What, if anything, can phenomenology teach psychopathology (and vice versa)?

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What can philosophy possibly teach empirical science? Many have thought that philosophers could at most help clarify the concepts used by scientists – sometimes used too loosely by the scientists, or used misleadingly, perhaps even wrongly stretched beyond their natural habitat. But given this sort of picture, how could *phenomenology* – a "continental" style of philosophy, the main proponents of which are often stigmatized as being impossibly abstract and obscure – have anything to tell *psychiatry*? The psychiatrist has to face the harsh reality of the clinic every day; and surely, this is far removed from the philosopher's ivory tower.

In this paper, I would like to offer some reasons for adopting a less simplistic view of the relation between phenomenology and psychiatry (and perhaps, by extension, between philosophy and empirical science generally). The paper may be viewed as an introductory outline of part of the research carried out at the Center for Subjectivity Research at the University of Copenhagen (www.cfs.ku.dk). In particular, I want to sketch some of the arguments that Josef Parnas, Dan Zahavi, and a host of Danish and international collaborators, have mounted in favor of the view that psychiatry has something important to learn from phenomenology in the Husserlian/Merleau-Pontyan tradition.[1] Towards the end I will also reflect a little bit on the kind of benefits that phenomenological philosophers may reap from engaging in a dialogue with psychiatrists and other empirical researchers, and very briefly consider some challenges that this kind of collaboration raises. But the main part of the paper

[1] A somewhat different phenomenological approach to psychiatry has been developed by the Japanese psychiatrist Bin Kimura. I cannot here trace the various differences and points of convergence between Kimura's approach and that of Parnas and collaborators. However, one thing that seems obvious to me is that, whereas Parnas and colleagues mainly emphasize the value of a phenomenological account of normal experience, as a contrastive background for detecting and understanding the experiential anomalies characteristic of schizophrenia, Kimura offers a much more ontologically and genetically committal account, centered on the notion of the "between" or "betweenness" (*Aida*), of which schizophrenia is claimed to be a "functional disturbance" (cf. Tani 2006, pp. 307-313).

address the question concerning the extent to which phenomenological ideas can be fruitfully applied to psychopathological research.

Let me start out by offering a "disclaimer". I am a philosopher, not a psychiatrist. And as a philosopher I probably am, as Dennett has put it, "better at questions than answers" (Dennett 1997, p. ix). As if that wasn't bad enough, from the point of view of a scientist searching for answers, I am barely even acquainted with the fundamentals of the science of psychiatry. What I will present here, in other words, is squarely based upon the research of other, infinitely more qualified researchers.

1. A Problem in Psychopathology

In order to understand what follows, it is important to have some rough definitions of a couple of central terms. "Psychopathology" does not refer to the study of so-called "psychopaths" or "sociopaths" – people who are apparently devoid of conscience, a sense of responsibility for their actions, and so on. Rather, it refers, simply, to the study of mental diseases or abnormalities. Indeed, in this talk I will really only discuss schizophrenia.

Schizophrenia is a mental disease that develops in a small percentage of a given population, usually in adolescence or early adulthood. It develops "naturally" in the sense that it is not caused by any externally or internally (e.g., in the shape of a brain tumor) inflicted damage to brain tissue. When the illness is in its fully developed form, a schizophrenic patient may suffer from severe delusions, such as apparently "believing" that the CIA is monitoring her thoughts, or constantly "hearing" voices talking about her. Before such fully-fledged "psychotic" symptoms emerge, however, there is a pre-psychotic period of typically four to five years – also called the "prodromal" stages (Parnas and Sass 2001, p. 117) – in which patients experience problems, and often seek out medical help, but in which they do not yet entertain any bizarre beliefs. (In a moment I will say more about the kind of complaints patients usually have at this stage.)

There are a couple of obvious reasons why a reliable method for detecting schizophrenia already at the prodromal stages would be of immense value to psychopathology. First, it might facilitate the discovery of the root causes of schizophrenia, of which very little is currently known. Secondly, full-blown psychotic schizophrenia is a terrible disease, about which not much can be done except prescribing anti-psychotic medication. But studies have indicated that "prognosis is improved when treatment is initiated *prior* to any overt outbreak of psychotic symptoms" (Sass and Parnas 2001, p. 352). In other words, the clinical value – and that ultimately means the value in terms of quality of life for schizophrenic patients – of early detection is enormous.

My point of departure in this talk will be a problem that concerns precisely the prospects of diagnosing schizophrenia already at the prodromal stages. Prior to their first admission to a psychiatric ward, many schizophrenic patients have been misdiagnosed by practicing psychiatrists or psychologists. As Parnas and Sass write, such patients are usually diagnosed as suffering from a major depression, and consequently the attempt is made to treat them with

antidepressant medication (Parnas and Sass 2001, p. 104). Presumably, a combination of different factors is responsible for these frequent misdiagnoses. One factor may be that prima facie, the complaints of the prodromal patients resemble the complaints of people with clinical depression. That is, both groups may complain of fatigue, lack of concentration, anxiety, of no longer feeling in touch with themselves, and so on. But the problem, so it has been argued, may also have to do with fundamental assumptions of contemporary psychopathology. Among these assumptions are the following two, closely connected ones: "a systematic underemphasizing of the patient's subjective experience" and a corresponding "emphasis on behavioral terms, in the hope of better reliability" (Parnas and Zahavi 2002, p. 140). And the trouble with emphasizing behavior at the expense of subjective experience is that "[p]rodromal features of schizophrenia, if defined behavioristically, seem to be too common in the general populations to allow for very accurate definition" (Sass and Parnas 2001, p. 352). As long as the schizophrenic patients have no outright psychotic symptoms, they can be hard to tell apart from subjects with less severe mental or personal disorders, if behavior is all you have to go by.

As mentioned, it is often assumed that abandoning the behavioral emphasis and importing more experiential richness to the psychiatric classificatory and diagnostic paradigm will compromise the reliability of classifications and diagnosis (e.g., McMillan 2002, p. 92). But as the just mentioned diagnostic problems illustrate, the exact opposite view seems to be closer to the truth. If progress is to be made in early detection of schizophrenia psychopathologists need to pay more attention to the subjective experience of the patients. The problem is just that the mainly behaviorist approach characteristic of much psychiatry has meant that "[v]ast domains of human experience […] have been deleted from the diagnostic manuals" (Parnas and Zahavi 2002, p. 141).[2] That obviously leaves the psychiatrist without a "suitable theoretical psychopathological framework to address human *experience*" (ibid., p. 140). Such a framework is hardly needed to diagnose overtly psychotic patients: the *content* of their beliefs is typically so bizarre that you don't need to worry about the subtleties of their subjective experiences. But in the prodromal phases, there is precisely no such bizarre mental content. So if you have no basic notion of what human experiences are, then how can you hope to be able to comprehend the subtle experiential anomalies of schizophrenic patients in the prodromal phases?[3] This is precisely where phenomenology comes into the picture.

2. How to Apply Phenomenology

As Parnas and his collaborators understand the term, "phenomenology" is a descriptive philosophical approach the principal aim of which is "the investigation of […] lived experience, a description of phenomena just as they present themselves or are given in experience" (Parnas

[2] Thus, as Parnas and Zahavi write elsewhere, "no major English-language textbook of psychiatry provides even a descriptive sketch of what it means to entertain conscious states" (Parnas and Zahavi 2000, p. 4).

[3] The psychiatrist, write Parnas and Zahavi (2002, p. 158), "must be familiar with the basic organization of phenomenal awareness. Otherwise he would only have a superficial, commonsensical take on experience at his disposal. That would force him to focus only on the content of experience, because he would be unable to address its structural alterations".

and Zahavi 2000, p. 12). This understanding is in tune with a broadly Husserlian (or Merleau-Pontyan) approach. A version of the same descriptive agenda is, for example, expressed in Husserl's so-called "principle of all principles", which stipulates that "*everything originarily offered* to us *in 'intuition' is to be accepted simply as what it is presented as being*, but also *only within the limits in which it is presented there*" (Husserl 1976a, p. 51).

The phenomenological approach recommended by Parnas and collaborators does not merely adopt this formal methodological principle, however. It also relies on a number of key phenomenological descriptions of such things as self-awareness, embodiment, intersubjectivity, and the life-world. Let me briefly outline some of these descriptions, familiar though they may be.

Self-awareness. I am aware of my own thoughts, beliefs, perceptions, sensations, emotions, and desires as *mine*. More precisely, these experiences are immediately given to me as "mine". I do not need to inspect them in order to find out whose thoughts, etc., they are. And I do not only become aware of them if I explicitly monitor or observe them, or think about them. It is not that I can consciously experience an object and remain unaware of my subjective *experience*, until some further mental state of mine is directed upon it. Nor do I need to scrutinize my experience to figure out what sort of experience it is (imagination, memory, perception, etc.). Of course, I can and sometimes do reflect on my own experiences. But reflection is not my default relation to my own mental life. And when I do reflect, there is no room for questioning whether the experiences I reflect upon are mine or someone else's. To have or undergo experiences is already to be tacitly and non-thematically aware of these experiences, in their first-personal mode of givenness, and thus to be aware of them as "mine".[4].

Embodiment. Under normal circumstances, I experience my body not as a mere physical thing – a *Körper* – from which my real self is somehow detached. Rather, I experience it as my lived body (*Leib*), as an original sphere of "I can" or " I do", as Husserl sometimes puts it (Husserl 1976b, pp. 108-10; 1952, pp. 11-2). This is not to say that I experience my body as a non-physical entity somehow. Rather I experience it as indivisibly physical and subjective, as *Leibkörper*. My body is my self, it is my perspective on the world, my "zero point" of orientation (Husserl 1952, p. 158). It is the absolute indexical "here" to which all perceived entities, in various modes of "there", invariably refer back (ibid.). And my immediate "kinesthetic" awareness of my body from the inside, of my subjective mobility, is arguably a condition for my perception of a spatiotemporal world around me (Husserl 1976b, p. 108). Again, however, it is part of my default relation to my body – to me, that is – that I do not observe it, or its movements thematically. Indeed, there is not need to, as I am immediately, though tacitly, aware of it all in the first-person mode. As is illustrated by the old story about the centipede that suddenly starts to think about how it actually goes about moving all those legs in just the right way to walk, and thereupon finds itself incapable of walking, it would be

[4] For the phenomenological account of pre-reflective self-awareness, see Zahavi 1999. For the full Husserlian account of intersubjectivity, see Zahavi 1996. For details on the Husserlian analyses of world and embodiment, see Overgaard 2004, especially chapters 4 and 5.

counter-productive to my walking, cycling, skiing, and playing soccer, if I was constantly focusing on every little movement I make.

The World. There is no question about how to hook up my thoughts, perceptions, etc., with the world. My experiences immediately reveal a world to me. In perception, the world appears to me as present "in person", in "flesh and blood", as it were (*leibhaft*). Nor do I normally stop to ponder or question the relation between my experiences and the world they concern. I am immersed in the world (Husserl 1976b, pp. 148-9). Whenever a putative world-revealing experience is exposed as an illusion or a hallucination, then it is exposed precisely against the background of an experienced world that retains its unshakable status as real: "'The' world is always there as an actuality; here and there it is at most 'otherwise' than I supposed; this or that is, so to speak, to be struck *out of it* and given such titles as 'illusion' and 'hallucination,' and the like" (Husserl 1976a, p. 61; cf. 1976b, pp. 112-3). The world is a life-world. It is a horizon of perceptual, practical, social and cultural meaning that buttresses even the strangest things we experience (Husserl 1976b, pp. 124, 141-2, 145-6 and passim). Everything is, at some level meaningful and familiar to us. If we fail to grasp the precise cultural significance of other people's behavior, at least we experience it as obviously human behavior (and that is why we feel certain that its precise significance escapes us). If we do not know what sort of animal is approaching – don't even know whether it is huge reptile or a mammal, say – at least it has the familiarity of being (some kind of) animal.

Intersubjectivity. The world is one that I experience as essentially shared with others. The existence of other people is not something I have to establish by way of shaky inferences from mere physical behavior. Rather, their existence is immediately given to me in and through the cultural world that surrounds me. My copy of Husserl's *Krisis* bears references to an author, a publishing company, a printer, as well as a previous owner and possible future readers (cf. Husserl 1973, p. 505). Not only that: the incomplete, perspectival givenness of all spatiotemporal objects is itself something that suggests the possibility of other experiencing subjects (Husserl 1952, p. 86). And finally, I perceive other subjects as such in and through perceiving their living bodies. Immediate perception is all it takes. No inferences are needed. I can, to some extent, look upon others as physical things. But this is an artificial stance that I can only adopt with some effort; and even when I do adopt it, the understanding of others as subjects or persons, remains present (*"mit da"*), implicitly, in the background (Husserl 1973, p. 506).

This is of course a rather sketchy and messy collection of oversimplified phenomenological findings, quite often taken out of their context. In other words, there is a lot more to say about all these things, and possibly some of the claims just made are even phenomenologically dubious. Nevertheless, I believe we have some roughly correct descriptions of the way we normally experience things, ourselves, and other subjects. We have some elements of what Husserl would call a description of the world of the "natural attitude". The fundamental idea of Parnas and collaborators is that something like this description of natural or normal experience from the "inside" can serve as a *contrastive background* for understanding the anomalies characteristic of the schizophrenic patient's experiences (Parnas and Zahavi 2002, p. 144). In other words, once

we have achieved a firm grasp of the characteristic features of normal subjective experience, we have something against which to understand and assess the *changes* that affect the experiential lives of pre-psychotic schizophrenic patients. The systematic neglect of experience has precisely prevented mainstream psychopathology from attaining such a background.

3. Phenomenology Applied: The EASE

So far, what I have offered (on behalf of Parnas and Zahavi) have been mere promissory or, at best, preparatory notes. To actually apply phenomenology in this context you would have to incorporate it in some tool that can actually be used in the clinical practice of the psychiatrist. This has been achieved very recently, in the form of a manual – the "Examination of Anomalous Self-Experience", or EASE for short – published by Parnas et al. in 2005. What the EASE is supposed to provide is a manual for conducting interviews with potential schizophrenic patients in order to work out the nature of their condition. The patient is encouraged to describe his or her own experiences, and the psychiatrist will try to determine whether various experiential anomalies characteristic of schizophrenia are present. As I go though a few of the 52 items in the EASE manual (not counting subtypes), it will hopefully be clear both what kind of experiential anomalies are characteristic of schizophrenia, and what their being *anomalous* consists in. To illustrate the importance of the phenomenological background, I will divide these points into the same four categories as above.[5]

Self-Awareness. One characteristic experience is a

> feeling that certain thoughts […] may appear as deprived of the tag of mineness […]. Thoughts feel anonymous (but not primarily in the sense of *content*), perhaps without a connection to the patient's self, perhaps as if they were not generated *by* the patient. (Parnas et al 2005, p. 240)

(The crucial phrase here, as in later examples, is the phrase "as if". The pre-psychotic patient will not attribute these thoughts to someone else, or deny that she is their origin. She typically *knows* very well that it is nonsense; and will say so if questioned.) Other symptoms that should be mentioned here are the following. A patient may experience his own thoughts as having acoustic qualities, or as being localized in a particular part of the head. He may also "be uncertain whether his experience is a perception or a fantasy" (Parnas et al. 2005, p. 242). Finally, there is what Parnas et al. call "phenomenological distance". In such a case, the "self is, so to speak, 'observing' its own mental contents and activities" (ibid., p. 245). One patient states: "I constantly regard myself. Sometimes it is so pronounced that I can hardly follow what's going on on TV. Even during a conversation with others, I observe myself to the point of having difficulty in grasping what my interlocutors are saying" (ibid., p. 246). That can make the

[5] This division differs from the one suggested by Parnas et al, but seems to me more useful for expository purposes. The difference is anyway minor.

patient's subjective experiences appear thing-like or object-like, a phenomenon that is sometimes called "phantom concreteness" (Sass 1994, pp. 88-97). This type of experience may also be accompanied by an experience of one's self or I as being divided or disintegrated (Parnas et al. 2005, p. 248). In general, one can say that "[e]xperience is more observed than it is lived" (Parnas et al. 2002, p. 133), and this seems often to be connected with a certain objectification of, and alienation from, one's own experiences – experiences that the normal subject simply "lives through" in a unthematic "milieu" of "mineness".

Embodiment. Some patients have momentary experiences – in the "as if" mode – of being somehow outside their own body, observing it from an external viewpoint (Parnas et al. 2005, p. 240). Others feel that there is something dislocated or alien about their body or certain parts of it. For example, they may say things such as, "I have a feeling that my left and right forearms have switched places", or "I have a strange feeling that it's someone else's body" (ibid. p. 252). A woman complains that she always feels "as if there was a little man in her head, steering this big robot" (ibid., p. 353). Another says, "I sense my body, but it is far away, some other place" (Parnas and Sass 2001, p. 106). Patients' complaints are sometimes like caricatures of Cartesian dualism. They may feel a gap or a lack of connection between their minds and their bodies. One patient thus describes a "split between his physical part, visible to others, and himself, i.e. all that happens in his mind" (Parnas et al. 2005, p. 353). Others again experience problems performing habitual movements or actions that they would have performed effortlessly and more or less automatically in the past. Excessive reflection on such actions has made them – as in the story of the centipede – impossible to perform without intense concentration. "None of my movements come naturally to me now", says one patient, and continues: "I've been thinking too much about them, even walking properly, talking properly and smoking – doing anything. Before, they would be able to come automatically" (Parnas et al. 2002, p. 133).

World. Patients may also describe themselves as having lost contact with the world, as no longer fully participating in the world. They may for example feel as if there is a barrier, a transparent screen, between themselves and their surroundings (Parnas et al. 2005, p. 247). Some patients also experience that the change has not occurred to them as much as to the world itself. They experience "*a decrease in the very primary sense of lived reality*", which they may express by such statements as the following: "The surroundings appear to me as unreal", or "Things are strange, as if they were only silhouettes" (ibid., pp. 247-8). Furthermore, a patient can feel that she is somehow unique or omnipotent, that the world is a mere figment of her imagination or that she is the center of the universe. Or she might feel that only whatever is in her experiential field is real (ibid., p. 255). Some may also feel that the meaning of the most ordinary events or phenomena becomes a problem for them. They may ponder why grass is green, or start to doubt the meaning of ordinary words (ibid., pp. 249-50). In sum, the seamless fabric of sense that for normal subjects form the basis even for our many failures to comprehend, the unquestionable reality of the world, and the natural immediacy of our access to and involvement in it – all these things can come undone for the schizophrenic patient.

Intersubjectivity. As already mentioned, some people suffering from schizophrenia have

quasi-solipsistic experiences of being somehow unique, or of the world being their own private spectacle, and thus no longer a world shared with others.[6] A patient may experience other people "as robots" (ibid., p. 255). Yet other patients feel as if they are someone else (or even an animal) (ibid., p. 249). The naturalness of social life is often compromised. The patient may have lost touch with social norms, and he or she may attempt to reconstruct these by considering human affairs as governed by rigid principles and rules; this is, for example, the case with the father who "buys a coffin for his dying daughter as a birthday present, because the coffin is something she is going to need" (ibid.). Or, perhaps even more disturbing, others may simply be experienced as "enigmatic, unreliable, or threatening" (ibid., p. 250), people from whom the patient feels he or she needs protection.

All in all, then, the EASE manual seems to be a very remarkable example of phenomenology being applied to real problems of mind, body and life. In the unambiguous words of the authors of the EASE,

> The background of the EASE is phenomenological – especially for grasping the nature of the self and the subject-world relation – and a familiarity with phenomenological description of the structures of human consciousness is indispensable in using the EASE for pragmatic, psychometric purposes. (Parnas et al. 2005, p. 239)[7]

Without grasping the phenomenology of ordinary experience, the psychiatrist has no background against which to appreciate the pre-psychotic experiential anomalies characteristic of schizophrenia. And an approach that pays more attention to the subtleties of the schizophrenic patients' subjective experience seems to be indispensable if progress is to be made in detecting schizophrenia before the onset of psychosis.

4. Further Questions

Let me now briefly reverse the question and ask what psychiatrists can offer us phenomenologists. One thing that Daniel Dennett has emphasized on several occasions is that actual real-life deviations from the normal can help us appreciate the essential nature of some phenomena better than imaginary variations or far-flung thought experiments (Dennett 1982, p. 230; 1997, p. 148) And they can certainly function as controls against too swift philosophical declarations of what the essence of, say, experience consists in. For example, say that you claim that it is essential to all human experience that it is characterized by a robust "mineness". The existence of schizophrenic patients with severe disturbances in precisely this domain would then force you to either adopt the extremely unconvincing view that schizophrenic patients have no

[6] For a vivid and philosophically interesting account of this aspect of the schizophrenic syndrome, see Sass 1994, chapter 2.

[7] In fact, this is not all. The methodological tool of "eidetic variation" is also invoked as crucial when it comes to singling out the essential features of a particular experiential anomaly (Parnas and Zahavi 2002, p. 157; Parnas et al. 2005, p. 238).

(human) experience, or else do what is right, and abandon the original claim (cf. Parnas and Zahavi 2000, pp. 9-10; Zahavi and Parnas 1998).

Another way in which psychopathology might be of value to phenomenology is familiar, perhaps especially from Merleau-Ponty's earlier works. Normal experience can be hard to get a proper grip on. As Wittgenstein once observed, it is very difficult to notice what is "always before one's eyes" (Wittgenstein 1963, § 129). We may be too familiar with normal experience to be able to describe it properly. Pathological cases such as Merleau-Ponty's (1962, part 1, chapter 3) famous case of Schneider, or the various patients described by Parnas and collaborators, can help us illuminate the structure of the normal precisely because of the ways they deviate from the normal. One may recall Heidegger's famous broken tool that, precisely because it is broken, may highlight the nexus of *Um-zu* references that, when all goes well, remains unnoticed (cf. Parnas and Zahavi 2000, p. 11).

So all is well, then, in the synergetic paradise of phenomenology and psychopathology? Based on my talk so far, one might certainly get that impression. And no doubt the research of Zahavi, Parnas, and others strongly suggests that the cross-disciplinary approach benefits both parties significantly. However, some might worry that there is a vicious circularity in play, if both sides are to benefit in the way suggested. For suppose that, with the help of phenomenological characterizations of normal experience, psychiatrists are able to get a better grasp of the experiential anomalies characteristic of schizophrenia. How can a description of these anomalies now in turn help illuminate the phenomenology of the normal? It would hardly be surprising if the psychopathological findings turned out to a very significant extent to confirm the claims that the phenomenologists have been making all along. For after all, those psychopathological findings were made against the background of the phenomenological account of the normal to begin with!

The circle need not be all that vicious, however. If the phenomenologically informed psychopathological approach would have already proven its diagnostic and classificatory worth – and thus obtained real, independent, scientific corroboration or validation – then surely some of that validation could reflect back on phenomenology, and the psychiatric findings be of use in maintaining phenomenology on the right course in future research. For one should not think that phenomenology is a closed subject. It is not a completed and exhaustive collection of results obtained by the great thinkers of the past, but rather an ongoing, unfinished, research project.

To end this paper, however, I want to suggest that the type of collaboration that I have been presenting also raises some fundamental questions for phenomenologists – questions of the most abstract kind, seemingly far removed from the problems of real life. For if phenomenology is able to interact in this way with an empirical science, what sort of philosophy is phenomenology then? Is the "object" – the *Gegenstand* – of phenomenology "experience" in the same sense as a psychiatrist talks about experience (to the extent that he or she does talk about it)? And if so, what, then, is the fundamental difference between phenomenology's vision of philosophy and the empirical sciences of the mind? Does it then turn out, as analytical philosophers used to claim, that phenomenology really is nothing else than a kind of amateur psychology to be

replaced (the sooner the better) with "real" science? On the other hand, if the phenomenologist means something else with "experience" than the psychiatrist does, in virtue of what, then, can the phenomenologist nevertheless have something important to tell the psychiatrist? No doubt the following suggestion has some merit: the phenomenological philosopher as such is engaged in a transcendental project, attempting to articulate the structures that make it possible for us to experience a world, whereas the psychiatrist, as empirical scientist and clinician, interprets the same experiential structures as psychological phenomena belonging to particular human beings. So the philosopher has another *interest* than the psychiatrist.

But even though this is in some sense correct, is it not clear that it constitutes a sufficient answer. For given that it is possible for an empirical science to study the very same experiential structures, it may seem as if the proper task for the philosopher must be simply to adapt the empirical findings to fit his or her transcendental agenda – to "translate" empirical facts into "transcendentalese", as it were. If we think there must be more to it than that, then we need to consider more carefully what sort of thing it is that we do, as phenomenological philosophers.

My point, in raising these metaphilosophical issues is not a critical one vis-à-vis the research I have relied so heavily on throughout this paper. Rather, my point is this: this type of cross-disciplinary work necessitates, for the philosophers involved, serious reflection on their own role and contribution. It raises the question of what philosophy, in particular phenomenological philosophy, is, what sort of issues philosophical issues are, and how one addresses them. The result of neglecting this question may not be cross-disciplinary collaboration blissfully liberated from bureaucratic trade union demarcation lines, but rather, at worst, dilettantism and confusion (cf. Bennett and Hacker 2003).[8]

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