INTRODUCTION

The great problem of the present systems of classification and diagnosis in psychiatry is that they are categorical, that is to say, that a determinate number of symptoms or features affirms or does not affirm the existence of a disorder, without taking into account transitions toward other clinical pictures and, to an even lesser extent, toward normality. Now, if the employment of absolute categories is already questionable in the realm of what we consider as an illness in psychiatry, such as schizophrenia or manic-depressive illness (given the absence of a substrate which delivers consistency to diagnosis), it is much more questionable in the field of personality disorders, since here it is not sure that it is even legitimate to talk about «disorder». Kurt Schneider (1962) already emphasizes the fact that «psychopaths» were not ill persons, but represented extreme variations with respect to an ideal average personality or, more precisely, extreme variations...
of some personality features. That is to say, Schneider’s «psychopathic personality» is closer to the dimensional than to the categorical model. This has been true for the employment of dimensional models for abnormal personality features and categorical for personality disorders as such (Livesley, 1985), which has contributed even more to the confusion in the field of classification and diagnosis of these behavioural alterations, which modern psychiatry insists on typifying in the same way as the diseases with the designation of «disorder».

Categorical diagnoses would be appropriate if a clear distinction between the presence or absence of a particular disorder could be established. But it is evident that not all categories for each one of the millions of possible combinations meeting DSM-III-R criteria for antisocial personality. And borderline personality and different ways of there are 93 possible ways of meeting DSM-III-R criteria for antisocial personality in the realm of personality disorders. Thus, they sustain that has made even some arithmetic calculations, which emphasize more to the confusion in the field of classification and diagnosis of these behavioural alterations, which modern psychiatry insists on typifying in the same way as the diseases with the designation of «disorder».

The first that should be said about this issue is that Husserl’s phenomenology has nothing to do with what the English language psychiatric literature calls «phenomenology» (DSM-IV-TR, 2000). The latter refers to the simple description of the more visible manifestations of a certain illness. Strictly speaking, they should talk about «descriptive psy-
chopathology» and not about «phenomenology». The signs and symptoms are the external and visible element of an ethiopathogenic context (the disease), which does not show itself. The phenomenon, on the other hand, is «what is shown in itself» (Heidegger, 1927, 1963) and includes signs and symptoms announcing it as well as the underlying process. Thus, phenomenology does deal with what is up front: (the obvious), but it attempts, by means of the epoché or reduction, to reach the intimacy of its structure, its essence. This procedure, completely developed by Husserl, has its origins in Greek philosophy itself, which based its episteme in going farther than the doxa, that opinion arising from the experience of how things spontaneously show themselves to human beings in daily life. It is the aspiration to penetrate up to the internal structure of what is real is what distinguishes scientific knowledge from ordinary knowledge. In a first approach, Husserl tried to study the subject of knowing, that is to say, our own understanding itself; but then he realized that he could know nothing of the knowing subject without also inquiring into that which is to be known, be this a natural object or a cultural object. Thus, he overcame in a way the subject-object and immanent-transcendent dualisms, when he proposed himself to study the subjective processes of knowledge together with that which is showed to us as the object in the act of knowing, that is to say, the phenomenon. And he called this act the intentional act. But intentionality is not a mere mode of relationship between subject and object, but an essential feature of the consciousness. Expressed in Husserl's words: «In the simple acts of perceiving we are directed to the perceived things, in remembering to the remembered ones, in thinking to thoughts, in evaluating to values, in desiring to objectives and perspectives, etc.» (1962, p. 237). And it is precisely due to that characteristic of consciousness that we humans find ourselves from the first moment with the things and we always remain close to them. And it is also the intentional character of consciousness that allows it to behave transcendentally with respect to itself. Without the discovery of intentionality, it would have been impossible to overcome the ingenuity prevailing both in natural or pre-reflexive as well as in scientific or logical experience.

In everyday life one finds oneself in a natural attitude naïvely directed towards the world of objects. However, this directs us neither to knowledge nor, even less, to scientific knowledge. In order to transform this natural attitude to scientific knowledge empirical or natural sciences reduce the living object to only one of its aspects. For example, when chemists consider water, they reduce all meanings of this object to its mere molecular composition: two hydrogen atoms and one oxygen atom. In essence, the natural scientist projects the chemical-physical theory of reality upon the entirety of the phenomenon, disregarding all other elements constituting the real object “water”. Chemists do not consider the capacity of water to quench thirst or to make fields bear fruit nor do they invoke the symbolism of the depth of the sea, the importance of clouds or the beauty of a lake. In contrast, when phenomenologists adopt a reflexive attitude, they direct their attention to the totality of the many ways in which an object is perceived in consciousness. In other words: in every real experience we experience more than that which is given by perception of the mere object. This was brilliantly formulated 100 years before Husserl by Goethe (1966, p. 687), who stated in one of his aphorisms: «The experience is always only half of the experience. We always live more than what we live, and experience more than we experience and to explore this other part is the great task of phenomenology. The Goethean principle, itself so parallel to Husserl’s, leads us directly to the oeuvre of the French author Marcel Proust. The deep meaning of his novel «Remembrance of things past» (1976) lies in the recovery of everything that he experienced in the past and lived at that moment almost without being aware of it. The major features of his novel parallel the founding phases of the phenomenological method: a total openness to reality, a reflexive attitude which perceives reality as given to a consciousness, and a progressive elimination of all presuppositions, prejudices and accidental element as an instrument to achieve insight into the essence of what is experienced.

The German physician and philosopher Karl Jaspers (1959, 1963) was the first to apply the phenomenological method to psychiatry. According to Jaspers, phenomenology is a «descriptive psychology». It is strongly related to facts and delivers an unbiased description of patients’ experiences. Jaspers combined an appeal to empathy (Ein-führen) with immediate understanding (Verstehen) of the other person, without exploiting other phenomenological techniques such as reduction (epoché), free variation in imagination and intuition of essential features. However, the present author does not share the opinion of Berrios (1989), who strongly contrasted Husserl and Jaspers. The differences between them are not so extreme as claimed by Berrios, at least not as far as the application of their phenomenological approaches to psychiatry are concerned. Some of Jaspers’ statements illustrate this opinion: «Phenomenology relates to what is experienced as real; it observes the psyche «from inside» through immediate representation (Vergegenwärtigung)» (1963, p. 326); or: «[He] who has no eyes cannot practice histology; [he] who repudiates himself or is unable to image the psyche and to perceive it as an living entity, can never understand phenomenology» (1963, p. 318). Thus Jaspers’ points of departure were in fact the same as those of Husserl: the return to things, the intentionality of psyche phenomena, and the change from a natural to a phenomenological attitude. A scrupulous search of the writings of Jaspers eventually also leads us to the Husserl’s intuition of essences, as when Jaspers calls for an ordering which puts the phenomena of the psyche together, in accordance with their phenomenological kinship, not unlike what occurs with the infinitely manifold colours in the rainbow» (1963, p. 324). Significant American authors, such as Wiggins and Schwartz (1992, 1997) have recently expressed a similar opinion regarding Jaspers’ link with Husserl.
THE CONTRIBUTION OF PHENOMENOLOGY TO THE STUDY OF PERSONALITY DISORDERS

There are three more basic contributions that, in my opinion, phenomenology has made in the field of personality disorders. In the first place, the concept of «ideal type» incorporated by Jaspers (1913, 1959) and taken again in recent years by Michael Schwartz and Osborne Wiggins (1987, 1991); in the second place, the concept of «existential type» coming from Binswanger (1932, 1956) and definitely introduced in psychiatry by Alfred Kraus (1991); and finally, the application of the dialectic perspective to the study of the personality disorders, initiated by Wolfgang Blankenburg (1974, 1981) and continued by this author (Dörr 1986, 1990, 1992, 1997).

Jaspers and the ideal types

Karl Jaspers (1913, 1959), following his master, the sociologist Max Weber, was the first one who introduced the concept of «ideal type» in psychopathology (p. 511). Jaspers thought that this Weber contribution could represent a way to categorize those psychiatric disorders which could not be conceptualized as nosological entities as such. Let us remember that he ordered mental diseases in three groups. In the first one, corresponding to every clinical picture of somatic origin, it is suitable to apply the type of diagnostic process proper of medicine in general, since an anatomical-pathological substrate exists in all of them. In the third group, encompassing Kurt Schneider’s abnormal reactions of the personal experience, neurosis and personality disorders, a medical diagnosis is completely impossible and in them only the application of a typological diagnosis is suitable. Group two, meanwhile, corresponds to idiopathic or endogenous diseases, and occupies with respect to this an ambiguous position, since we think of these pictures as diseases, but as we do not yet know the substrate, we are obliged to use the method of the «ideal type».

Now, what is the ideal type for Max Weber and Karl Jaspers? For Weber (1958) the ideal types are constructs by means of which the human being attempts to understand reality, but which do not necessarily represent it. Weber describes the construction of these ideal types with the following words: «An ideal type is formed by the unilateral accentuation of one or more points of view and by the synthesis of a great quantity of diffuse, more or less present and occasionally absent individual phenomena, which are disposed in accordance with these points of view unilaterally accent in a construct of unified thoughts» (p. 90). The ideal types are idealized descriptions of the concrete characteristics of the things, as seen from a determinate point of view. The usual is that it is difficult to distinguish between the multiplicity of things, since the limits between their identities are blurring, fluid and vague. By means of the ideal type we leave aside the ambiguous character of things and imagine something like a «pure» case, in which the more relevant characteristics appear in a different and univocal form. Even more, in a concrete case the characteristics can vary in such a way that each individual seems unique and incomparable with respect to the others.

Jaspers (1913, 1959) emphatically distinguishes between class and type: «A case belongs or not to a class (e. g., general paralysis), while a case can belong more or less to a type (e. g., hysterical personality)... A type is a fictitious construction corresponding to a reality with diffuse limits and with respect to which the particular case has to be measured. It is important, consequently, to measure each particular case in relation to many types, as far as, if possible, to exhausting it» (p. 469). The types are the product of our intuition, which pretends to seize coherent totalities within the multiplicity of the real. Jaspers distinguishes «average types» from «ideal types». The first ones result from the determination of measurable characteristics in a numerous group of cases, while the ideal type, on the contrary, can arise from the experience of only one case.

Schwartz and Wiggins (1987), following Weber and Jaspers, define the ideal types with a view to having them applied to psychiatry, as «idealized descriptions of typifications... The type depicts the perfect case: the case in which the most characteristic features are fully present» (p. 282). In real life cases, meanwhile, many of these features may be absent or present in an incomplete or atypical way. It will be the task of the clinician to develop the ability to determine, in these «imperfect» cases, their greater or lesser degree of proximity to the ideal type. And this is what we do in clinical practice not only with personality disorders, but with all the diseases lacking a substrate, as it is the case in the previously called «endogenous diseases». Schizophrenia is an ideal type and also paranoia and bipolar disease and in each specific patient we have to «recognize» the type through the multiplicity, variability and the diffuse character of the symptoms. Now, this diagnostic method, based upon the recognition of the type and the determination of the degree of approximation the case we have in front of us shows with respect to the ideal type, has a series of practical advantages in comparison with the arbitrariness of the categorical diagnosis, which is obliged to simply say: this disorder exists or does not exist. And this because the clinician will be obliged to investigate why in that concrete case there are elements of the recognized ideal type missing and others exceeding. Let us imagine a patient with a depressive syndrome, which in many aspects approaches the ideal type «endogenous depression» or «melancholia» described by the classics (E. Kraepelin, 1916; E. Bleuler, 1916, 1975; Tellenbach, 1961, 1983), but which has elements not belonging to it, such as an extreme dryness of the skin and an increase of the cardiac size, for example. The psychiatrist will be obliged to «give his reasons» for this «excess», of what does not belong to the ideal type «endogenous depressions», for which he will have to do a series of tests, which will definitely allow him to prove the existence of a severe hypothyroidism. In other cases it will be necessary to look for the explanation of
The existential types

The concept of existential types goes back to Binswanger, in particular his studies of schizophrenia (1957) and his book «Drei Formen missglückten Daseins» («Three forms of frustrated existences») (1956). In these books, as well as in some previous articles (1932, 1955), Binswanger states his concept of anthropological proportion as norm with respect to which the concrete human being can deviate, constituting here the ontological fundament both of determinate pathological behaviours and of eventual typologies. The horizon from which Binswanger defines these proportions is Heidegger’s (1927, 1963) ontology, in which human being is defined as being-there (Dasein) and as being-in-the-world (In-der-Welt-sein). Now, and unlike Heidegger, Binswanger does not conceive the being-in-the-world only as a universal structure of the human being, but as the concrete unity of one-self and world inherent to each human being. A typical existential proportion is the one given between height and width, or said in other terms, between verticality and horizontality. Thus, for example, in the schizoid personality, with its eccentric ideals and its lack of temporality, there would be a disproportion in favour of verticality, while in typus melancholicus (Tellenbach, 1961), characteristic of the persons predisposed to unipolar depression, with their ease in moving about in the day to day world, their scarce tendency to metaphysical fancy and their difficulty in transcending «no way out situations», the disproportion would be in favour of horizontality and to the detriment of height.

One of the elements contained in the Greek concept of person as mask is dialectics between being in-one-self and being as-if, between self identity and role identity (Kraus, 1985), between factuality and transcendence. The actor is himself and simultaneously the represented character. And this duality was signalled in Greek theatre through the mask. The more the actor is transformed in the represented character, he will be less himself, and on the contrary, if his self is too manifest, the profile of the represented character will be lost. This extreme situation of the theatre actor is permanently given in real life, because the human being will never be able to have an absolute identity with himself as material things have. The being of the man is distended between a being-for-one-self or factuality (in other terms self identity) and a being-for-the-other - a role. Sartre has characterized this situation with a double negation: «One is what one is not and one is not what one is» (1943, 1966). «We will never be able to withdraw into a «materIALIZED» being with an identity like an inanimate thing, since a basic ontological difference prevents us from being absolutely identical with our respective role (and yet), with our values and feelings», asserts Kraus (1985). Now, there exists a...
natural distancing between the being-for-oneself and the being-for-the-other, between one-self and the role, a distance which is necessary to preserve, because both a shortening of that distance in the sense of abolishing the ontological difference, and an excessive withdrawal of the two poles of this dialectic tension between identity and not-identity, are sources of derangement and insincerity. Maintaining the adequate distance, rather, is the source of life and of growth and not, as one could think at first, a tragic impossibility to be identical to one-self. Both elements of polarity determine themselves reciprocally and thus, my factuality, what I am as my-self, is going to give a unique seal to that collective role and, in turn, that role, for example, of physician, will complete me. The problem arises if I «over-identify» with my role, because it implies a negation of the rest of my possibilities of being, and although I win with it stability, I am losing the capacity to change and adapt. The inverse process, that of non-identification with social roles, leads to isolation and to a sterile coming to a halt of a one-self lacking that sort of «protective layer» which is the role. The role both brings access and sets limits in relations with the other person and so when it is lost, such a loss makes the other inaccessible and at the same time intrusive. That is what occurs in schizophrenia. It is well known that schizophrenics marry with lower frequency, work less and badly, descend in the social scale, isolate themselves, etc. And at the same time, the more isolated and lacking social importance, the more persecuted they feel. Many explanations have been given for these phenomena, but the most consistent has been provided by Kraus (1984), who postulates that schizophrenics’ lack of identity derives from their incapacity to assume social roles, which would explain, among other things, the tendency to a negative spontaneous course. So, if the acute episode is overcome with the help of different treatments, the patient does not find roles in which to take refuge again. In the so-called endogenous depressions or melancholies, meanwhile, what is a mere project, something which becomes a permanent tendency to dive into projects without sufficient preparation, can be as negative as remaining imprisoned in the will of reference, between progression and regression. We know very well the problems that the regression in any of its forms brings with it. But an excessive «progression», a permanent tendency to dive into projects without sufficient preparation, can be as negative as remaining imprisoned in regressiveness. Let us consider, for example, the case of those patients suffering from delusions, how they live so immersed in the future that they consider as already achieved, of temporality, there are also two polarities, which demand to be maintained in adequate proportions for the avoidance of deviations and disproportions. I am alluding here to the polarity between having the future and the past as a point of reference, between progression and regression. We know that schizophrenia is a chronic illness, but in the sense of being rooted. It would be appropriate, then, to divide people into those who have more «a sense of freedom», or more liberty, versus those more attached to the land, to traditions, to the past, etc. In the realm of horizontality, two significant directions could also be distinguished and an adequate proportion between both could be considered as normal and perfect. I refer here to the relationship between being oriented toward advancing ahead, toward one only goal, and on the other hand being oriented toward diversity, toward and broadness. These last persons are tardier and they emphasize the importance of the here and now, and are in a way enriched, as opposed to achieving many goals rapidly. In the realm of temporality, there are also two polarities, which demand to be maintained in adequate proportions for the avoidance of deviations and disproportions. I am alluding here to the polarity between having the future and the past as a point of reference, between progression and regression. We know very well the problems that the regression in any of its forms brings with it. But an excessive «progression», a permanent tendency to dive into projects without sufficient preparation, can be as negative as remaining imprisoned in regressiveness. Let us consider, for example, the case of those patients suffering from delusions, how they live so immersed in the future that they consider as already achieved, what is a mere project, something which becomes a source of systematic failures, especially as we see in the field of economic activity.

With this brief digression on the proportions between the different polarities in which the human existence is displayed, and whose disproportions lead to the genesis of different existential types, we follow with the last chapter of this essay, and refer more precisely to the application of dialectic perspective to psychopathology and in particular to the study of personality disorders.

Typologies and polarities: the dialectic conception of personality disorders

But if normality is a «measure», a perfect proportion between two imperfect extremes (in the Aristotelian sense of measure), it could be possible to see these extremes dialectically, that is to say, as repelling and attracting, as poles...
with a mutual need. Something pathologic at one of the extremes; the euphoria of a manic, for example, could be conceived not as a negative deviation from the average mood, but rather as ‘the other side of depression’, as a defence against that immobility, that frozen anxiety, that stopping of time. And on the contrary, the depressive could be seen as a displacement of that dialectic tension toward the dark side, certainly, but also as protection against levity, disrespect, abusiveness, of that incapacity to maintain thought and behaviour within the usual patterns that are typical of the manic patient. In other words, it would be a matter of seeing the positive of the negative, which would allow us a deeper understanding of reality, dominated, as we know since Heraclitus, by the dialectic principle.

After Heraclitus it was Hegel (1958) who definitely introduced into philosophy the dialectic thought and with it the question of the positive view of the negative. Hegel even said that ‘negativity is the universal principle of all natural and spiritual life’ (op. cit., p. 54). But Goethe is also someone who was able to perceive the polarities in their complementariness.

‘The most important thing would be to understand that all that is factual is already a theory’ (Aphorisms, p. 723).

He added later another aphorism along the same lines (p. 703):

‘Nature and idea are not separable and if do we attempt to separate them, not only art, but also life is destroyed’.

In another text he makes a list of opposites, between whose poles life moves and which he called ‘the duality of phenomena’:

«We and the objects, light and darkness, body and soul, spirit and matter, God and the universe, idea and extension, the ideal and the real, sensuousness and reason, fantasy and understanding, being and nostalgia» (p. 707).

But we owe the systematic introduction of dialectic thought in psychiatry to the German psychiatrist and phenomenologist Wolfgang Blankenburg (1974, 1981). His most important contribution is the change that this perspective could produce in the physician-patient relationship. It is very different to approach a patient with the idea or prejudice that he is a person somehow deformed, with deficits, than to approach him without any prejudice about health or disease and open to the possibility of seeing the positive of his negative aspects or, in another moment, the negative of his positive aspects. I quote Blankenburg (1981):

«Access to the schizophrenic is very difficult if we don’t identify ourselves, even if only partially, with what is happening to him; if we do not ask ourselves ‘against what’ this behaviour and way of experiencing is directed, this which in the first moment of contact with the patient, we perceive as a new way of being in the world. In summary, if we do not ask ourselves about the positive of the negative, we will not gain the right access to him...» (p. 57). Along with rescuing the positive, as for example in the schizophrenic, his sensitivity, his capacity to perceive aspects of reality that escape the ordinary person, his extreme authenticity, etc., the dialectic perspective allows us to estimate the real dimension of that other element which configures any psychotic or neurotic breakdown, i.e. the triggering situation – as it is put in Hegelian terms: Das Aufheben, in its triple meaning in German: being able to finish something, being able to maintain the best of it and being able to deal with the new reality. Thus, it would appear to be a mistake to express certain psychopathological characteristics in more or less absolute dimensions, e. g., ego weakness of such and such intensity, or arrest of the more or less deep psychosexual development. Instead, in each case it will be necessary to determine to what extent the crisis has to do with the explosive potential of the challenges the patient must confront. This can be important for the prophylaxis of new crises in the sense of avoiding giving the patient tasks which could weaken his already fragile structure.

In summary, from a phenomenological perspective one could suggest urgent changes to the concepts of normality and abnormality. These changes will allow us not only to be more faithful to reality, but also to reach a deeper understanding of complex psychopathologic phenomena and, not least, a radical change in the therapeutic capacity of the psychiatrist. This is because it becomes much easier to establish an alliance with the patient if he feels not only understood, but also stimulated to develop his positive aspects, those which society has seen up to now only as negative. So, the points to take into account are the following:

1. Psychopathologic phenomena will not have to be seen as mere deficiencies with respect to an average normality. More fruitful seems to be the starting point of searching the positive of the negatives (Blankenburg, 1981).

2. The case of the geniuses (Kierkegaard, Rilke) shows us that in the global historical perspective, what in a given moment could have been considered as a symptom, and therefore abnormal, can mean the fundament of a development toward superior forms of the spirit and, consequently, toward normality in the true sense of the term (Dörr, 2001).

3. The existence not only of the positive of the negative, but also of the negative of the positive (the case of...
Hysteria has always been seen as negative, to the point that nowadays the term is almost an insult. But if we approach these persons without prejudices and from the dialectical perspective previously described, the result is that the hysterical features appear to us in all their positive aspects (Blankenburg, 1974). It is no longer a deviation from a presumed norm, not even the result of determined «neurotic» defence mechanisms, but rather the search for a way of being which avoids the freezing of the project of life into rigid patterns of behaviour, in over-identification with very scarce roles, which by the mere impossibility of their being fulfilled, despite the best of intentions, can plunge the subject into the abyss. This occurs for instance with depressives, whose personality constitutes, as we saw, a polarity with respect to hysteria. This search for freedom in relation with the assumption of roles, which is characteristic of hysteria patients in their «flight from paralysis» that takes place in melancholia, is only one of the positive things we find in them. Another would be what appears when contemplating without prejudices the other polarity: hysteria-obssesive personality. While obsessive patients live «facing inwards», tormented by their sexual and aggressive impulses, worried about each one of the internal changes in their bodies, eager to establish in their immediate environment that order lacking in their chaotic interior, the hysteria patients turn themselves toward the world and others. They do not feel their internal bodies nor are they tormented by their otherwise weak instincts. Their lives revolve around being looked at or admired, letting themselves be seen, albeit on the surface; they live spontaneously, break the rules, skilfully manage interpersonal relationships and how their partners love them! I have never seen more unconditional love than that of the partners of hysterical personalities. Is this only masochism? Is it not rather that the hysterical person knows how to «entertain» better than anybody, that his permanent theatrics so reproached by Jaspers (1959, p. 370), is only a slightly more accentuated version of that role-playing which is life, the same play which made Calderón de la Barca doubt if «life is a dream? The result is, then, that hysteria is the positive slope of the obsessive personality and inversely, the obsessive is the opposite of hysteria. Though the obsessive may be «anal» in his requirements, as psycho-analysis tells us, but what capacity of work, of perseverance, what instinctive force! Let us remember the case of the philosopher Soeren Kierkegaard, how he tormented himself with the strict moral norms imposed by his rigid father during childhood, how each decision made him sweat, how even the remote possibility of a sin made him repent from his engagement to the sweet Regina, though she was the only one he was able to love. And yet, in his last years, he began to «loosen up» and sought fame, he fought with his editors not wanting to leave a single thought of his unknown to the world. It is as if the maturing of his genius would have been possible through a certain degree of «becoming hysterical» (Dörr, 1998). Ergo: the remedy for hysteria would be a little of obsessive character and for the obsessive persons a dose of hysteria. Saint Theresa of Ávila had an hysterical personality and Ignatius Loyola was an obsessive. In the ecstasies of the first and in the works (in particular the Spiritual Exercises) of the second we find the unmistakable traces of these two psychopathologic structures. Now, would we call them «abnormal personalities» or «borderlines» or «psychopaths»?

But we must face many patents with the most diverse abnormal features, which sometimes form some of these known personality structures by which they suffer or make others suffer, as K. Schneider (1962) said. And it would be very important that we learned to leave aside the prejudices or value judgements and pay more attention toward the positive side than toward the negative, because the personality is historic and maintains, certainly, the identity, but through change and this permanent play between one-self and role only finishes with death, when both are one again, as occurs with inanimate objects. And though «psychopathics» the personality may be there always possibilities of some change, be it for a stroke of luck, for loves that move one deeply, for religious conversion or for violent encounters with God, as occurred to the fanatic (psychopath?) Saul of Tarsus, on his way to Damascus. And these changes have to occur in the sense of the opposing polarity. In the case of the hysterical structure, it is toward the obsessive, while in the case of the schizophrenic structure, toward the depressive (Dörr, 1972). The depressive can give to the schizoid his
common sense and his excellent management of interper-
sonal relationships. And inversely, to the pre-depressive
personality or *typus melancholicus*, in the sense of Tellen-
bach (1961), with its almost irritating virtuosity, with that
rigidity in the fulfilment of norms and duties, with that al-
most inhuman forgetting of one-self, would it not do well
to take a little metaphysical flight and freedom in the face
of norms and values, so characteristic of the schizoid and in
a certain way also of the hysteric, both being related from
the structural point of view, as was early held by C. G. Jung
(1907, 1971)?

In abnormal personalities or personality disorders and
unlike the declared psychoses, be these organic or endoge-
nous, the degree of inevitability of their manifestations is
never complete or, in other words, they always maintain an
important degree of liberty, to which the psychiatrist will
have to appeal in his eagerness to modify, But it will always
be a mistake to orient the patient towards a mere adapta-
tion to that inexistent «average». On the contrary, all the
positive of his supposedly abnormal features will have to be
highlighted for him, but in such a way that he has cleared
the way to cross in the opposite direction, toward his oppo-
site pole, which is not so foreign to him, because in a way it
preceded him; in a way it is still in him. And then to wait
and watch as the maturing steps go taking him nearer and
nearer to the centre of polarity, to the midpoint, to the Greek
metron or norm, without ever losing hope, because as the
old Heraclites wisdom says:

«(With time) the cold becomes warm, the warm be-
comes cold, the humid becomes dry and the dry be-
comes humid» (Fragment Nr. 126).

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