

# Human suffering and psychiatric diagnosis

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## Abstract

This article aims at investigating and specifying the form of suffering that is characteristic of mental illness in relation to other forms of human suffering, such as political suffering, existential suffering, and bad luck suffering. It does so by making use of a theoretical framework found in phenomenological philosophy, according to which the flourishing or suffering of a person can be understood as an attuned and embodied being-in-the-world in and through which a person aims to realize core life values made meaningful by way of a life narrative. The importance of such a phenomenological analysis lies in pointing towards how contemporary psychiatry needs to involve the life world and life narrative of the patient to make a reliable and valid diagnosis and how such a phenomenological diagnostic approach can act as a counter movement to unnecessary medicalization in psychiatry.

**Keywords:** suffering, illness, psychiatry, phenomenology, medicalization.

Although not the only or even the dominating view on how to determine a diagnosis in psychiatry, the idea of assembling proof for mental illness by checking and adding symptoms and clinical signs of different kinds into diagnostic patterns has become extremely influential [1]. Psychiatric diagnoses are important since they determine things like treatment options, reimbursement for sick leave, self-understanding, and sometimes even questions of identity for the persons who suffer from them. When used in psychiatric and epidemiological research, the diagnostic criteria will in addition to this determine how many people are currently considered to be mentally ill in our society and in what ways. When the prevalence of diagnoses like depression, general anxiety disorder and ADHD – the main examples that will be discussed in this article – increases rapidly – such as have been the case in many Western countries recently – debates about over-diagnosis and whether it is society that is sick rather than the individuals are bound to occur [2]. How a psychiatric diagnosis is to be specified and what is to find shade under its symptomatic umbrella, in contrast to the rainy landscape of normality, have become high-stake questions for patients, practitioners, researchers, politicians, and, not to be forgotten, the companies that profit from selling psychiatric drugs.

In this article I will explore and try to conceptualize how suffering in the case of mental illness (disorder) could be understood by way of phenomenological philosophy. My aim with this is twofold. First, I think a

phenomenological theory of suffering could support doctors, not least physicians who are not trained in psychiatry, in establishing psychiatric diagnoses that goes beyond the mere checking of symptoms and clinical signs as they are outlined and clustered in psychiatric-diagnostic manuals such as DSM-5 [3]. A phenomenological analysis could aid physicians by highlighting the meaning of symptoms as belonging to *persons* in everyday life situations (their ‘being-in-the-world’ to speak in a phenomenological idiom) rather than treating symptoms as merely signs of underlying brain-dysfunctions [4].

My claim is not that phenomenology would be able to offer an account of mental disorder that could replace brain-physiology based theories all together. To my mind, Karl Jasper’s more than 100-year-old idea of combining an explanatory cause-based and a phenomenological understanding-based account in psychopathology is still fruitful and the best option we got [5]. Such a combinatory theory of mental disorder has been presented by Jerome Wakefield in the form of what he calls “harmful dysfunction” [6]. This is also the view on mental disorder we find in the introduction to DSM-5, even if the definition is not made use of systematically in the manual itself:

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a *dysfunction* in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant *distress* in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.” [3, p. 20; italics F.S.]

Provided with the combinatory disclaimer, phenomenology could significantly *add* to our understanding of what abnormality amounts to in the cases of mental disorders by specifying how the suffering of mentally ill persons is *different* from (and/or similar to) other forms of human suffering without taking the dysfunctional detour. Phenomenology offers a more *in-depth understanding* of the way persons suffer from various mental disorders. This, finally, brings me to the second aim of this article. As will become obvious I think phenomenology could be helpful in specifying different

*forms* of human suffering. Such an analysis could potentially make us better equipped in separating cases of human suffering that are *not* cases of illness from the ones that truly are, and thus counteract medicalization forces at work in contemporary psychiatry.

### Phenomenology of health and illness

I have made earlier attempts to show with the aid of phenomenological philosophers, such as Martin Heidegger, Jean-Paul Sartre, and Hans-Georg Gadamer, how the healthy versus the ill life can be understood as *homelike* versus *unhomelike* ways of being-in-the-world [7–9]. Suffering, according to such a theory, is an *alienating mood* overcoming a person and engaging her in a struggle to remain at home in the world in face of the loss of meaning and purpose in life. Homelikeness and unhomelikeness in a phenomenology of health would refer to two opposed dimensions of the being-in-the-world of human beings. To be ill means to be not at home in one's being-in-the-world, to find oneself in a pattern of disorientedness, resistance, helplessness, and perhaps even despair, instead of in the familiar transparency of healthy life. We will return below to how illness suffering as a particular way of inhabiting one's body and world is different from other forms of unhomelike being-in-the-world, such as existential suffering and political suffering.

It is important to stress the fundamental difference between a phenomenological illness concept in a theory such as this and the concept of disease (dysfunction) in its biomedical sense. A disease is a disturbance of the biological functions of the body (or something that causes such a disturbance), which can only be detected and understood from the perspective of the doctor investigating the body with the aid of her hands or medical technologies. The patient can also adopt such a scientific perspective towards his own body and speculate about diseases responsible for his suffering. But the suffering itself is an illness experience of the person who is in a world, embodied and connected to other people around him. Illness has meaning, or, perhaps rather, *disturbs* the meaning processes of being-in-the-world in which one is leading one's life and understanding one's personal identity by way of a life narrative [10].

The most intriguing part of the phenomenology of suffering is perhaps the way a person's suffering is both determined and potentially changeable by way of the *core life values* she embodies. What does this mean? If I am a professional musician, the sudden painful inability to move my little finger is much more important to me than if I am a philosophy professor. To be caught cheating in playing cards is much more devastating for a person who has invested his life and value in such an activity in comparison with a person who only does it for fun and does not care much. Charles Taylor, in his

book *Sources of the Self*, analyses the way our personal beings are built up by way of such evaluations. Most important are those priorities he calls “strong evaluations”, about the things that make a human life worth living beyond satisfying the basic needs of food, drink, sleep, safety, sex, and so on [11, p. 4ff.]. These strong evaluations concern moral matters in a narrow sense: what responsibilities I have for the life and flourishing of other persons. They also, however, concern questions about what a good life means for me and how I attain self-respect in the eyes of others. To be able to play the violin or a card game in the company of others matters differently to persons according to their strong evaluations – their set of core life values.

### Psychopharmacology and medicalization

Let us return to the issue of a human suffering and the threat of medicalization in contemporary psychiatry. In contrast to science-fiction medical technologies described by transhumanists wanting to enhance the human condition [12], cosmetic surgery and psychopharmacology show us what medical enhancement looks like already today [10]. Cosmetic surgery is by definition in the business of changing our looks according to cultural norms rather than repairing injuries or congenital defects, and it is often criticized for reinforcing sexist, ageist, and racist aesthetic ideals [13]. According to such a critique, the enforcement of these ideals by way of surgery not only prohibits rather than supports the flourishing of the persons who are operated on but also makes life worse for *other* individuals, who do not satisfy the norms (who cannot afford or do not wish for surgery). In addition to cosmetic surgery, medications for sexual dysfunction, baldness, menopause, premenstrual syndrome, and a whole flora of steroids and anti-ageing pills are all examples of contemporary enhancement drugs. However, the most challenging cases of enhancement (and thereby medicalization) today are found within psychopharmacology.

The advent of Prozac in the late 1980s inaugurated a debate about what it meant to be put in a state that was ‘better than well’ by means of psychiatric medication [14]. The new antidepressants (SSRIs, SNRIs, and others) transformed the treatment of mood disorders – depression as well as anxiety disorders – in the 1990s and sold in numbers beyond imagination. The rapidly increased use of Ritalin and other drugs to treat ADHD (attention-deficit/hyperactivity disorder) during the same period of time proved to be a parallel example of how psychopharmacological drugs have effects on the mood and personality traits of millions of people [15, 16]. What is striking in surveying these two examples, as well as many of today's other pharmacological enhancement technologies, is the way the technologies are implemented: not by directly subscribing to en-

hancement but instead by expanding the domain of the diseased and disordered. In a way this is the inevitable consequence of how pharmaceuticals are tested, approved, and sold according to a system of clinical trials developed in the 1960s [17]. In order to get a drug into the system the pharmaceutical company developing and eventually selling it needs to get the drug approved for the treatment of a diagnosed disease or mental disorder. Consequently, the enhancement of moods and personality of patients must always take place as the curing or relieving of an unhealthy state of being. Naturally, pharmaceutical companies try, by means of marketing, sponsoring, and other interactions with doctors and patient groups, to push the inclusiveness of the diagnoses they are developing drugs to treat [18]. As the French historian and philosopher of medicine Georges Canguilhem remarks, the meaning of the Latin and Greek roots of the word “normal” are to “make geometrically square” and to “enforce grammatical order”, respectively [19, p. 239, 244]. Canguilhem was Michel Foucault’s teacher, and in these etymologies we already discern the latter philosopher’s analysis of ‘biopolitics’ as a dominating practice and discourse in modern Western societies [20]. According to the theory of biopolitics, the successes of the new antidepressants and ADHD medications are both examples of *normalization* in the sense that the norms for feeling and behaving well in contemporary Western culture and societies are made tighter and less inclusive with the help of the drugs. In tandem with this narrowing tendency of the healthy, the cultural ideals influencing what we may term human flourishing in contrast to human suffering also change in our society. Antidepressants and ADHD medications foster the ideal of a positive, in-control, energetic, and socially competent personality that it is now possible to achieve by way of taking medication. There are no more excuses for staying melancholic and neurotic or disorganized and impulsive if this can be fixed with the help of a drug. When the new pharmaceuticals have been introduced, the old ways of life are no longer viewed as cases of unhappiness or socially cumbersome behaviour; they are viewed as states of mental disorder. Normalization by way of pharmaceuticals is consequently typically a process of *medicalization* that expands the domains of the unhealthy at the expense of parts of the previously healthy and/or socially deviant behaviour, previously likewise considered abnormal, but in a moral sense relating to cultural ideals and not to theories of mental disorder. Medical enhancement, which in the standard bioethical definition is that which takes us *beyond* the curing of diseases, is currently argued for and propagated in terms of achieving health, not in terms of making people better than well.

## Phenomenology of human suffering and flourishing

Gadamer, in his late work *The Enigma of Health*, points out, in the spirit of Heidegger’s philosophy, that health cannot be produced by the doctor using technical and scientific skills; rather, health must be *re-established*, as something that has been lost, by helping the patient to heal himself. Health, according to Gadamer, is a kind of self-restoring balance, and the doctor provides the means by which a state of equilibrium can re-establish itself on its own power:

“Without doubt it is part of our nature as living beings that the conscious awareness of health conceals itself. Despite its hidden character, health nonetheless manifests itself in a kind of feeling of well-being. It shows itself above all where such a feeling of well-being means that we are open to new things, ready to embark on new enterprises and, forgetful of ourselves, scarcely notice the demands and strains which are put upon us. [...] Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being-there, of being-in-the-world, of being together with other people, of being taken in by an active and rewarding engagement with the things that matter in life. [...] It is the rhythm of life, a permanent process in which equilibrium re-establishes itself.” [21, p. 112–4; translation has been altered, F.S.]

The conceptual backdrop for Gadamer’s analysis of health in the quote above is undoubtedly Heidegger’s phenomenology of everyday human being-in-the-world, found in *Being and Time*, which is also the starting point for my own analysis of suffering and illness in this and other papers [22]. Despite the fact that Heidegger did not address and develop any phenomenology of health himself in approaching technology and medicine, his philosophy offers a promising starting point in such endeavours.

Might Prozac and Ritalin be neurotechnological examples of *producing* health – rather than reinstating health in Gadamer’s sense – by means of producing newly diagnosed individuals who are then treated with the drugs? Since some of the patients treated with antidepressants and ADHD medicines describe their experiences as having never before felt the way they now feel, and some of them even have the experience of “being themselves” for the first time on the drug [23], the answer to this question seems to be yes: health is not brought back by helping the body to reinstate its lost norms; it is produced as a novel state of being. Gadamer actually criticizes modern psychiatry for exactly this reason:

“I am thinking of the world of modern psychiatric drugs. I cannot separate this development entirely from the general instrumentalization of the living body which also occurs in the world of modern agriculture, in the economy and in industrial research. What does it signify that such developments now defines what we

are and what we are capable of achieving? Does this not also open up a new threat to human life? Is there not a terrifying challenge involved in the fact that through psychiatric drugs doctors are able not only to eliminate and relieve various organic disturbances, but also to take away from a person her deepest distress and distraught?" [21, p. 77; translation has been changed, F.S.]

The keyword to understanding the instrumentalization-medicalization process of psychopharmacology from a phenomenological point of view is, I think, the concept of *alienation*. Psychiatric drugs (when they are effective) relieve patients of their suffering as they become more at home in their life on the interconnected levels of embodiment, everyday engagement in the world with others, and life narrative [10]. The fear Gadamer harbours is that by doing this – by relieving symptoms like feelings of hopelessness, anxiety, and restlessness – the drugs also may separate the person from that which Gadamer names her true self. When the pills flatten the life moods of the patient he is no longer forced to challenge himself on the true meaning of his life: what he wants to accomplish and who he wants to be. By producing health the drugs would therefore – at least in some cases – alienate the patient from herself.

This line of thinking seems to clash with my previous efforts to understand health as a homelike being-in-the-world. How could the pharmaceuticals make the being-in-the-world of the patients homelike – assuming their life was previously unhomelike due to stressful moods – and simultaneously alienate them by blocking access to strong-value exploration [11]? In order to stay clear of this potential confusion and contradiction we need to distinguish four different things in the phenomenological analysis: suffering, illness, health, and flourishing (the good life). We have already touched upon the issue that not all suffering is of the illness type when discussing medicalization issues in psychiatry. There is human suffering due to other forms of alienation than illness: political suffering and existential suffering are the two main examples. By political suffering I intend a broad category that includes suffering caused by poverty, political injustice, war, and exploitative labour, but also suffering due to politically repressive norms (remember the cosmetic surgery examples). By existential suffering I intend exactly the kind of fundamental life quest that Gadamer fears Prozac and Ritalin will eradicate: anxiously exploring who one wants to be and what to accomplish in life. In addition to these two kinds of suffering we should add the suffering brought to us simply by bad luck in life matters (say losing a loved one due to a car accident). Such suffering is not necessarily political (if one does not blame the society for the poor conditions of roads) and even if it may lead to existential suffering it is not existentially caused.

In the same way that the phenomenology of suffering proceeds from embodied moods, life world, and narra-

tive of a person, a phenomenological theory of illness and health will use human experience and understanding as its springboard. Illness does not equal presence of disease (biological dysfunctions) even though the standard reason for this type of human suffering will be exactly diseases and other disordered conditions of the body, including the brain (mental disorders). The main difference between illness suffering and other types of suffering seems to be that the alienation in question is experienced in a *bodily manner*. Certainly, every human experience involves the lived body subconsciously performing in the background to offer us a focus of attention in the world, but in cases of illness the pain, resistance, disorientation, and helplessness make themselves *known* on this bodily level. The body “dys-appears” in illness instead of disappearing, to use a characterization coined by Drew Leder [24, p. 69].

What about mental (psychiatric) illness in this regard? The point of using the adjective “mental” for this type of illness and, likewise, referring to “disorders” instead of diseases seems to be precisely that mental illness does *not* manifest itself by way of bodily symptoms. However, every experience arguably has both a bodily and a mental dimension; meaning is ingrained in the patterns of lived bodily intentionality, and thinking has a bodily element in the way it is experienced and carried out by persons living in a world [25]. Moods are experienced bodily and open up the life world as a meaningful territory in which thoughts can be formed. Actions depend on the lived body’s preconscious capacity to carry out meaningful undertakings in the world that can be extended to thoughtful plans and projects in the life of a person. How a person feels and what she is able to do are therefore the crucial things to explore in a phenomenological analysis of illness, whether “somatic” or “mental” in nature.

Mental illness, like somatic illness, is standardly connected to agonizing feelings and difficulties in carrying out everyday actions. These feelings of suffering and difficulties in following everyday patterns of meaningfulness clearly have bodily features, also in cases when the pains and difficulties are commonly referred to as mental in character and the illness in question as psychiatric. Anxiety disorders and depression are connected to having panic attacks and experiencing moods of sadness and boredom, which make themselves known in making the body painful, immobile, and paralyzed, the lived body being unable to make itself at home in the world [26]. ADHD is defined by patterns of inattention and hyperactivity that are visible through the actions of persons and surely also experienced as moods which “fill up” the body when the diagnosed person struggles to concentrate or stay calm [16].

Political suffering, in which the features that prevent flourishing are found in the world of the person rather than in her body, and existential suffering tied to self-searching and self-realization, as well as other cases of unhappiness due to sheer bad luck, are all experienced

by way of feelings of alienation. Political suffering may lead to illness suffering and so may existential suffering or sheer bad luck. But they need not, and it is important to point out the differences between illness and these other types of human suffering, differences that appear symmetrically on the other end of the spectrum in distinguishing between health- and non-health-related well-being. Health is experienced, or rather, not experienced, as the founding mood of everyday action in the life world. Health is a disappearing mood of familiarity that makes it possible for us to concentrate on the things we are usually doing and to embark on new projects, open to the possibilities of life, as Gadamer puts it [21, p. 112–4]. Health is the opposite of bodily and everyday-activity alienation, but it is not the same thing as well-being, if the latter means to feel happy. Health is not the same thing as human *flourishing* (a concept which is not mixed up with health as easily as “well-being”), which consists in ways of examining and fulfilling one’s individual capacities and life goals, a definition of the good life that we find at work already in the philosophies of Plato and Aristotle [27]. To be at home with oneself in the existential sense is therefore not the same as being healthy; human flourishing is typically made possible through health, but it could also be absent in health or, indeed, be present in severe illness if the sufferer has managed to make peace with his life story despite being in pain and bodily incapacitated. A flourishing life rests on *authentic* self-understanding, according to most phenomenological thinkers, since the core life-narrative values that a person honours have been attained at through some sort of critical and honest self-scrutiny [11, 22].

### Existential suffering and psychiatry

Let us sum up the phenomenological characterization of suffering so far:

Suffering is an alienating mood overcoming a person and engaging her in an embodied struggle to remain at home in the face of the loss of meaning and purpose in life. It involves painful experiences at different levels of the person’s being-in-the-world that hang together through the suffering-mood but are nevertheless distinguishable by being primarily about 1. her embodiment, 2. her engagements in the world together with others, and 3. her core life values enacted by way of her life narrative.

Whereas somatic illness appears to make life unhome-like by progressing from 1. by 2. to 3., mental illness rather progresses in the opposite direction. Somatic illness typically involves existential suffering only in severe cases, whereas mental illness involves existential suffering in most cases, including the cases referred to as mild and looked upon as bordering to unhappiness (e.g., mild cases of depression). The bodily aspects of mental illness become more pronounced and visible

in severe cases, when the mood is alienating to the point of making the body heavy (depression) or strange (psychosis) [25, 28].

That existential suffering is typically involved in a different and more constitutive way in mental illness than in somatic illness means that psychiatry is even more prone to medicalizing tendencies than somatic diagnostics. We have concentrated on the prescription of certain types of pharmaceuticals, but an even greater danger from the phenomenological viewpoint lies in the standardization brought by the increasing use of diagnostic manuals. The risk with using diagnostic manuals in psychiatry is not only over-diagnosis and the medicalization of healthy behaviours and feelings, which are cases of political or existential suffering rather than illness suffering by the phenomenological characterizations given above. The risk is also that persons are stereotyped, made into their diagnoses instead of being approached and understood in the empathic and hermeneutic manner, addressing life-world concerns, that is characteristic of good health care [10]. The effects of Ritalin may have a stereotyping effect as concerns moods and ways of being-in-the-world, but even more so does the tendency to map and sort persons in diagnostic categories like ADHD.

Diagnosis is a necessary and important instrument of medical practice, but when it is used to categorize human experiences and behaviours rather than to explain what has gone amiss in the body, it blocks the view of what should be the real concern of the doctor and health care team: the patient’s being-in-the-world. DSM wants to create the impression that doctors can explain and cure the sufferings of the soul in the same manner as they explain and cure the sufferings of the body, but, of course, they cannot, since life-world matters and existential questions are not amenable to biological analysis in the way the functions of the body are. Diseases can be detected with the help of medical technology, and the way they cause illness suffering can be explained by medical science. Mental disorders can at best be described in everyday language and understood by way of good psychiatric practice. In both cases medical drugs, surgery, or other technological interventions may help in relieving the suffering, but in the case of diseases the doctors are also often able to *cure* the diseases, whereas mental disorders heal through the work of time or remain for the entire life of the patient. The reason for these differences between mental and somatic illness is not only that the brain is the most complex organ of the body; it is also that existential and political suffering are enmeshed in mental illness in a manner that often makes it hard to discern what is the most important *reason* for the suffering in question. Did the poverty and family-related problems of a person lead to depression, or was it the other way around? No brain scans can answer this question; only the life story of the patient told in a meeting with a psychiatrist (or other health care professional) can. From the phe-

nomenological point of view, the difference between illness suffering and other forms of human suffering cannot be defined by way of brain-disease findings, even though abnormalities in biological functions of the body (including the brain) could be taken to *indicate* that the suffering is medical in nature. However, when it comes to the functions of the brain, the challenge of defining normal intervals is even harder than in the cases of somatic illness, inevitably leading us back to the *experiences* of potentially diseased/disordered people.

## Conclusion

To refer to the functions of the brain in attempts to distinguish illness suffering from other forms of human suffering will not work as a cure for medicalization in contemporary psychiatry, even though studies of brain physiology could lead to future breakthroughs in our view on mental disorder [6]. Instead, the demarcation and difference between mental illness and political, existential, and sheer bad-luck suffering will have to be made on the phenomenological level of the being-in-the-world of the patient. Alienation in terms of embodiment and inability to carry out everyday actions are major signs of *illness* suffering; other forms of suffering tied to failure to attain core life values could *lead to* illness, but they should not be considered medical in character from the start. In cases of *mental* illness – not denying the symptom-relieving effects of psychopharmacological drugs – diagnosis and treatment should primarily address the everyday realm of the person's life rather than her brain chemistry. This is best done by expanding diagnostics beyond the checking of symptoms and clinical signs to include the life world and life narrative of the patient.

## Zusammenfassung

Ziel dieses Artikels ist, die für psychische Erkrankungen charakteristische Form des Leidens im Verhältnis zu anderen Formen menschlichen Leidens, wie politisches Leiden, existentielles Leiden und Leiden aufgrund von Pech, zu untersuchen und zu spezifizieren. Dabei bedient sich der Autor eines in der phänomenologischen Philosophie gefundenen theoretischen Rahmens, gemäss dem das Gedeihen oder Leiden einer Person als ein abgestimmtes und verkörpertes In-der-Welt-Sein verstanden werden kann, in dem eine Person darauf aus ist, die durch eine Lebensgeschichte sinnvoll gewordenen zentralen Lebenswerte zu verwirklichen. Die Bedeutung einer solchen phänomenologischen Analyse liegt darin, aufzuzeigen, wie die zeitgenössische Psychiatrie die Lebenswelt und die Lebensgeschichte des Patienten einbeziehen muss, um eine zuverlässige und valide Diagnose zu stellen, und wie ein solcher

phänomenologischer diagnostischer Ansatz als Gegenbewegung zu unnötiger Medikalisation in der Psychiatrie wirken kann.

**Schlagerworte:** Leiden, Krankheit, Psychiatrie, Phänomenologie, Medikalisation, Psychiatrie.

## Résumé

Cet article a pour but d'étudier et de préciser la forme de la souffrance qui caractérise la maladie mentale par rapport à d'autres formes de souffrance humaine, comme la souffrance politique, la souffrance existentielle et la souffrance liée à la malchance. Il y parvient en utilisant un cadre théorique que l'on retrouve dans la philosophie phénoménologique, selon lequel l'épanouissement ou la souffrance d'une personne peut être comprise comme un être dans le monde accordé et incarné à travers lequel une personne cherche à réaliser des valeurs fondamentales de la vie, rendues significatives par un récit de vie. L'importance d'une telle analyse phénoménologique réside dans le fait de montrer comment la psychiatrie contemporaine a besoin d'impliquer le monde de la vie et le récit de vie du patient pour faire un diagnostic fiable et valide et comment une telle approche de diagnostic phénoménologique peut agir comme un contre-mouvement à la médicalisation inutile en psychiatrie.

**Mots clés:** souffrance, maladie, psychiatrie, phénoménologie, médicalisation.

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Manuscript submitted: 16.11.2017

Revisions submitted: 2.2.2018

Accepted: 6.3.2018

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