INTRODUCTION

The word ‘phenomenology’ (plural: phenomena) derived from Greek and refers to outward appearances as adopted by Kant and Hegel. However, the meaning of phenomena shifted with latter philosophers. In Heidigger, Husserl and Jaspers, phenomena were understood in terms of internal subjective experiences. In contemporary psychiatry, the term refers to study of psychopathology, broadly defined, including signs, symptoms and their underlying thoughts and emotions. When used in this way, phenomenology provides the basis for nosology, or the development of disease definitions, diagnostic categories and dimensional classifications.

It also involves the observation and categorization of abnormal psychological events, the internal experience of the patient and his/her consequent behaviour, thus rendering the patient’s experience understandable, making it a valuable therapeutic tool, "phenomenology, though one of the foundation stones of psychopathology is still to be refined". This is still true as all experiences reported by patients may not readily fit classically defined phenomenological terms or may appear as a blend of different psychotic phenomena or appear to lie on a continuum between normal and psychotic spectra. It was even suggested that there is some pressure to ignore such reports. But, phenomenology, as it requires the doctors’ skill to explore and understand the inside of his patient’s mind, has a place in psychiatry research which has not yet been fully exploited. To introduce experimental methods into research in descriptive psychopathology, will involve case studies which depict rare, indefinable phenomenology. This will enrich the understandability of abnormal human experiences in general and help develop cognitive accounts of belief formation and its relation to perception.

We report two cases of schizophrenia, where patients voiced experiences that bypassed typical phenomenological labelling, thus providing nourishment for productive, yet diverse thought and debate among clinicians.

CASE HISTORY

Case 1: A 25 year old Asian man, an engineering student, hailing from a well educated family was admitted to hospital for psychiatric care and treatment with complaints of academic deterioration, hearing of
voices, talking to self, of about one year duration with no history suggestive of any substance use or any other medical condition. He was diagnosed to have paranoid schizophrenia based on duration criteria and elicited phenomena like thought broadcast, III person auditory hallucinations, bizarre persecutory delusions. A part of his sample speech was as follows, “whenever I see my image in the mirror, I can also see other people in the neighbourhood can immediately see my image in front of their eyes and then they can make out that I am thinking about sex…. that’s why they feel I am bad and filthy.....”. Patient was started on atypical antipsychotics and started responding to treatment by end of week one of hospital stay.

**Case 2:** A 27 year old Asian, unmarried man, bus conductor by occupation, from a mid socio-economic class was admitted under department of psychiatry for complaints of assaultive behaviour, talking to self, hearing voices, feeling tired and not going to work since 7 months. There was no history suggestive of any substance use or of any general medical condition. His mental status examination findings revealed III person auditory hallucinations, kinaesthetic and command hallucinations, thought broadcast, bizarre persecutory delusions, somatic delusions, delusion of control and was duly diagnosed to have paranoid schizophrenia and hence appropriately treated with atypical antipsychotics. But sample speech recorded revealed much more colourful phenomena, which is as follows – “two girls are there, A and S, one of them a computer engineer, they monitor me and my actions since long, probably through a computer screen and they can and know all about my actions, even they can see the same dream and control what I see in my dreams.... they keep telling me what to do even in dreams.. I feel very tired. They drain blood from my body leaving me bloodless.....circulation has become stagnant now.....”

**DISCUSSION:**

**Case 1:** In the above case mentioned, the diagnosis of paranoid schizophrenia (as per ICD-10) was obvious, as phenomena like bizarre persecutory delusions, auditory hallucinations, thought broadcast were elicited. But, the experience, as told by the patient, as cited above, intrigued clinicians as it did not readily fit into the classically defined phenomenological realm. The phenomena of believing that others can see him when he sees himself in a mirror can definitely be typified as a ‘bizarre delusion’, but, it does hold more element than just that. Discussion followed in lines of whether it could be called as a ‘primary autochthonous delusion’, where the concept of patient is ultimately understandable, or is it a two-membered ‘delusional percept’ where it was considered to be the abnormal significance, attached to a real percept (here, the image in mirror). Whether the entire experience can be summed up just into a collective term of ‘paranoid state’ where the content is unduly self referent was also thought of. Another school of argument suggested that this be considered as a form of ‘thought passivity’ experience where patient ascribes his internal thought process to outside influences and thereby, we even considered daring to venture out a new term ‘image broadcast’! Opinions generated also directed us into considering Schroder’s concept of hallucinatory syndromes; which could be a ‘fantastic hallucinosis’ with a strange, fantastic set of ideas based on auditory and visual hallucinations. Bodily hallucinations and delusions. After diverse debate, it was concluded that here, the primary delusional experiences woven together with feelings of passivity, hallucinations, and misinterpretations based on mood and delusional attitude formed the basis of secondary paranoid delusions in which primary delusional experiences are embedded.

**Case 2:** The sample of speech, here though rich in psychopathology, it would be a mistake to expect phenomenological terms to reveal themselves tidily from patients’ conversation. The patient’s concept of someone else being able to see and control his dreams is bizarre and interesting at the same time as it has not been reported or described anywhere else. No doubt, doubt arises in one’s mind, whether we could label this phenomena simply as ‘thought broadcast’ taking dreams to be part of one’s thought (though unconscious), or take the liberty of coining a new term, something like ‘dream broadcast’ or the controlling of dreams taken as simply ‘delusion of control’ or a typical ‘passivity experience’? The delusion is no doubt, bizarre, persecutory and has blended qualities of somatic passivity, delusional percept and mood, if it can be labelled as delusion. One also wonders that if this symptom of ‘patient seeing others seeing his dreams’ could be thought of as autoscopy or heutoscopy, which is a complex psycho-sensorial hallucinatory perception of one’s own body image (here along with dreams) projected into external visual space or is it a type of Schroder’s ‘fantastic hallucinosis’? But phenomenology can only be concerned with what is conscious and it cannot comment on that which is unconscious like dreams. Secondly, the meaning of dreams belongs to the dreamer and not to an interpreter or theorist as the same dream is not experienced by the interpreter. Dreams are highly complex experiences and have defied adequate analysis and explanation. But dreams can be described as psychic events and hence we may still be partially correct in applying alienation passivity phenomena onto dreaming.

**CONCLUSION:**

The present case studies highlight the fact that experiences reported need not always readily fit...
standard symptom descriptions or definitions as also reported by Strauss and Chapman.\textsuperscript{[5, 13, 14]} When reporting such experiences, patients may have great difficulty describing what happens/happened in clear or definitive terms (for example, a thought or a voice), or it may appear as a blend of different phenomena or even seem to lie on a continuum between normal and psychotic spectra. It may also seem to us, to represent, in part, an intermediary state between the normal perception and belief of one’s own action as self–generated and the abnormal state (like delusion of control).\textsuperscript{[5]} Strauss even suggested that there is some pressure to ignore such reports. In spite of such pressure, the analysis of phenomenology must receive its deserved importance, because traditional clinical diagnostic schemes have been demonstrably lacking in furthering our understanding of psychopathology.\textsuperscript{[12]} Fundamental questions concerning nature of abnormal experiences arise which include: Is the experience based on a normal or an abnormal percept or the combination of two? Can hallucinations and delusions be described in mutually exclusive terms? From a theoretical cognitive perspective, what are the differences between these two states in terms of dysfunctional cognitive systems? To what extent do they involve affect or conation as well as perceptual or other cognitive process?\textsuperscript{[5]} Though answering these queries may require extensive research and understanding. What we do know is that these abnormal experiences reflect the personal concern of perceiver and are conceived as part and parcel of his belief systems and hence have significant powerful relationships with the perceiver. The meaning or the personal relevance of the experience is of paramount importance than the perceptual process.\textsuperscript{[9]} We cannot say that individual symptoms are only important in so far as they direct us towards our ultimate goal of identifying underlying disease process or that phenomenology is an independent entity with research following completely separate line of enquiry.\textsuperscript{[5, 10]} If we do so, we seriously question the reliability and validity of current diagnostic systems.\textsuperscript{[15]} Researches now argue in favour of ‘focus on symptoms’ and stress the advantage of ‘symptom approach’. These approaches attempt at understanding that these abnormal experiences may be cast in terms of some of the most powerful theoretical and experimental paradigms available in psychology today like cognitive theories, neuropsychological, etc.\textsuperscript{[11–13]} The study of varied dysfunctions in realm of thought may help develop cognitive accounts of belief formation and their relation to perception. Thus, it can be concluded that the study of abnormal experiences that stretch themselves beyond typical phenomenology may have a major role in construction of such accounts.

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References:


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