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110 years of Karl Jaspers's *Allgemeine Psychopathologie*: is there still a role for Jaspers's phenomenological approach to psychopathology in the DSM era?

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Karl Jaspers had accomplished no more than a few years of psychiatric practice in Heidelberg University Clinic when *General Psychopathology* (*Allgemeine Psychopathologie*) was first published in 1913, in a personal journey that would later lead the young author and physician to become a famous philosopher – a profession he embraced intensively until his death.[1,2]

Jaspers applied Husserl's phenomenological method to develop an innovative way of clinically assessing a patient's inner psychic states.[2] While the sophistication of his proposal was unequivocal, it also caused resistance and divergence. In fact, acceptance of Jaspers's method differed from place to place, apparently greater in Europe and lower in the U.S.[2] Later, when Jaspers was supposedly trying to evade the Nazi regime, the complexity of his philosophical work would have led Albert Einstein to oppose his hiring by Princeton University in 1945, declaring Jaspers to be as obscure as Hegel.[3]

More than a century since its first edition, *General Psychopathology* has undoubtedly influenced several generations of psychiatrists worldwide, although the neo-kraepelinian nosological model of the DSM took on dominant status in clinical practice in recent decades.[2] Thus, today, one might inquire as to the remaining relevance of Jaspers's phenomenological approach to psychopathology for psychiatry; more specifically, whether it should be taught in psychiatry residencies.

Obviously, this inquiry may have more than one answer depending on the ontological and clinical perspectives of the respondent. We shall offer one possible answer by pointing out some of Jaspers's core conceptual features for advocating the use of the phenomenological approach to assess psychiatric patients. First, it was his intention to create a method to assess psychic states in an aprioristic manner, thus freeing psychiatrists from both *a priori* physicalist and psychic determinisms of human mind and behavior. Second, it was his belief that psychiatry was a hybrid field of knowledge, straddling the natural and social sciences. Thus, adequate assessment of psychic phenomena required a different approach, which should involve using empathy to understand another person's perspectives. Third, by doing so, Jaspers's intention was eminently scientific, although a distinct method was demanded due to the specific nature of the object to be studied – namely, man in his uniqueness. Fourth, while aiming to describe as precisely as possible the patient's conscious psychic phenomenon, Jaspers achieved some of the most comprehensive and systematic knowledge of psychopathological phenomenon manifestations, which still serves as a relevant theoretical reference for current Brazilian psychopathology manuals.[4,5]

Finally, and perhaps most importantly, Jaspers wanted to elevate psychopathology as a science to access first-person experience, a method he pointed out (in the seventh edition, revised by Kurt Schneider) as more comprehensive even though his peers often described it as phenomenological. In our opinion, alongside other fundamental disciplines for the training of psychiatrists, Jaspers' psychopathology remains essential, whether because of its historical relevance or its unique descriptive psychopathological framework, but mainly because Jaspers's belief in the irreducibility of conscious experience places first-person experience as an object of interest for psychiatrists. As some have stated, "put the person back into psychiatry."[6]

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Discussing clozapine adverse effects and monitoring strategies: a focus on ethnic diversity

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We read with great interest the article by Goldani et al.,[1] which found that clozapine did not increase neutropenia risk in a sample of 5,847 psychiatric patients – 1,038 on clozapine – from Hospital de Clínicas de Porto Alegre. The study design was retrospective; data were collected from electronic medical records (EMR). Cox regression analysis identified ethnicity (specifically non-Hispanic white) and absolute neutrophil count (ANC) $>$ 2,000/μL during the first year of monitoring as protective factors against neutropenia. Presence of severe medical conditions was a risk factor, while clozapine use was not. These data hold considerable significance; nonetheless, we have some concerns about the conclusions drawn therefrom.

First, we have reservations about its external validity to inform updates of nationwide monitoring strategies. Porto Alegre is the capital of Rio Grande do Sul, a southern state of Brazil, with most of its population descending from European immigrants. More than 85% of the Goldani et al. sample comprised white non-Hispanics. This is not representative of the Brazilian population – with only 43% of white ethnicity and over 50% of self-declared black or mixed ethnicity according to the last national survey, conducted in 2021[2] –, which could lead to bias, such as a different incidence of benign ethnic neutropenia (BEN). BEN is knowingly associated with African, Arabian and Mediterranean ancestry, and could potentially lead to lower ANC at baseline and/or after treatment initiation.[3]

The absolute risk of low ANC consistently showed higher numerical values in the clozapine group. Limitations related to study design – retrospective, EMR-based – and power should be taken into account when interpreting the results as a lack of association between clozapine and moderate neutropenia. We have concerns over the possible clinical translation to psychiatric practice of such statements.

Despite these issues, we agree with the article's fundamental conclusions. Agranulocytosis is indeed a relatively infrequent adverse event – with a reported incidence of 0.9%[4] – and excessive precaution should not preclude the prescription of clozapine to patients in need. In a recent review of monitoring strategies worldwide, countries with the highest rates of clozapine usage[5] were among those with the least stringent monitoring guidelines.[6] These findings reinforce the idea that modifying monitoring strategies could enhance access to clozapine treatment.

On the other extreme, there have been claims that monitoring should be restricted to the first months of clozapine administration.[4] Against this suggestion stands evidence that, though less frequent, late-onset hematological effects of clozapine should still be a concern, with little more than 10% of agranulocytosis occurring after the second year of treatment.[7]

Taking all this into account, we support evidence-based flexibilizations of the monitoring strategy to improve accessibility and prescription of clozapine to at-risk populations, while acknowledging the risk of neutropenia arising from this prescription. In this regard, we believe that additional data from a more ethnically representative sample of the diverse Brazilian population is needed to support more generalizable treatment monitoring guidelines – which should also consider specificities when defining ANC thresholds, such as for patients with BEN.

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