of hearing hallucinated voices. Once again, I felt I was very understanding and tried to act in ways that appreciated what I presumed were the difficulties of undergoing such an experience. Then several years ago, Carrie Clark, a good friend of mine, had made one of the earliest “auditory hallucinations” audiotapes and asked if I wanted to hear it. She and her colleague had created the tape by recording what they thought such hallucinations might be like and then getting critiques from several people with schizophrenia and modifying the tape accordingly. I put the tape player on my belt, the earphones in my ears, and started the tape. The voices were at first pretty ordinary, then they faded, then they stopped, then they came on again, and I found myself rapidly drawn into being totally preoccupied by them, “Would they start up? What was it they were saying?” Would they stop again? It was really bizarre. Carrie and I were supposed to go out to a movie that night, and she handed me a movie guide and told me to choose a movie. I was annoyed by her even talking to me and trying to take my attention away from the voices, but when I went to the movie guide to choose where we would go, I could not even find the list of movies, IN THE MOVIE GUIDE! It was an overwhelming experience. I realized, even from this benign experience, that I had previously had no idea of what someone who had auditory hallucinations might be going through. Some time later, when I was doing a repeat follow-along interview with a young man with schizophrenia who was in our study, he told me that yes he was hearing voices still, but he had decided to return to college nevertheless. My admiration for his courage was enormous, something I had never felt before in such an instance. Even though mine was the most tepid version of his experience, I had known of course the source of my voices and that I could turn them off at any time, the experience of listening to the tape had entirely changed my understanding of what he was going through.

You call that data?!

Before getting to the question of whether all these really are data and make any difference in how we understand and deal with these experiences and the people who are having them, I would like to suggest a framework for conceptualizing this kind of information. Gathering momentum in the early 19th century, with the rise of the scientific method, philosophers, especially on the European continent, began to explore the possibility that the study of human beings needed to include an approach to understanding subjective experience involving the scientific method but that did not limit itself to the dictates of that method as it was applied to inanimate objects.2–6

The ideas for accomplishing an expanded approach to science as it relates to the study of human beings that involves considering both the objective and the subjective aspects of experience have taken many paths, but I would like to adapt one, namely, the idea that it can be helpful in our field to hypothesize two kinds of knowledge, one that we could call discursive and the other that we could call experiential. The hypothesis adds that neither of these kinds of knowledge is reducible to the other. An example illustrating the need for such an hypothesis that I particularly love occurred several months ago when I was attending a play being given by the Yale Repertory Theater, “Notes from the Underground” an adaptation from Dostoevsky. The story is absolutely grim (although fascinating). There are two characters in the play, a rather sleazy self-pitying man and a young woman who has been sold into prostitution by her parents. After the play, there was a talk back session and during that time I asked the
two actors how they were able to be in such a grim play night after night. The man said, as I recall, that it was difficult at first, but as he went on, he got somewhat used to it. The actress, Merritt Janson, said, “Every night I think it may come out differently.” I loved that response because it was at once so stupid and so beautiful. It was of course “stupid” because they were doing the same play every night, saying the same lines. There was no way it could really “come out differently.” The reply was so beautiful because it was so human and so reflective of how we often feel and act as human beings. In this “stupid but beautiful” comment, as is so often the case, the communication of the experience aspect of subjectivity was accomplished by eliciting the feeling in others rather than by using the usual psychiatric feeling terms like depression or anxiety or confusion. Besides the paradoxical statement made by Merritt Janson, eliciting a feeling of an experience in another person can be accomplished by many means, by metaphor, or by a story. I have noticed, for instance, in master classes in the arts a famous pianist working with already advanced students will often say something like, “You like walking in the woods you said. When you play that section this time think of walking in the woods.” Rather than saying “play that D with your fourth finger” or “slow down during that passage,” the direction is to imagine an experience.

What kind of science is that????

You will perhaps have noticed that I am often reporting here first person accounts of my own experiences. What kind of science is that, you may be thinking, and I have often posed the same question to myself. (As one person from the audience said during the discussion period following one of my early presentations on this topic, “John, you used to do such good research.”) I will start by what I think is a major proposition: It is not good science to ignore data simply because you do not know how to measure them.

If the goal of science is to understand phenomena, “reality,” then method, including methodological limitations, cannot be the tail that wags the dog. It is not good science to ignore data wantonly, and people’s feeling experiences are in fact data. Now the problem with this way of looking at subjectivity and taking seriously the “experiential knowledge” is how to deal with it. I see one approach particularly in the arts, for instance, the piano master class where the famous pianist tells the already very skilled student, “When you play that section, this time, think of walking in the woods” or in an acting class where the teacher working with two students and a script tells the woman, “all right, now as you’re saying that, fix his collar” and as a result, lines that when they were spoken just a minute before were dead now leap to life. Or in the approach of a friend of mine in Paris, a young woman who works as a clown in palliative care wards. She embodies a clown that is more familiar in European culture (or in the United States someone like Charlie Chaplin), someone who relates to people’s hopes, fears, disappointments, and not the kind that juggles, or falls down in funny ways, etc. I was following her as she was working one afternoon. I was trying to look like I was just a relative of one of the patients, but in my mind, with my previous experiences as head of inpatient and outpatient units and head of a psychiatric hospital, I asked myself would I let this woman in her frilly dress, her red bulb nose, huge overly red lips, braids held out at right angles to her head by invisible wires, and MP3 player at her waist emitting (at low volume) bird calls, would I let this woman on my ward? I sadly answered to myself, “Probably not.” And yet, there she was relating to many patients and even to staff, in an area of human reality which traditional medicine rarely reaches. We published an article in a French journal in which she describes, for instance, going into the room of one woman and the woman responding instantly to the clown, the woman saying to my friend Sandra, “I heard the bells last night.” And Sandra replying, “What did they say?” And the woman saying “They asked if I was ready to come” And Sandra—“What did you tell them?” And the woman—“I told them I knew I had to come soon but that I wasn’t quite ready.”

I think we need to let these kinds of data into our field. One way to do that of course is by reducing them to objectivity using traditional scientific techniques. That is important but not sufficient. To capture the experiential aspect of subjective experiences, we need to borrow from our own experiences and the arts, especially the theater and literature, without reducing these experiences to numbers or categories.

But why bother?

There are many areas where getting a better feel for the nature and power of experience is important. In the area of a person’s activity on his or her own behalf, for instance, it is important for us to know what it is and how it feels for a person to have the sense of, “I knew I could do better than this so I decided to pull myself together.” In fact, in a follow-along study, we carried out to trace the course of disorder and a person’s life we noticed in reviewing our reliable ratings at many points over several years that actually no patients had a course that traced a straight line. Many of our subjects talked about their ups and downs, but it was not until later that we began to note that many talked about things not only like “I knew I could do better and decided to pull myself together” from their “Low Turning Point” but also in a decision like that following a psychotic episode when they felt they needed a period of rest (which we called Woodshedding) rather than working to improve in a linear fashion. Some people with severe mental illnesses report their actively seeking and finding things they can do that appear to make their symptoms better.
And, of course, for people with psychiatric problems (as for most of the rest of us), there is the major impact of the experience of their efficacy. It seems likely that people’s course of disorder and life is actually strongly influenced by their subjective feelings of what they need and what they can deal with.

There are other areas in which getting a better “feel” for the nature and power of subjectivity may be particularly important. I will focus here on two of these. The first is in grasping the sense of self of the person with the psychiatric problem and the predictability and sense of understanding of that self in the world. As they are becoming psychotic, people often describe the dissolution of that sense. The absolute creepiness of that dissolution is powerfully communicated in certain literature. Conrad has described the sense of dissolution and its evolution into psychosis objectively but the impact of this on the person comes across more clearly in an unfiltered report of the experience. One person I saw in a research interview described in a way that gave me chills how she had been more or less fine although very concerned about certain personal problems that seemed almost overwhelming. And then one dark evening as she was walking home from the bus stop after work she noticed that something strange and frightening was going on. She then noted that the lighted windows of apartment buildings seemed to form patterns, important patterns. The patterns were trying to tell her something, something life threatening, something dangerous. She then realized they were trying to tell her that she was being observed by the FBI. She did not know why they were doing it, but it must have been because something catastrophic was approaching, she must run, run fast to get home quickly. The next thing she knew, she was being taken by ambulance to a psychiatric ward.

The need to have a sense of self, a sense of security, a sense of understanding reality, and a certain amount of predictability and control in the world have certainly been a major need throughout human history. Sometimes this need seems to lead to the cultural acceptance of rather special beliefs. To think that someone could believe strange things as part of a cultural conceptual structure—for instance, that the sun was really Apollo driving a chariot through the skies—is testimony to the strength of this need and how people will develop certain beliefs to fulfill it.

Another area as an example of the subtlety and importance of experiential subjectivity in severe psychiatric disorder is that of relationships. To start with, I would like to suggest that we as professionals often badly underestimate the power and importance of this area and overestimate our ability to appreciate it. Several years ago, Larry Davidson and I were doing an extended workshop on schizophrenia at Madison Wisconsin. Madison is certainly one of the more sophisticated communities in the world on this topic, and in trying to decide what we might contribute, we decided to start the program out with a role-play where Larry would be the admitting doctor and I would be a person coming to the emergency room with psychotic symptoms. Having not discussed in more detail how we would conduct the interview, we began the program by explaining that we would do the role-play, and then, Larry started it by asking me what brought me to the hospital. I said I heard voices. He proceeded to go through what to me seemed like a mental checklist of all the “doctor questions” about voices: man or woman, what did they say, did they tell me to do things, when did I hear them, etc. In posing those questions, it was clear when I tried to explain to him what they were like that Larry was not really interested at all. I was a check sheet, not a person.

Larry and I have been close friends for many years, but about 2 minutes after the start of that interview, I hated him. And yet, it was clear that I had to be polite because I needed him for my medicines or other treatment. So I started to respond in monosyllables. Nevertheless, after a few more minutes, I could not take it any more so stopped the role-play, and we began discussing it with the audience. I tried to explain how furious I had become, and many people in the audience of professionals refused to believe I really meant it. Very strange.

Several years later, I was doing an extended program in Tromso at the north of Norway. In my experience with many professional visits to that country, I have been impressed with the mixture of expertise and humanity I see among the mental health professionals there. Two years earlier, on the island of Stockmarkness, I had done a role-play in front of a small group of about 20 students in psychology and psychiatry. I was being interviewed by a wonderful psychiatrist. We would stop the interview every few minutes to discuss what was going on, how it might have gone differently, etc. The program went very well. So 2 years later at Tromso with the same psychiatrist, we decided we would do another role-play, this time in front of a group of about 150 people, mostly mental health professionals, but with some consumers and consumer family members as well. We decided it would be a follow-up interview because we had already done an “intake interview” 2 years previously. As we began, he asked me how things had gone since we last met, and I said, they were better that I still heard the voices but they were not as disturbing. We discussed this a bit further and then he asked me if I had been working at all and I said I had a job at McDonalds, that it was not great but it was better than nothing. He began asking me about friends and family, and quickly, I did not feel like talking to him any more. That became a real problem and after a few more minutes, I stopped the role-play. It was embarrassing because there I was, the invited expert in front of a fairly large audience, and I did not feel like talking. We began to discuss the role-play and several in the...
In 2009, Rachel Alexandra was the first filly in 85 years to win the Preakness horse race. Following the race, her jockey, Calvin Borel, was asked if they had much trouble with her. He said, no, that she was a very nervous horse, but you know that horses are herd animals so she travels with her stablemate and she is fine. Now if they could notice that, why is it that we have so much trouble noting and learning about the experiential aspect of relationships in severe psychopathology? In the International Pilot Study of Schizophrenia we noted the importance of “poor rapport” in identifying people who received the diagnosis of schizophrenia, and clearly there is an extensive literature on social cognition. But beyond those objectifications, which are important but incomplete, why have we not made more progress with the subjective aspects of relating? Patients with schizophrenia who have improved, in being interviewed for longitudinal studies, often state the most important thing in their improvement was “someone who cared” or “someone who took me seriously” sometimes but not very often a mental health professional. In an ongoing research project (E. Flanagan, A. Johnson, L. A. Solomon, P. Ridgway, J. Strauss, L. Davidson, preparation), people with severe disorders often reported how isolated they felt and how difficult it was to get others to understand what they were going through. As one woman said:

The doctors don’t fully understand, they really don’t. A lot of people don’t fully understand. Number one, they think you’re crazy, you know, like a lot of people I talk to. And I’m not a crazy person, but it’s the point that we go through things that people can’t even fully imagine, you know. We can tell you certain things, but it’s almost like saying you’ve never been to prison. I can tell you about prison. I can tell you everything. But until you experience being in prison, it’s a whole different story. And that’s how it is with this sickness thing that we’re diagnosed with.

We are not herd animals like Rachel Alexandra, but our entire nature as human beings to say nothing of our survival as infants and children centers around how we learn and get sustenance from people around us and how dependent we are on that. One of the most feared punishments for adults is solitary confinement. It is even said to contribute to becoming “stir crazy.” The power and complexity of the subjective experiences in relating is so relatively poorly understood in our field.

And the implications for our field?

For theory, practice, research, and training in the mental health and illness domain, a better comprehension of the experiential aspects of subjectivity seems to be really crucial. In the area of training, for instance, the effort to help the trainee know the “rational” information in the field as required often carries with it the danger or even the impetus to stamp out the experiential and feeling aspects. Awareness of this problem can help lead to such practices as role-play where the person becoming the expert or even (or maybe especially) the expert takes the role of patient. I lead writing groups for people who work with persons who have severe psychiatric problems. These writing groups, “Writing Creatively about Clinical Experiences,” allow the expression and sharing of clinical and related subjective experiences among people who work with and or study persons with severe psychiatric disorder. This helps to validate these experiences, to draw attention to them, to hold them up to be noticed, reacted to, and further understood. There is much to be learned also by such experiences as listening to audiotapes of “hallucinated” voices so that whether one is trainee, expert, investigator or administrator, one gets at least a small bit of experiential knowledge about how the problem we deal with actually feels. One of my best learning experiences was working during the summer after my first year of medical school as an aide on a psychiatric ward, spending all day with patients, not allowed to read their charts, and having minimal power. All these means and others yet
to be discovered can be used to generate more subjectively sophisticated research, practice, training, and theory.

Our field, perhaps because it has struggled to be accepted in the rest of medicine and perhaps because it wants so much to be a real science, has had a major problem accepting the power and subtleties of the subjective experiential data that are all around us. This problem has been increased by the difficulty in making a meaningful link between consciousness and biological neuroscience and bridging the “explanatory gap” explaining the causal links between mental and physical events.23–25 Rational explanations and the objective data are highly valued, as they should be. Important efforts toward integration of biological and experiential data are highly valued, as they are appreciated by the mental health field to be a true human science.

For theory, practice, research, and training, a better comprehension of the experiential aspects of subjectivity is essential for the mental health field to be a true human science.

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