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Typifications The First Step for Clinical Diagnosis in Psychiatry

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Reigning views on psychiatric nosology regard as "too subjective" certain features of diagnosis which respected psychiatrists have reported and several empirical studies have confirmed. We describe two of these persistent "mysteries" of psychiatric nosology: rapid diagnoses and the praecox feeling. We then demystify these mysteries by explicating the workings of "typification" in the diagnostic process. The criteria of disorders which are provided by classification manuals, such as DSM-III, are shown to presuppose such typifications. Psychiatric typification, although a preconceptual skill, can be rendered fully scientific and objective.

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In recent years we have witnessed a remarkable resurgence of interest in psychiatric diagnosis and classification. Only two decades ago psychiatrists were seriously discussing Menninger's recommendation that classification systems be abandoned altogether and that psychiatric diagnoses by replaced by formulations (Menninger, 1963). Now, following the successful reception of DSM-III (American Psychiatric Association, 1980) and in anticipation of preparations for DSM-111R and ICD-10, the methodological, theoretical, and practical issues involved in nosology are being probed and debated by psychiatrists of different persuasions and viewpoints (Freedman, 1984; Mc- Hugh and Slavney, 1983; Kendell, 1984; Klerman *et at.*, 1984; Spitzer *et at.*, 1983).

Such a change reflects a growing concern for the scientific stature of psychiatry. In the 1950s and 1960s, criticisms of psychiatry as a science, such as those of Szasz (1961) and Laing (1968), were augmented by discouraging findings from investigations into the reliability of psychiatric diagnoses (Beck, 1962; Katz *et at.*, 1968; Zubin, 1967, 1968). This crisis in psychiatry was worldwide. Thus a report to the World Health Organization in 1959 concluded that the attitude of psychiatrists toward conventional classificatory schemata had become "one of ambivalence, if not cynicism" (Stengel, 1959, p. 602), and that there was "almost general dissatisfaction with the state of psychiatric classification, national and international" (Stengel, 1959, p. 604).

Major contributions toward psychiatric nosology during the past two decades, such as DSM -111 and Kendell's *The Role of Diagnosis in Psychiatry* (Kendell, 1975), have been informed by concerns for securing and advancing the scientific stature of psychiatry. A consensus seems to have emerged that diagnostic classificatory systems should emphasize descriptions, remain initially atheoretical with respect to etiology, operationalize terminology, and attain high levels of reliability.

In an earlier essay we attempted to disclose the influence of a particular philosophy of science, namely, logical empiricism as represented by Carl G. Hempel, on this process (Schwartz and Wiggins, 1986). The present essay provides a sequel to this earlier one. Here we shall argue that explicitly defined categories and classificatory criteria, if they are to lead to reliable diagnoses, presuppose a more fundamental way of apprehending mental disorders. Classificatory schemes are fully meaningful and useful only to someone who can already identify and distinguish mental disorders in this more fundamental manner. This way of apprehending disorders we shall call "typification." The present article is devoted to explaining what typification is and how it operates in psychiatric diagnoses. We shall contend that the ability of the experienced psychiatrist to typify patients in a preconceptual manner is a fundamental aspect of actual skilled practice.

We shall approach this issue of typification by first discussing some "mysteries" of psychiatric diagnosis. By mysteries we mean certain constituents of diagnosis which seem to remain too subjective to playa viable role in a truly *scientific* psychiatry. But despite their apparently subjective status, the presence of these components in the process of diagnosis has been both empirically established through extensive testing and reported by many highly respected psychiatrists. We shall then introduce and discuss typifications as a way of explaining what is really at work in these persistent mysteries. When we show how the use of typifications in diagnosis can become truly scientific, we shall be able to demystify these apparent mysteries.

In a subsequent essay we shall show how typifications form the basis for those explicit definitions of criteria and categories that compose classifications. In that essay, however, we shall provide an alternative to the presently reigning view of psychiatric classifications, which, we have maintained, remains influenced by logical empiricism. This alternative approach to classifications we shall call "ideal types," following its originator, the sociologist Max Weber (1949). Weber's influence on Jaspers' *General Psychopathology* (Jaspers, 1963) will be demonstrated. Hence we shall

then develop and defend a Weberian-Jaspersian approach to psychiatric classification.

Some Mysteries of Psychiatric Diagnosis

It is not only the critics and opponents of psychiatric diagnosis who have recognized certain unexplainable and troubling features of it. Even firm defenders of diagnosis in psychiatry have pointed to diverse constituents of it which are difficult to justify in scientific terms. Gauron, Dickinson, Kendell, and other researchers have noted the rapidity with which diagnoses are made (Cooper, 1983; Gauron and Dickinson, 1966, 1969; Kendell, 1975, 1983; Sandifer *et al.*, 1970). Riimke (Riimke 1942, 1959) has described a "praecox feeling" that he deems essential to the diagnosis of schizophrenia. But whereas many of these researchers are concerned - if not worried - about these apparently unscientific components of diagnosis, they do not offer us any definite means for surmounting them. This omission, of course, leaves the door open for critics of psychiatry, such as Scheff (1966, 1974) and Laing (1985), to cite these mysterious components of diagnosis as evidence for its dubious and even dangerous nature.

These two mysteries of psychiatric diagnosis seem to us to rotate around a common center: the suspicion that diagnoses are too subjective. Diagnoses are too subjective because they seem to depend too heavily' upon *characteristics of the examining psychiatrist* and not sufficiently on the characteristics of the patient examined. Dissolving such mysteries, then, would require that we establish the *objectivity* of psychiatric diagnoses. And objectivity would appear to lie in assuring that diagnoses be firmly based upon *characteristics of the patient.*

After examining the rapidity of diagnoses and the praecox feeling, we shall describe a hitherto unnoticed component of this process - a component we shall call "typification" - which allows us to account methodologically for these mysterious procedures. In addition, we shall contend that typification, if used correctly, guarantees the objective and scientific status of psychiatric diagnosis.

First Mystery: Rapidity of Psychiatric Diagnoses

Gauron and Dickinson (1966, 1969) have maintained that the psychiatrists they studied often formed quite definite diagnostic impressions within the first minutes of an interview. In fact, Gauron and Dickinson pointed out that these impressions are very often formed within the first 30 to 60 seconds. Sandifer *et at.* (1970) produced similar findings. They showed that after 3 minutes of film viewing, psychiatrists arrived at a diagnosis which in three of four cases remained the same as their final diagnosis. Kendell (1975) has confirmed these results. He examined diagnoses made by an audience after 2 minutes and then after 5 minutes of watching 5-minute videotaped interviews of hospitalized patients. Such quick diagnoses showed an extremely high correlation with final diagnoses made by the patients' own doctors after complete courses of evaluation and treatment. Kendell concluded from his experiment that "it is clear that most of the diagnostically important information in a clinical interview is available in the first few minutes and that a high proportion of diagnoses are, or can be, made correctly at that stage" (Kendell, 1975, pp. 56-57).

Some of these same studies also demonstrated that in arriving at diagnoses, psychiatrists use criteria different from those which they believed themselves to be using. And, moreover, psychiatrists may not be aware of which items of information are crucial for them in making their diagnoses (Gauron and Dickinson, 1966, p. 205).

Second Mystery: The Praecox Feeling in the Diagnosis of Schizophrenia

In 1941, Rümke maintained that the praecox feeling was essential to diagnosing genuine schizophrenia. Upon encountering a schizophrenic person-"often at a glance"-the experienced psychiatrist may have the "feeling" that this person is schizophrenic (Rümke, 1942, p. 168). Rümke himself suggested subsequently that this be called the praecox experience rather than praecox feeling "for it is not truly a feeling" (Rümke, 1959, p. 305). Writing in an era when psychiatric nosology was strongly opposed, Rümke was one of its more assertive proponents. Rümke maintained, however, that the symptomatology upon which diagnoses of schizophrenia were based must include the praecox feeling of the psychiatrist.

Rümke reasoned as follows: The symptoms themselves are not a reliable basis for diagnosis unless the psychiatrist can also claim that they are "schizophrenic" symptoms. And the psychiatrist acquires this realization that the symptoms are schizophrenic through the praecox feeling. The reasoning here appears to move in a circle. It seems that a psychiatrist must first know that the symptoms are schizophrenic in order to know that they are symptoms upon which he or she can base a diagnosis of schizophrenia. The appearance of circularity vanishes, however, when we recognize that the schizophrenic quality of the symptoms is an observable quality that the experienced psychiatrist directly *sees* when he or she directly sees the symptoms themselves. As Riimke expressed this same idea:

> Even if we are unable to describe accurately what we observe, all the same we do observe something! Not infrequently we base a diagnosis on something we observe positively, but cannot communicate in words to others. We cannot "word" or "verbalize" it (Rümke, 1959, p. 303).

Furthermore,

> ...every examiner with great experience of "genuine schizophrenia" knows very precisely what this word "schizophrenic" refers to. But again he cannot put it into words or verbalize it (Riimke, 1959, p. 304).

Although he stressed his conviction that this experience cannot be adequately verbalized - he even termed it "indefinable" (Rümke, 1942, p. 168) - Rümke tried, nonetheless, to describe it as well as he could. He characterized it as the psychiatrist's "inability to empathize" with the patient (Rümke, 1942, p. 168). This inability to empathize with the patient does not mean simply that the doctor cannot empathize with the patient's *emotions.* It signifies, rather, an inability to enter into contact with the patient's *personality* as *a whole.* Rümke maintained that this inability to enter into contact with schizophrenic patients arises from the fact that such patients in a basic way cannot "draw near" another person.

Rümke recognized the possible danger involved in using the praecox feeling as a criterion for diagnosis. He noted that this inability to empathize with a patient might arise from a shortcoming *in the physician* rather than from some lack in the patient. Consequently, the psychiatrist who uses the praecox feeling for diagnosis must be sure first that this incapacity issues from some deficit in the patient. It is the patient and not the physician who must lack the basic capacity to "draw near" another person (Rümke, 1942, p. 169).

More than a decade before Rümke's publications, Jaspers had already suggested that a failure of empathy and understanding (*Verstehen)* is the common element in diagnosing schizophrenia (Jaspers, 1963, p. 581). Jaspers himself called this failure of empathy an experience of "the un-understandable" (Jaspers, 1963, p. 581). He described the physician's encounter with the schizophrenic as follows:

> We have intuitions of a whole which we call schizophrenia but we do not grasp it; instead we enumerate a vast number of particulars or simply say "un-understandable" while each of us only "comprehends" the whole from his own new experience of actual contact with such patients (Jaspers, 1963, pp. 581-582).

Following Jaspers, Schneider (1925) also maintained that a lack of personal rapport felt by the psychiatrist for his or her schizophrenic patient is one of the most reliable diagnostic symptoms (Slater and Roth, 1969, p. 315). In 1973, an empirical study by Carpenter *et al.* (1973) using data from the International Pilot Study of Schizophrenia strongly supported this assertion. Of a list of several hundred possible items, the physician's judgment that a patient is incapable of good rapport was the second most reliable discriminator of schizophrenia (reliability = .86).

In a review chapter concerning schizophrenia in the *Comprehensive Textbook of Psychiatry-II,* Lehmann cited a study in which 54% of 1000 psychiatrists affirmed that the praecox feeling was a reliable criterion for making a diagnosis of schizophrenia (1975, p. 913). For Lehmann, these findings indicated the acceptability of the praecox feeling in the diagnostic process. Yet he also warned, "At this stage of knowledge, it appears to be unwise to substitute a single subjective approach for a whole range of other, traditional clinical skills" (1975, p. 913). Lehmann preferred using multiple criteria in diagnosis (1975, pp. 913-914). And indeed, recent approaches to diagnosis and classification, such as DSM -III, do use multiple criteria. But the praecox feeling is omitted altogether because it is considered so vague and subjective. And, as we shall show later, the eminent philosopher of science, Carl G. Hempel, has singled out the praecox feeling as irremediably unscientific.

Criticism of the Rapidity of Diagnoses

Laing has derived extreme consequences from the rapidity of diagnoses:

> On the basis of possibly less than five minutes from the first laying on of eyes on a stranger, without that stranger perhaps ever having moved or said anything (so: he is either malingering, or he is a mute catatonic schizophrenic), a psychiatrist in any developed country can sign a printed form or make a phone call. This will be enough for that person to be taken away, imprisoned and observed indefinitely (1985, p. 14).

Although its terms appear to be exaggerated, Laing's concern does force upon us the question of the justifiable uses of diagnoses which can occur so quickly.

Criticism of the Praecox Feeling in Diagnosis

The role of the praecox feeling in diagnosing schizophrenia has been criticized by the prominent philosopher of science, Carl G. Hempel.

Hempel asserts-quite rightly, we think-that:

> Science aims at knowledge that is objective in the sense of being intersubjectively certifiable, independently of individual opinion or preference, on the basis of data obtainable by suitable experiments or observations (1965, p. 141).

On these methodological grounds Hempel rejects the occurrence of the praecox feeling in the physician as one indication of schizophrenia in the patient he or she is examining. Hempel's objection is this: "the occurrence of the specified outcome, the praecox-feeling in regard to a given patient, is not independent of the examiner" (1965, p. 142). Hempel seems to us to be arguing that the praecox feeling is simply a feeling the examiner has. If it is merely a feeling, there is no way to guarantee that other examiners, when confronted with the same data, would have the same feeling. A mere feeling cannot function as a basis for reaching an intersubjectively certifiable judgment.

We would agree with Hempel that a mere feeling cannot serve as a basis for a diagnosis. An experience on the part of a psychiatrist must be based upon observable or understandable data in order for that experience to playa legitimate role in diagnosis. And the data which give rise to the experience must be intersubjectively certifiable in the sense of being experienceable by other examiners, independently of individual opinion or preference. Rümke was fully cognizant of this scientific requirement. That is why he struggled to characterize the signs and symptoms in the patient which gave rise to the praecox feeling. He focused on the patient's inability to draw near other people, but he also considered several other signs and symptoms as related to this feeling (Rümke, 1942). Furthermore, Jaspers' suggestion that the lack of personal rapport with a patient arises from what is un-understandable in the patient's behavior provides an additional attempt to specify the empirical givens which produce the feeling.

We, too, think that the praecox feeling must be studied far more carefully in order to determine the basis for it. This basis, we suspect, will be found in data emerging from investigations - now only in their beginnings - into the subtleties of interpersonal communication, such as facial expressions, gestures, vocal styles and intonations, patterns of eye contact, and body language (Wolfgang, 1984). And it remains possible, of course, that there is no basis. If there is none, then Hempel's objection stands. But the study by Carpenter *et at.* (1973) indicates that poor rapport with a patient is a highly reliable *(i.e.*, intersubjectively certifiable) basis for diagnosing schizophrenia, "independently of individual opinion or preference." Yet the methodological perplexity that Hempel raises persists: even if we know that *as a matter of fact,* poor rapport displays high inter-rater reliability in the diagnosis of schizophrenia, we must still explain *why* it provides, if it does, an objective justification for such diagnoses.

Laing has most harshly criticized this absence of rapport as a basis for diagnosis. He wrote:

> The attribution to the other (person) of an incapacity to form a human bond was and is the basis for the diagnosis of schizophrenia. Both this attribution and the causal theory to account for it are crushed into the diagnosis. He or she is cut off (schizophrenic in a descriptive sense) and this is so because he or she is suffering from a mental illness, namely, schizophrenia in the causal sense.
>
> In my first book, *The Divided Self,* I tried to show the situation here. The attribution (the patient is autistic) is made by a person, in the role of diagnosing psychiatrist, about a person, in the role of patient-to-be-diagnosed. It is made across a gulf between them. The sense of a human bond with that patient may well be absent in the psychiatrist who diagnoses the patient as incapable of any such bond with anyone. Many psychiatrists have become very angry with me for pointing this out (1985, p. 8).

Laing was arguing as follows: As a matter of fact, psychiatrists find it impossible to form a human bond with certain patients. Now, in principle, this incapacity could issue from two different sources. It might arise, for instance, from the fact that the psychiatrist cannot, in general, form human bonds with other people. But the psychiatrist does not consider this alternative. Rather, the psychiatrist merely assumes that he or she cannot form a bond with this patient because the. patient suffers from schizophrenia. Laing contends, however, that the inability to form a human bond may

characterize the psychiatrist rather than the patient. If this incapacity is to serve as an objective criterion for diagnosis, we must be able to locate it within the patient rather than within the psychiatrist.

As we have seen, however, Rümke - more than 15 years before the publication of *The Divided Self (*Laing, 1960) - was already well aware of the kind of problem Laing mentioned. Rümke (1942) had warned that the physician may have the praecox feeling simply because he or she has an overly restricted or narrow capacity to draw near other people or because he or she has little knowledge of the wide scope of what is possible in empathizing with other people. Yet Laing would seem to be right to this extent: if this inability to form a human bond can reside either within the psychiatrist or within the patient, then we must secure some methodological means for determining just whose inability it is.

Toward the Demystification of the Mysteries of Diagnosis

Rapidity of diagnosis and the praecox feeling *appear* to be mysteries in psychiatric diagnosis. This is so, we submit, because they issue from a fundamental and necessary constituent of diagnosis which no one has yet described or even noticed. This essential constituent we call typification (Husserl, 1973; Schutz, 1962, 1966). When the workings of typification in the diagnostic process are elucidated, the above-mentioned mysteries of the process are stripped of their mystery. Not only do these mysteries disappear, but, moreover, the truly *objective* and *scientific* status of psychiatric diagnosis can be explained and justified.

Direct Observation and the Origins of Typifications

Textbooks and manuals such as DSM-III and ICD- 9 provide classificatory categories which have been explicitly articulated and defined. These explicit categories and criteria, we shall contend, presuppose typifications. Without the more basic capacity to typify, psychiatrists could never understand or apply the general categories and criteria of diagnosis. This more fundamental capacity to recognize various mental disorders arises, not through mastering conceptual definitions, but rather through directly encountering individual patients who manifest these disorders. Through such direct encounters we learn the typical forms of the various mental disorders. We learn what is distinctive to each condition and how to distinguish these conditions from one another.

An Example of Typifications in Everyday Life

We shall try to show how the intelligibility of definitions presupposes this more fundamental capacity to recognize and distinguish objects when they are directly given. Our example will be a nonmedical one. This use of a non psychiatric illustration will serve our purpose of demonstrating how typification pervades *all* of our experience. The workings of typification in psychiatry can then be viewed as a special case of a more general component of human awareness.

Suppose our friend, Pow, has just arrived in the United States from his native land, a land which remains non-Western and unmodern. In Pow's country no motorized vehicles exist. Now suppose that we must explain to Pow what buses are and how one rides them. Pow will in all likelihood have an extremely difficult time understanding us correctly because whatever we say he will interpret in the light of what he himself has directly experienced in his own society. In other words, he will understand a bus to resemble some means of transportation he has known in his native culture. Beyond these conveyances with which he is already familiar, he will acquire from us - no matter how thoroughly we describe buses - only a vague notion of what a bus is. If, however, Pow *directly sees* a bus or two, matters will be different. His ability to recognize buses will improve even more when he directly perceives a few trucks and realizes that trucks do not look exactly like buses. Moreover, Pow will know how to ride a bus only after he himself has fumbled his way through a bus ride or two. It is *his* own direct observation and experience that will teach Pow how to recognize and use buses, not our verbal descriptions and instructions.

Direct experience and action therefore play crucial roles in learning the meanings of categories and criteria. It is impossible, accordingly, for clinical psychiatrists to master the meaning of classificatory terms by simply studying *the verbal definitions* of these terms. In addition to studying these conceptual formulations, psychiatrists *must* actually observe and work with patients who exemplify these disorders in order to come to know what schizophrenia, major affective disorder, histrionic personality, and so forth, are. "Hands on" work with patients provides a detailed and precise understanding of disorders without which psychiatrists would never comprehend what their basic terms mean (Husserl, 1973).

The biologist and philosopher of science, Michael Polanyi, has also maintained that physicians acquire the ability to recognize symptoms only through actually dealing with patients. Polanyi asserts that reference to a checklist of symptoms is useless in diagnosis unless the doctor has already learned, through his or her own direct experience with patients, how to identify these symptoms. Polanyi writes:

> Unless a doctor can recognize certain symptoms, *e.g.*, the accentuation of the second sound of the pulmonary artery, there is no use in his reading the description of syndromes of which this symptom forms a part. He must personally know that symptom and he can learn this only by repeatedly being given cases for auscultation in which the symptom is authoritatively known to be present, side by side with other cases in which it is authoritatively known to be absent, until he has fully realized the difference between them and can demonstrate his knowledge practically to the satisfaction of an expert (1964, pp. 54-55).

Essential Features of Typifications

In what does this basic ability to recognize and distinguish mental disorders consist? It consists in what Schutz (1962, 1966), following Husserl (1973), has termed "typifications." The psychiatrist who has acquired this capacity will be able to recognize - relatively quickly and accurately - certain features of a new patient's behavior as typical of a particular kind of condition. After encountering only a few aspects of the patient's behavior, the doctor will already anticipate other typical aspects.

Schutz (1962) has shown how typifications pervade all of our ordinary experience of other people and objects. As we walk into a room for the first time, we immediately typify the room as a living room and already typify the objects in it as chairs, lamps, tables, and so forth. Or, consider another example from everyday life: As we stand outside our house, we see a man across the street holding a very young girl in his arms and speaking with a slightly older boy. We typify the man as the new neighbor whom we have not met and also as the father of the two children. Accordingly, we typify the children as his daughter and son. These typifications then inform our conversation with him as we proceed to welcome him to the neighborhood (Schutz, 1966).

Human personalities can also be typified. On the basis of facial expression, posture, gesture, vocal intonation, and other features of language and "body language" - or even dress, handwriting, and other personal accoutrements - we typify people as angry, sad, excited or excitable, irritated or irritable, timid, meditative, and so forth. Note that momentary personal states as well as enduring personal traits can be typified.

Norwood Russell Hanson, a well-known Wittgensteinian philosopher of science, has pointed out that most of our seeing is a *seeing as* We see the man standing across the street as the father of the two children. We see the young boy as his son and the girl as his daughter. We see the red-faced man who is wildly shaking his fists and shouting as angry. Hence acts of perception are *interpretive.* But Hanson argues strenuously that the interpretation is not an additional act superimposed on a perceptual act. The interpretation is rather there in the seeing. Seeing is not *mediated by* an additional act of interpretation. Seeing is rather an *immediate* seeing as. ..(1965, pp. 19-21).

We have claimed that this capacity to typify people and things must be acquired. And we have also stressed the fact that it is acquired through directly observing and dealing with the objects so typified. Once a typification has been acquired, however, it assumes the form of a skill. We take our characterization of a skill from Polanyi:

> ...the aim of a skillful performance is achieved by the observance of a set of rules which are not known as such to the person following them (1964, p. 49).

People are able to typify objects without knowing exactly *how* they typify them: people have little or no cognizance of the rules which they themselves are applying when they typify things. When we enter a room and typify it as a living room, we do not know which visual cues we are using in typifying the room in this manner. Indeed, if we tried to point to these cues, we would experience some difficulty in describing how they differ significantly from the cues by which we would typify another area as a family room or den. With regard to some objects, of course, it remains relatively easy to specify-if we should be called upon to do so - the properties by which we recognize them. But regarding others, the features that distinguish them from similar things are not at all obvious to us.

Furthermore, if typifications are skills which must be acquired, some typifications may be acquired fully, adequately, poorly, or not at all. The mastery of a skill, in other words, is always a matter of degree. It should not be surprising, then, to notice that some people exercise much more skill in typifying objects than other people do.

Typification Is Not Conceptualization

Typification is a skill, and skills are characterized by the fact that in performing them we remain unaware of the rules we are following. This ignorance of the rules we are using in typifying objects indicates that typification differs from conceptualization; in order to conceive of an object as instantiating a concept, we must be able to specify those features of the object which make it a member of this class.

The examples of typification cited above show that typification is not conceptualization. When we walk into a room for the first time, we need not explicitly enumerate the list of attributes which define the concept of living room and then compare this list with what we see in order for us to see this room as a living room. Typifications do not require explicit acts of thought; rather, they structure our immediate experience in implicit and automatic ways. In his characteristically lively manner, Hanson has pointed to this nonconceptual component of perception:

> We do not ask "What's that?" of every passing bicycle. The knowledge is there in the seeing and not an adjunct of it. ...We rarely catch ourselves tacking knowledge on to what meets the eye (1965, p. 22).

There are cases, of course, in which we encounter objects and persons that we cannot immediately identify. In such cases we may have to stop and think before we can categorize them with some confidence. Suppose, for example, that we see the man standing across the street holding a young girl and speaking with a boy. Now, we may not immediately typify him as our new neighbor. To use Hanson's terminology, we may not immediately see him as our new neighbor. We may simply perceive him as a man. And suppose that, because he is unfamiliar to us, we now begin to wonder who he may be. Suppose, additionally, that after a little thought it occurs to us that he is our new neighbor. It should be noted that even before we began to wonder who he was we already typified him as a man and the other people with him as a young girl and boy. Our seeing, therefore, was already *interpretive.* Accordingly, our ability to stop and think, *i.e.,* our ability to conceive of certain alternatives and possibilities, presupposes that more fundamental typifications have already been made and that these typifications delimit the alternatives and possibilities of which we then conceive. We do not, for instance, conceive of the possibility that he is a new tree which the township in its Neighborhood Beautification Project has just planted along the sidewalk. And we do not conceive of this possibility because we already typify him as a human being. Typifications predelineate the range of conceivable alternatives and possibilities. They thus rule out from the beginning certain alternatives as impossible or inconceivable. Typifications operate below the level of explicit conceptualization, and they prestructure the experiential field within which such conceptualization can occur (Husserl, 1973; Schutz, 1966).

Typifications Prestructure the Field of Our Experience

Typifications thus structure and organize the *field* of our experience. Whenever we focus on some particular entity as unfamiliar or unrecognizable, this focusing occurs within a field of items which are already familiar and known to us. If, while driving a car, we come to suspect that we are going in the wrong direction down a one-way street, we can have such suspicions only because we already typify the objects around us as automobiles, streets, road markers, and pedestrians. Typifications bestow a meaningful structure on the surrounding field within which we can then ask whatever questions we decide to ask. Furthermore, they need not be thematized. They may simply provide the unthematized - but already meaningful - context within which we choose to thematize other items (Husserl, 1973; Polanyi, 1964, pp. 55-65).

Of course, we could at any time transform a typification into a theme for conceptualization. Although we immediately typify the room into which we have entered as a living room, we could also focus on this meaning which the room already has for us and explicitly conceive it as a living room. We wish, however, to stress the fact that the concept may never succeed in formulating adequately what is perceived in the typification. To revert to the example of our foreign friend, Pow, the concept of a bus makes sense to Pow only because he is now able to recognize a bus on sight. What Pow sees when he looks at a bus can be only incompletely expressed in the concept. Thus Rümke can claim that what the skilled psychiatrist sees when he or she confronts a schizophrenic patient remains indefinable (Rümke, 1942, p. 168). When Rümke then seeks to define this phenomenal datum, his definition makes adequate sense to him and his readers only if he and they can see it.

A **General Characterization of Typification**

We can now provide a comprehensive description of typification. Through typifications we immediately recognize individuals as exemplifying certain general types with which we are already familiar. Because typifications

occur relatively quickly, they occur on the basis of little evidence. Yet typifications set up certain expectations in us. When we typify an individual as being a certain sort of person, we expect the individual to behave in certain predelineated ways. We expect the person's subsequent behavior, in other words, to conform to type (Schutz, 1962). It remains possible, of course, that the person will behave in ways that conflict with and thus negate our typification. We learn in such cases that we were mistaken to typify the person in that manner. Because typification always predelineates more aspects of a person's behavior than we have directly observed thus far, those other aspects of behavior, when they do achieve direct givenness, could always fall outside of and thus cancel our typification (Husserl, 1973). As Hanson has written:

> Seeing an object X is to see that it may behave in the ways we know Xs do behave: if the object's behavior does not accord with what we expect of Xs we may be blocked from seeing it as a straightforward X any longer (1965, p.22).

Nothing, therefore, protects typifications from error. Yet errors in typification can be corrected in the ways in which all mistaken assumptions can be corrected: through additional direct givens that run counter to them.

Typifications arise through the direct givenness of objects. Those features of things that are directly given to us become meaningful by predelineating other not-yet-given features of the same things. As we approach a building from the outside, we may typify it, because of the structure of its exterior, as a private residence. Thus on the basis of what is presented to us by the outside of the building, we already expect to encounter, upon entering it, rooms typical of private homes. Those features of the exterior of the building which we directly perceive lead us to expect that the not-yet- seen interior of the house will have certain familiar features (Hanson, 1965, pp. 19-24; Husserl, 1973).

As we enter the house and directly observe those features of it which we previously only anticipated, our typifications usually grow more specific and definite. When we walk into the building, we see that it is not merely a private home but that its furnishings are extremely contemporary. Through this transformation of the merely anticipated into the directly given, our typification takes on a more precise and determinate sense. The gradual unfolding of the various features of an object render our typification less vague and general and more definite and specific (Husserl, 1973).

With regard to human beings, *communication* plays a crucial role in this delimiting and specification of typifications. When we first see a woman across the room, her outward appearance already leads us to typify her in a general way. But this visual appearance usually furnishes few features to guide more specific and determinate typifications. Yet as we begin to interact and speak with her, we shall progessively acquire a more definite understanding of who she is. It is through such communication that we encounter those features of other people that motivate more specific and definite typifications.

The typifications which one applies depend upon the activity in which one is involved or the purposes one has (Schutz, 1962). One normally typifies the objects arranged on one's study shelves as books to be read. But when a strong breeze unexpectedly blows through the study, one may typify the same objects as mere heavy things which can function as weights for holding loose papers in place. Typifications, in general terms, are situation-tied or project-determined. If we are walking down the sidewalk on our way to work, we may typify the other pedestrians merely as other people. But if we see someone suddenly fall ill, we may look around and immediately typify one of these people, namely, a woman wearing a white coat, as a doctor.

Typifications are one-sided. One set of typifications will give us access to only certain features of things and people. A different set of typifications will have to be applied in order to gain access to other features of the same things and persons. No single group of typifications, in other words, can allow us to grasp *all* aspects of an object or person. We may say, then, that typifications provide only a perspectival apprehension of realities.

From Prescientific to Scientific Typifications

What we have said thus far applies to all kinds of typifications. If we are to appreciate the peculiarities of psychiatric typifications, however, we must distinguish them from everyday or prescientific ones (Schwartz and Wiggins, 1985). As Schutz (1962) again has shown, in our everyday experience of people and things we usually typify them in a *taken for granted* manner. When we decide to pay for our groceries in the supermarket, there is usually not much question in our minds that the person standing behind the counter and near the cash register is the person whom we need to pay. We simply take it for granted that that person, standing in a place typical of cashiers, is a cashier. In our ordinary, prescientific experience we thus typify things with what Husserl (1973, pp. 120- 129) has called a "simple certainty."

By simple certainty Husserl means a certainty of belief that occurs before any questioning or doubt. As we have indicated, this certainty can prove to be mistaken. When the o1ject fails to conform to type, our simple certainty changes into uncertainty and doubt. But such changes of belief are always privations of simple certainty. In everyday life we simply assume without question that our typifications are accurate. This assumption without question is an assumption until further notice, *i.e.,* until something is given which leads us to doubt it (Schutz, 1962).

The scientific attitude is in part distinguished from the prescientific attitude insofar as the scientist does not typify things in this taken for granted manner. Scientific work requires what Husserl (1970, pp. 120- 129) has called "a critical attitude." By critical attitude Husserl means an attitude toward things and people in which we vigilantly doubt or question the meaning they appear to have. In our prescientific attitude we may simply assume, as we step out of the house, that the weather threatens to be damp and rainy. But if we adopt a scientific attitude, we begin to question or interrogate the apparent indications of this kind of weather. We ask, What in particular indicates that rain is imminent? Are these signs of rainy weather reliable signs? What else, besides rain, could these events indicate? Note that the issue remains the raininess of the weather and that only our attitudes toward this raininess have changed. In our prescientific experience we simply took it for granted. If we adopt the critical attitude of a scientist, however, we doubt and question this raininess. The change in attitude is a change toward the appearance of raininess. In prescientific experience we accept appearances at their face value. In everyday experience no distinction is made between appearance and reality until something proves to be merely an appearance and not a reality.

In scientific experience, on the other hand, objects are approached from the outset as mere appearances, *i.e.*, in the critical attitude objects are approached as appearances which purport to be realities of a certain sort but may not truly be (Husserl, 1970). To revert to Hanson's terminology, we might say that scientists must become critically aware of the interpretive element involved in seeing and that they must repeatedly test such interpretations.

An Example of Scientific Typifications in Psychiatry

Let us now consider an example of typification in psychiatric diagnosis. Soon after meeting a new patient, Dr. Cartwright, a skilled psychiatrist, may "sense" that this person is schizophrenic. This sense that the person is schizophrenic is what we have called a typification. The person behaves in certain ways that Dr. Cartwright perceives as typical of schizophrenics. And because she has typified this patient as schizophrenic, Dr. Cartwright expects him to exhibit other signs and symptoms typical of this disorder. In other words, although Dr. Cartwright has observed thus far only a few elements of the patient's behavior, these few features are apprehended by her within the horizon of other components of schizophrenia. What little she has already perceived signifies to her the presence of other constituents of schizophrenia which she has yet to perceive.

Yet if Dr. Cartwright maintains a scientific attitude toward this person, she will view his schizophrenia as questionable or uncertain. She will, in other words, maintain a critical attitude toward her typification of him. But this typification, however suspicious Dr. Cartwright remains toward it, has already predelineated other, not yet observed components typical of schizophrenics. She will, as a consequence, begin to look for these additional components in the patient's behavior. But because she remains critical of her typification of him as schizophrenic, she will also look for other features of the patient's comportment which conflict with and thus throw doubt on this typification.

Because of Dr. Cartwright's critical stance, the typification which informs her examination of the patient will be subsequently tested against ample empirical' evidence. And through such testing, it may be falsified, revised, or confirmed. Because the typification predelineates and calls for other aspects of schizophrenia before they actually appear in this particular patient, it has the hypothetical status of a scientific prediction. And, like all scientific predictions, the eventual appearance or nonappearance of the events predicted will determine the truth-value of the hypothesis. Although Dr. Cartwright has at first the sense that this patient is schizophrenic, certain nonschizophrenic features could well emerge and Dr. Cartwright will then begin to weigh the possibility that this person has a different problem.

We can now appreciate the *scientific objectivity* of typifications in psychiatry. Typifications are scientific *only to the extent that they are based upon and tested by evidence* (Schwartz and Wiggins, 1985, pp. 345- 346). Such evidence is given through observation and communication: *i.e.,* it is given through direct observation of the patient’s appearance and behavior and through communication with the patient regarding his or her experience. Only such direct evidence *regarding the patient* can ground typifications in features of the patient's life rather than in features of the psychiatrist's life. In other words, only such evidence *regarding the patient* establishes the *objectivity* of typifications.

Typifications, however, provide only a *general* context within which the patient's behavior and experience make sense to Dr. Cartwright. As she acquires a better understanding of her patient in the light of a typification, her comprehension of the patient will assume a more individualized meaning. The general meaning through which Dr. Cartwright began to know the patient will move into the background as the uniqueness of the patient emerges. As a general context within which the patient makes sense to Dr. Cartwright, however, the typification remains operative. It simply loses its prominence for her as the unique nature of the patient acquires prominence. This occurs as more and more aspects of the patient are directly disclosed. Understanding initially established through the typification is gradually accommodated to the particularities and details of the patient's life (Husserl, 1973).

Typifications, accordingly, are not stereotypes. They would remain stereotypes only if their generic sense alone defined the patient. We have stressed, however, the fact that typifications prove valuable in psychiatry only because they initially orient and predelineate clinical investigation. As this investigation proceeds, the generic meaning of the typification is supplemented by a far richer and more detailed comprehension of the patient as an individual human being. The psychiatrist appreciates the patient as fully unique while still viewing him or her as an instance of a general class.

The generic typification, however, remains essential to effective treatment. Psychiatry is not concerned with unique individuals; rather, it is concerned with unique individuals viewed as suffering from general kinds of mental distress. Even after the psychiatrist has come to understand the patient's individuality, the typification remains operative in guiding the ongoing treatment (Schwartz and Wiggins, 1985).

Objectivity of Psychiatric Diagnoses

Objectivity of diagnoses depends on both characteristics of the patient and characteristics of the psychiatrist. Diagnoses, in order to be objective and scientific, must be securely based on features of the patient's illness, but not just anyone can detect and certify the presence of these features. Only those people who have acquired sufficient training and experience in directly dealing with patients are able to do this. Only such trained and experienced people have acquired the *skills* to detect and confirm the features of illness. The psychiatrist, in other words, must have acquired the skills to elicit, perceive, and confirm these features when they are in fact given. The mere presence of these features in the patient is not sufficient for them to be detected and observed by the interviewer. One of the characteristics the psychiatrist must have in order to see them is the skill to typify disorders. The skill to typify illnesses is necessary for the psychiatrist to have access to them (Polanyi, 1964).

Some commentators have maintained that the crucial issues lie neither in the doctor (the subject) nor in the patient (the object) but rather in the special nature of the "relationship" between them. We agree; however, this relationship, we contend, is not a matter of some ambiguous "vibrations" or feeling tone. Instead, it consists in the physician's ability to elicit, detect, and observe actual features of the patient's life. The patient must disclose these features, either spontaneously or through interaction with the psychiatrist, and the psychiatrist must be able to recognize and understand them.

Rapidity of Diagnoses

Diagnoses can occur rapidly because experienced psychiatrists possess the skill to typify patients when only a few aspects of the patients' behavior have been given. People who lack experience in psychiatry, *i.e.*, people who have not directly observed and communicated with many psychiatric patients, have not acquired these psychiatric skills. Consequently, if such inexperienced persons rapidly typified other people in psychiatric ways, these diagnoses would be radically unreliable. Such unskilled persons would not be able to see a certain configuration of behavior as schizophrenic. *Seeing* such behavior as schizophrenic, we have maintained, constitutes a necessary part of psychiatric typification. And we believe that it is precisely such seeing as. ..that is at work in the rapid diagnoses studied by Gauron, Dickinson, Kendell, and others.

Yet this seeing as.... remains insufficient for genuinely scientific typification. In order for typifications to become scientific, they must be guided by a *critical attitude.* This critical attitude would consider typifications dubious and suspect until much additional direct evidence had confirmed or falsified them. Hence one is justified in worrying about the scientific status of rapid diagnoses if such diagnoses are not carefully tested through extended direct observation of and communication with the patient. The initial diagnosis, in other words, remains merely the first step. The subsequent steps consist in the critical gathering of additional evidence which will either substantiate or invalidate the diagnosis.

Our characterization of psychiatric typification as a skill, moreover, permits us to explain another hitherto puzzling component of rapid diagnoses. Cooper reports that in the studies of Gauron and Dickinson and of Kendell:

> The psychiatrists were often unaware of which items of information they were using for diagnostic decisions, and that some items they thought to be crucial, such as behavior and projective test results, in fact carried little diagnostic weight (1983, p. 205).

Skills, we have said with Polanyi, adhere to "a set of rules which are not known as such to the person following them" (Polanyi, 1964, p. 49). If rapid diagnoses, then, arise from the psychiatrists' skills in typifying patients, it should not be surprising that psychiatrists would remain "often unaware of which items of information they were using for diagnostic decisions" and that "some items they thought to be crucial....in fact carried little diagnostic weight." People who are able to perform skillfully never fully know what they are doing. The critical attitude of science probably requires that we should, nevertheless, become as clear as possible on precisely what we are doing. But this lack of explicit knowledge does not automatically imply that skills are unscientific. Indeed, Polanyi (1964, pp. 49-65) argues that they constitute an inescapable part of all scientific work.

The Praecox Feeling

A psychiatrist has the praecox feeling, according to Rümke, when he or she experiences the patient's behavior and symptoms as "colored" in a specific manner, namely, in a schizophrenic manner. This schizophrenic coloring or quality which permeates the patient's behavior the skilled psychiatrist can directly *see.* To have the praecox feeling, therefore, is to *see* a patient as schizophrenic. It consists in *seeing* the patient as schizophrenic because it is not a

classifying or conceiving of the patient as schizophrenic. For, as Rümke says, it involves something indefinable. What one directly sees with the praecox feeling cannot be adequately expressed in classificatory criteria or concepts (Rümke, 1942, 1959).

Rümke remarks that the praecox feeling often occurs "at a glance." As long as it remains a mere glance, however, it remains unscientific. Yet the praecox feeling should be mistrusted as unscientific only if it is not subjected to critical testing through an extended examination of the patient. There is, therefore, nothing irremediably subjective in the role played by the praecox feeling in the diagnosis of schizophrenia. It can be established as objective when sufficient evidence regarding the patient is produced in order to confirm or falsify it.

It has already been shown that psychiatrists' sense of poor rapport with patients has high inter-rater reliability in discriminating schizophrenia (Carpenter *et al.*, 1973). This sense of poor rapport is also, we suggest, a typification of the patient as incapable of empathic relationships with other people. Because it is a skill, it may not be possible to define precisely what this psychiatric sense of poor rapport is. This inability to define it exactly need not count against its scientific usefulness, however. Like the praecox feeling, this sense of poor rapport can be verified or falsified through additional direct encounters with the patient.

We should note that the problem raised most forcefully by Laing has not disappeared. A psychiatrist could be wrong in ascribing poor rapport to a particular patient because the inability may lie with the doctor rather than the patient. The finding that there is high inter-rater reliability in this regard indicates, however, that it is less likely that the difficulty rests with *all* the doctors. Yet such an improbability might not dissuade the determined antipsychiatrist from drawing precisely this adverse conclusion. Furthermore, Rümke warning may apply: a particular psychiatrist may actually have trouble drawing near other people and might indeed always err regarding poor rapport.

Yet these problems merely disclose the well-known fact that abilities to master skills vary from person to person. It is true that some psychiatrists may not be able to rely on a sense of poor rapport in order to detect schizophrenia because these physicians themselves have difficulty drawing near other people. This simply means, however, that these psychiatrists do not possess the skill required to notice poor rapport in other people. This is analogous to saying that someone cannot acquire the skills to race in the Olympic Games because he is too obese or that someone else cannot become a professional violinist because her hearing has been damaged. The common fact that some people cannot master particular skills does not entail that no one can. It rather implies that the mastery of a skill usually presupposes other attributes and capacities.

A Caveat: The Weaknesses of Typifications

Although typifications constitute essential parts of the skills of scientific psychiatry, they have certain 'inherent weaknesses that can lead to misuse. Typifications, as we have said, are *preconceptual* skills. As a result, psychiatrists are not always explicitly aware of them, of how they are used, or of what is involved in them. Indeed, one of the reasons we have sought to describe the functioning of typifications in psychiatry is to render explicit what tends to remain implicit and in that way to guard against potential oversights and misuses. We think such safeguards are to be sought in securing the thoroughly *scientific* use of typifications: that is to say, typifications should be used only in the *critical attitude* and only on the basis of the *evidence.* Moreover, the value of typifications lies in orienting and structuring the first steps in psychiatric investigations, not in determining and stipulating their ends. We shall delineate four ways in which psychiatrists can misuse typifications.

1. Typifications may continue to be applied on the basis of insufficient evidence. We typify persons or things whenever a few of their features are directly given to us. Thus typifications are from the outset based on evidence, *i.e.,* directly observable features, but the evidence which first gives rise to a typification may be very limited. Mistakes ensue whenever additional evidence - either confirming or disconfirming - is not purposefully and systematically sought. We might, for example, encounter a handsome person, and because of his attractiveness alone, we may typify that person as also very sociable, a good dancer, and enjoyable as company. This "halo effect" which surrounds directly given data characterizes all typifications. But with additional direct encounters with this handsome person, *i.e.,* with further direct evidence of him, we might come to realize that, although he is an accomplished dancer, he is in fact not very sociable or enjoyable. A necessary condition for recognizing our mistake, then, lies in the securing of additional evidence. One necessary condition for *scientific* psychiatric practice is the commitment to the search for more and more evidence-either confirmatory or disconfirmatory evidence.

2. The above condition, while necessary, remains insufficient for a genuinely scientific psychiatry .We might not discover our mistakenness even with additional direct encounters with our handsome gentleman: we might not recognize the subsequently given data for what they truly are. Because our typifications lead us to expect certain

features, we might misinterpret new evidence. In this way "self-fulfilling prophecies" could lead us to sustain erroneous typifications.

Also necessary for a scientific psychiatry, therefore, is the requirement to maintain a *critical attitude* toward the evidence. In the critical attitude, as we have explained, we maintain a suspicious, doubtful, and even skeptical stance toward the meaning of the directly given. We consider the various alternative interpretations of this evidence. And moreover, we purposefully search for possible disconfirming evidence. Ultimately, expert psychiatric decisions are made by a skillful weighing of the alternatives, and these decisions remain tentative, *i.e.*, always pending additional evidence.

3. The repertoire of typifications that any psychiatrist has acquired through past experience could always contain various misperceptions and misconstruals. For example, in the late 1960s, because of a disparate appreciation of thought disorder and mood disorder, the US-UK Cross-National studies of diagnosis showed that most American psychiatrists had very different typifications of schizophrenic and manic-depressive illnesses than did British psychiatrists (Cooper *et al.*, 1972). Subsequently, new evidence provided by psychopharmacological advances, such as the clinical employment of lithium, has changed the American typifications of these disorders. The repertoire of acquired typifications, therefore, can always be revised and restructured with the advent of new evidence.

4. Typifications can always be misused as stereotypes. Clinical investigation should advance toward a more and more individualized understanding of the patient. This increasingly individualized comprehension of the patient should proceed on the basis of the disclosure of additional evidence. When this occurs, generic typifications usually recede into the background. It is always possible, of course, to ignore the evidence that particularizes the patient and, as a result, to view him or her merely as a *generic type* of case. To do so, however, is to misconstrue the purpose of typifications in psychiatry. This purpose consists in providing an orienting framework for additional investigations. When typifications become the conclusion of psychiatric inquiries rather than the first step, a serious error has been made.

From Typifications to Classificatory Categories

Skillful psychiatrists are able to diagnose patients because they are already able to typify these patients as exhibiting the various mental disorders. Physicians know what these disorders are only if they possess the relevant preconceptual typifications.

Of course, medical students and other beginners who do not possess the typifications are able - with much uncertainty and frequent errors - to diagnose patients by referring to a checklist of signs and symptoms. But we submit that this procedure of comparing a patient's signs and symptoms against a checklist of criteria cannot produce trustworthy diagnoses. Such diagnoses remain undependable because the *meaningfulness* of the written criteria presupposes the diagnostician's ability to recognize these disorders in patients when he or she *sees* them (Husserl, 1973).

If effective use of a checklist of criteria thus presupposes the capacity to typify, how does a checklist arise in the first place? Classification schemes, we maintain, can arise only through the explicit articulation of typifications. These classificatory criteria and concepts remain dependent upon typifications because, as we have claimed, the ability to comprehend the *meaningfulness* of general concepts depends upon a prior ability to typify the disorders. The process of defining a concept simply renders explicit what one already knows through typifications. Of course, such definition may also entail a critical examination and redefinition of typifications. But even this critical examination and redefinition presupposes a prior articulation of typifications.

Conclusion

We have sought to disclose and describe a component of psychiatric diagnosis which, although essential, is usually overlooked in present-day discussions. Typifications, our preconceptual familiarity with mental disorders, orient and guide the first steps in diagnosis. And although they are preconceptual, typifications can be rendered genuinely scientific. Moreover, if we recognize our use of typifications, we become able to appreciate the nature and legitimacy of what we have termed mysteries of diagnosis: the rapidity of diagnoses and the praecox feeling. Although typifications cannot replace explicitly defined diagnostic categories and criteria, such as those found in *DSM-III*, these categories and criteria depend for their meaningfulness and applicability on implicit typifications. Because they remain crucial in diagnosis, acknowledgment and assessment of typifications is an essential factor in a psychiatry which is conscious and critical of its own methods.

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