

I AM SCHIZOPHRENIC, BELIEVE IT OR NOT! *A Dialogue about the Importance of Recognition*

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ABSTRACT: The main aim of our article is to discuss the importance of recognition in the psychotherapeutic process. To achieve recognition, patient and clinician should be able to build a space where the patient can find an “ecological niche” in which he can find an “adaptive equilibrium” between the burdensome demands of his psychopathological condition and the external, imposing demands of society. The clinician’s recognition is to a patient the condition of possibility to survive the “oceanic” social currents without integrating too much into them, and in so doing losing all his “non-adaptive” traits, his “pathological” freedom and unique and valuable way to interpret and henceforth live in the world. A schizophrenic person and his psychiatrist discuss the patient’s condition and his way of dealing with it. A dialogue between a “view-from-within” and a sympathetic “view-from-without” whose purpose is to build a circle of reciprocal recognition that allows the patient to come out of isolation and try to construct a fulfilling, even though schizophrenic, life. The concluding remarks will not be a definitive and “closed” examination of the material brought forth by the dialogue, but the opening of a series of questions for further research on this very important and promising theme in the psychotherapy of schizophrenia.

KEYWORDS: Dialectics, dialogue, isolation, recognition, schizophrenia

THIS ARTICLE ARGUES for the necessity of a *dialectical recognition* for the schizophrenia-stricken patient for him to find his own *vital space* in the world, as the intersubjective path of least resistance in building up a capacity to balance the pressures coming from within himself (imposed by his psychopathological condition) and those coming from without, exercised by society (to integrate into its own system, accept its values and then *behave* properly), in so doing tearing from the other an avowal that he is an autonomous self-consciousness (Ricoeur, 1977).

Here “dialectical” does not carry a diminutive meaning, equated with “rhetorical”: a word-playing game that has at its heart only what is plausible but not in itself true, as the ancient philosophical tradition would divide them. For example, in the *Gorgias* (1984), Plato makes his title character answer to Socrates: “That which in very truth is the greatest good, Socrates, is at once cause of freedom for men themselves and of rule over others in their city” (*Gorgias*, 452d), by which it means that rhetoric is a thing of power and therefore a great good, since it gives to its possessor freedom for himself and rule over others; Aristotle, for his part, writes in the *Rhetoric* (1924):

Rhetoric may be defined as the faculty of observing in any given case the available means of persuasion. This is not a function of any other art. Every other art can instruct or persuade about its own particular subject matter [...]. But rhetoric we look upon as the power of observing the means of persuasion on almost any subject presented to us; and that is why we say that, in its technical character, it is not concerned with any special or definite class of subjects. (*Rhetoric*, I,2)

On the contrary, “dialectical” is here understood as the formal principle for the foundation of structural psychopathology. The dialectic understanding of mental disorders acknowledges the vulnerability constitutive of human personhood. It assumes that the person is engaged in trying to cope, solve and make sense of new, disturbing, puzzling experiences stemming from her encounter with alterity. Each patient, urged by the drive for the intelligible unity of her life-construction, with her unique strengths and resources, plays an active role in interacting with these experiences. The product of this yearning for meaning can be establishing a new identity, or producing psychopathological symptoms (Stanghellini & Aragona, 2016). In this way, dialectical psychopathology subsumes the three meanings that “dialectics” has assumed in the Western philosophical tradition, from its inception as etymologically derived from the Ancient Greek verb *dialégesthai* (“to talk with,” “to reason with”):

- the *method of division*. This meaning can be found in Plato: the process that articulates a genus in its species (*diairesis*) or that gathers various species in the genus that encompasses all of them (*synthesis*);
- the *logic of the probable*. This meaning is cast upon dialectics by Aristotle, for whom it is the rational, non-demonstrative way to be implemented when we lack true hypotheses and we have to move from plausible and shared ones;
- the *synthesis of the opposites*. This is the meaning brought about by Hegel, for whom in the synthesis, thesis and antithesis meet their reconciliation because they find out their relationship in the interplay between identity and change (*Aufhebung*).

All these philosophical understandings of dialectics underpin the person-centered dialectical model of psychopathology (Stanghellini, 2017) first introduced by Pinel in his “*Medico-philosophical*

Treatise on Mental Alienation” (1800; 2008) and find their way into a psychotherapy derived from this model (Stanghellini, 2019). In the psychotherapeutic practice, the dialectics patient-clinician is intended as a kind of *conatus agnoscendi* exerted by the psychotherapist in (hopefully) unison with the patient, who still needs to do his hurtful process of self-understanding, for him to find a dynamic equilibrium in his approach to the world. At the same time, the dialectics patient-clinician is here understood as the struggle for recognition by the patient as an autonomous, even though idiosyncratic, consciousness (Hegel, 1807; 1977), and for taking possession of the internal and external processes and developments (Jaspers, 1913; 1997) of his psychopathological condition. This struggle starts from the therapeutic relationship, but then it continues with the opening up to the many worlds and spheres (Sloterdijk, 2011) into which the patient partakes. The clinician offers his guidance in helping the patient achieve this goal.

This person-centered dialectical psychotherapeutic practice is necessary because the only way to have access to the experiences of a person is through *dialogue*. To be able to instantiate a dialogue of mutual recognition with the schizophrenic person, a reciprocal meaningful framework of comprehension mediated by a shared vocabulary, is of utmost importance for the success of the therapy, understood as a process guiding the patient to acknowledge at once his limits and unique possibilities and capacities and so survive the terrifying reality into which he finds himself immersed.

Of the three aforementioned understandings of dialectics, the *Aufhebung* is the most psychotherapeutically pregnant. In German, it is a composite word of *auf* (“away”) and *heben* (“to raise”) that is often translated as “sublation,” and Hegel uses it in his “*Science of Logic*” (2010) to explain the dialectical movement of the logical principle (*das Logische*), that is a form of negation which is not abolition or annihilation. There is *Aufhebung* when a conceptual determination is thought of together with its opposite: it therefore implies the acknowledgment of the opposition as the foundational structure of logicity and world. In the triangle thesis-antithesis-synthesis, the *Aufhebung*

is the “becoming-other-from-itself with itself,” for the synthesis retains everything that was worth saving in both the thesis and the antithesis, each having found its negation in the other and, in so doing, their common relationship.

As a basis for psychotherapy, the *Aufhebung* is the recognition of the importance of *contradictions* in the life-world of the patient, especially in those with schizophrenia, contradictions which shape, substantiate and move the life-experience of the person. Contradictions can arise in emotions, values, stances; and for them holds the premise of Jaspers’s understanding of Nietzsche’s thought (1965): when Nietzsche contradicts himself (and this happens several times; e.g., about Christianity, Christ, Jews, Luther, etc.), every single contradiction is not merely a logical fallacy, rather a meaningful break into the kind of truth discovered by modern consciousness—a kind of truth that embraces contradictions rather than stigmatizing them, quite as much as contradictions in a patient are meaningful splits into his life-construction. When Nietzsche comes back to a topic and delves into it, cutting deeper furrows every time, it opens up a *hole* right at the heart of modern consciousness, and in doing this it pushes the poles of the contradiction to their logical limit. Much as a patient does, and a schizophrenic person possibly is forced to do. Now, the therapist can cast the *Aufhebung* principle upon this buttered consciousness, not just to gauge the measure of the distance between the poles (every contradiction has, in fact, its own level of discrepancy and hence solvability), but to try to fill the gap and recompose, through *dialogue*, the contradictions in the life-world of the patient. This is the aim of an *Aufhebung*-oriented psychotherapy: to give recognition of both the grief stemming from the contradictions and the meaningfulness of their epiphany as pathways into the hermeneutical stance the person takes regarding her vulnerability.

As will be clear as the dialogue unfolds, one of the main messages of Lorenzo’s story is that psychiatric/psychotherapeutic success cannot simply be measured as a diminishing of diagnostically significant symptomatology assessed by some rating scale. The way forward is for the schizophrenic person to embrace his existential and cognitive

“pathological freedom” (Sass, 1992a) and make societal groups acknowledge his peculiar way of life, trying hard to reinstate in his existence the “ontological difference” between the ontic and the ontological levels of experience and inquiry (Heidegger, 1927; 2010), which is lost at the onset of even the pre-psychotic stages of the illness (Sass, 1992b). Symptom reduction is not the main address of psychotherapeutic practice, rather symptom deciphering is the meaningful pathway to the therapeutic care of underlying grief of the patient (Stanghellini & Mancini, 2017), which is ultimately to be found in the isolation imposed on him by schizophrenia.

THE DIALOGUE

LG: I’m schizophrenic, am I not?

GS: Yes, I think you are, although I’m quite sure some of my colleagues would disagree.

LG: I’m afraid you are right. No-one believed me when I tried to explain that this is my diagnosis, or better: *my condition*. No-one would take me seriously. First, the many therapists (psychologists but mainly psychiatrists) I have seen in the last twelve years. They diagnosed me with various “minor” disorders: panic attacks, identity disorder, major depression, obsessive-compulsive disorder, schizoid personality disorder . . . Some psychotic slippage was accounted for, but disregarded. Yet, something was puzzling me: why would they give me antipsychotics (like risperidone, quetiapine, ziprasidone, olanzapine, etc.), in addition to benzodiazepines and antidepressants? It felt like they would fool me, without telling me the truth I was yelling back at them: “I think I am psychotic, I think I am *schizophrenic!*”

GS: I know that was a trauma for you, not being recognized. We all need recognition. And recognition cannot be achieved as an individual separated from the others, but only through *interaction*.

LG: I completely agree. And neither my therapists nor my family recognized my condition. Abysmal. My estranged father waged war on me right after I told my parents I felt unable

to go on studying Math at the university, by going to court to prove that I had, in fact, nothing: everything was in my head, I simply didn't want to study or work and instead live at the expenses of my divorced, poor parents (read: father) . . . My mother was frightened: frozen between a guilt complex (exasperated by my father) and an inability to process what was going on, left alone by her entire family. My family at large was absolutely absent and annoyingly present, in harmful ways. Disgusting and indifferent. *Prats!*

GS: Do you think there were some clues signaling the seriousness of your pathological condition to the people closer to you?

LG: Of course: for example, I slept too much, then, suddenly, too little. I ate too much, then, suddenly, too little. Yet I never dismissed my personal hygiene (on the contrary! I was, and still am, very obsessive-compulsive about hygiene, in all its dimensions), though.

GS: Do you agree that recognition is more than a struggle for life, it is a struggle to tear from the other an avowal that I am an autonomous self-consciousness?

LG: I do agree!

GS: And what about friends?

LG: Well, friends . . . Big word choice. They simply deserted me. I was too odd to comprehend, and everyone has to mind his/her own business, right?

GS: "Odd"? Can you explain?

LG: On the surface, I always seemed, and really am, much more "sane," "balanced," and "grounded" than 99% of the population. Yet, something felt terribly wrong, deep inside me.

GS: Being odd means not-to-be-in-touch-with-the-others?

LG: Not-being-in-touch-with-the-others is just one side of the coin. The other side is not-being-in-touch-with-oneself.

GS: Let's start from the first.

LG: I was socially isolated. I refused to have contact with anyone I could get away with. And at times I was out-of-touch with everyday chores and lifestyle. I didn't go on with

university, but still I spent my whole time studying, on university textbooks, nonetheless.

GS: Aha! This is an example of departing from common sense, isn't it?

LG: Sure. Another example of my oddness was mannerism. Compatibly with my economic conditions (I come from a low- and single-income family), I dressed oddly, in a dandyish way, with broccato ties and jackets (my mother owns a small clothing shop), and just for my own pleasure. All of the above was smoke-screened behind a cloak of superiority and aristocratic disdain.

GS: A way to mask your odd interiority with an odd surface. Some of my colleagues would call it a "false Self." Did you feel so vulnerable, then? Were the others such a threat to you?

LG: Yes. The simple truth is that I don't understand people—this is what makes me vulnerable. And yet this is, in fact, not true. My high-school fellows would always come to me for advice when they were in trouble, and I always gave a piece of it to them. And they always came back, because my insights on other people's mind and behavior were far more far-fetching than their own. My "analytical mind," as someone at some point christened it, was something of an oracle for them. (But then, again, when the crisis was over, they would usually forget about me for years, until the next one; until I stopped all this pain and sent all but one of them to hell).

GS: Capable of doing extraordinary things, but not ordinary ones?

LG: Yes, maybe (*blushing*). This is a point where matters start to be really odd. I'm reasonably able to understand other people, but not by common sense. The way I understand the others relies on a kind of algorithm developed by an ethologist, who studies the other to grasp the rules of how to command oneself with other peers: I lack what Blankenburg (1971) would call "natural evidence," the pre-reflexive, pre-cognitive understanding of social games and the deeply rooted subjec-

tive, stable personal identity from which to express myself.

GS: (*ironically*) I can understand now why my colleagues were reluctant to diagnose you as a schizophrenic person! Too sophisticated a quotation for them. You know: some (perhaps many) psychiatrists and psychologists still think that schizophrenia is a kind of dementia...

LG: I'm afraid I met some of them!

GS: Please, carry on—sorry to interrupt you...

LG: No problem! For example, I always felt excluded by the circle of friends: I wasn't able to fit in, not beyond a certain point. Intimacy was out of the question; yet, in a contradictory way, people would come to me and tell me things they would not dare to tell anyone else. Because they knew I would understand them better than themselves and I would never judge them. Yet entertainment was out of the question; entertainment was always with somebody else.

GS: You lacked common sense, were dis-attuned to the others, felt odd; you started wearing a mask to protect yourself from the others' gaze and judgment; and at the same time, or perhaps as a response to all this, you developed an extraordinary ability to decipher the others' lives via an algorithm, a kind of artificial system with which you could analyze and explain their existential sufferings...

LG: Yes, it feels right said this way . . . I feel I'm not able to understand the world. Also, this isn't at all true. I can understand the world better than my peers, that's why my analyses and predictions about politics, economy, society would prove far more accurate than anybody else's. My mother's mantra is: "You're always right!" Yes, I can understand the world. What I cannot understand is *the world with me into it*. And here we come back to Blankenburg's (1971) point . . . I must live my life through an enormous effort relying almost exclusively on what would be called "intellect," as opposed to "intuition" . . .

GS: It seems that all what for other persons is intuition for you needs an intellect, that is

reflection. Instead of being immersed into reality you see it from without.

LG: Yes. All that points to one ugly truth: I live myself as the Schopenhauerian (1966) ideal of the "winged angel-head without a body," an absolute eagle-sighted eye, always pointed on the world and on myself. Something like a cyborg scanner, or a scanner cyborg. This is the other side of the coin of my oddness: estranged both from the world and, more deeply, from myself.

GS: Disembodied. I am afraid that this would not convince my colleagues that you are schizophrenic... Too much philosophy in it. Not all clinicians are aware of Jaspers's aphorism: *schizophrenia is the most philosophical of all mental illnesses*. Many would believe you are too intelligent to be schizophrenic, as they may think that schizophrenia is a disorder affecting cognitive and intellectual capacities...

LG: I think it does! But the other way around: it forces you to become more intelligent than the non-schizophrenics since what you must understand is something more difficult to grasp than ordinary, common sense experience.

GS: In order to understand non-ordinary experiences you need a non-ordinary intelligence. Of course, only a few succeed in this, and only a minority has the courage even to talk about this. Do you suffer from more "common sense" (I mean DSM) schizophrenic symptoms?

LG: Sure. Voices. Voices who would discuss with me, order me to do stuff, even bad stuff, or praise me. Telling me first that I wasn't fit to live, the next second that I was a genius, a Nobel-in-the-making. At first, I think, there were only "bad" voices and "good" voices. Then they grew in duration and frequency until they changed, and with them changed my mental landscape. Yes, there still were bad voices who compelled me to kill myself because I didn't deserve to live, and yes, there still were good voices who would say incredible things to me, describe the bright future I still got; these last ones had to appear to com-

pensate for the former, truer ones. But, for the most part of the duration of the psychotic state, there were quite normal voices, with which I would talk about everything that passed into “our” minds, from daily happenings to world affairs. I would be immersed in this voices- and rumors-filled world, and only come out by external demand . . .

GS: Were these voices only a hindrance, or in some way a help for you?

LG: They would install themselves on my mind in such a way that my thinking is now dialogical in nature. As Oscar Wilde could not think but in the form of a narrative, I can’t think but in the form of a dialogue.

GS: Do you mean that without voices you cannot think?

LG: I cannot think *at all* without them. It all grew up to the point of becoming a *private world*, besieged and restrained by the shared world of common sense every normal person partakes to. This enchainment to my own private world is why every antipsychotic medication goes straight into the bin.

GS: Voices then contribute to your inner dialogue and to losing contact with shared reality. They are helping you to think and are a hindrance to be immersed into the real world at the same time. If you want to think you must isolate yourself in your own world filled with voices. This makes you fly away from reality...

LG: Right. But this process of upwards-floating identity is obviously a consequence of something more profound: my “unrootedness”—of not being rooted in my own personal lived-body. But what am I saying? I know I have a personal body because I deduct it from many clues spread around me, but I don’t *feel* it.

GS: To put it simply with an image: a huge head and a tiny body? Or you “here” and your body “there”?

LG: No personal body at all. I am not grounded in my body. I have never had a feeling of harmony and fusion with my own body. I always felt strange within it, constrained in some way. Since I can remember, the

language of my body was so distressing I would suffocate it with the pure intellect of my Eye. It’s frightening. Most of the time I feel my body is restricted to my head, sometimes expanded to include the whole world; sometimes I would feel my body completely outside of the body itself, in someone else’s body or something else’s beings, sometimes I would just experience my body as incorporating only parts of it and parts of the external world. Making myself coincide with my geometrical body would provoke an incredible and fainting pain, and the unleashing of the worst voices, sometimes for days. As when my parents forced me to try to drive and get a driving license. Since I am not grounded in my body, I can’t expand it to pan out the necessary sizes to drive a car in the traffic. Everyone can expand his/her body to pan out new spaces, as a driver, a blind man who walks with a stick or as the lady with a long bird wing on his hat, who needs to adapt his new height when crossing doors . . .

GS: Extenuating reflections, attenuated intuition. Detached, separated from your body, your thoughts, the world, the others, and from common sense...

LG: Deep inside me, I always felt I was born wrong, in a way that couldn’t be fixed, by nobody, never. The hope that inspired the phrase by Ellen West, one of Ludwig Binswanger’s (1957) most famous patients, in her diary: “Dear Lord, make me new again, but this time make me better,” would not apply to me. No omnipotent being could repair the fracture I feel in myself.

GS: Were there also, at this point, mood swings coupled with all these symptoms?

LG: Most obviously, I would usually go through ebbs and flows of depression. Very deep depression. A kind of depression, again, with no hope, where neither death would be there to hail my sufferings. I believed (and still believe) that my sufferings would simply continue after I’d died. The main problem is that the *source of every sorrow and grief is the consciousness of myself*.

- GS: So what did you do about that?
- LG: My intellectualistic predispositions and my feeling of incomprehension *vis-a-vis* my therapists slowly but increasingly brought me to try and find out by myself what was really wrong about me. I had already read a lot of psychology books in my high-school years, before the first crisis that struck when I was 18. Most of what I knew came down to the works of the major psychoanalysts. With time I broaden and restricted my horizons at the same time: widening my study to psychiatry, but focusing on the schizophrenia spectrum disorders. At first there were the easiest to find books, as the “*American Psychiatric Publishing Textbook of Schizophrenia*” (2006) of the APA, and then the “*DSM-5*” (American Psychiatric Association, 2013). Both those readings of superficial psychopathology strongly pointed to a diagnosis of schizophrenia. Then, when I discovered the “*DSM-5 Handbook of Differential Diagnosis*” (First, 2014), my self-diagnosis came out corroborated.
- GS: And what with these?
- LG: Well, there was always the same point: how could I be schizophrenic (since I met all the criteria for the full diagnosis) and appear “normal,” even act “normal”? Obviously, I was able to do that because I would simply erase all the stuff and the situations that I knew would destabilize me. But still, something was definitely missing in the picture. I came across Blankenburg’s “*The Loss of Natural Self-evidence. An Introduction to Pauci-symptomatic Schizophrenia*” (1971). There was a strong possibility that something suboptimal in my clinical status was at play to explain such high-functioning, such refined coping strategies . . .
- GS: And then, what happened?
- LG: Well, maybe it was my study, maybe it was just growing up, but I started questioning not only myself, but also the professionals that were in charge of taking care of me. I felt not understood, frustrated, depressed. I decided it was then or never. I came out and went looking for someone who I thought could well understand me, what was wrong with me.
- GS: So?
- LG: I found you. You told me from the beginning I was right in being serious about the status of my grief, that it was in fact double: the sorrow that came from the illness itself and the sorrow that came from my unusual hyper-consciousness of it.
- GS: What do you mean?
- LG: Well, two things. First, the consciousness that I am schizophrenic, an acknowledgment I had even when my therapists thought otherwise . . . Second, a series of experiences in which, how can I say . . . I do not experience *something*, I experience the *experience itself*: I see myself seeing, I listen to myself hearing, I’m aghast at touching something since what is in the fore is the feeling of feeling myself when feeling . . . Does this make sense to you? It is as if the *I* that feels and the *I* that is felt are two distinct objects.
- GS: Mmhhh . . . I understand. And what did you take from my stance regarding your condition?
- LG: You gave me recognition and took me seriously enough to defer me to the public mental-health system, where they still take care of my medication. In the past two years, many things have passed, including two hospitalizations that both worsened the situation. Many drugs I tried, including lithium, which destroyed me; and other, newer antipsychotics. But now I have hope. I have hope because I have recognition of the massive roots of my suffering. It’s not all in my head. I am in deep pain, and it carries a lot of work to try to fix even the smallest thing, because the soul never heals completely. And, even if I am schizophrenic, I can still be very high-functioning.
- GS: And what about recognition?
- LG: Drugs don’t cure. Meaningful relationships do. The recognition I got was instrumental in my own taking possession of my condition, and in delivering the same recognition for the people around me, starting from my mother and then everybody else. I was never embar-

passed to use the word “schizophrenic” for the stigma that brings; I was afraid because I always thought nobody would believe me. Now, I tell everyone, if it comes to it, most naturally. This article is part of my project to let everyone know how important is self- and other-recognition in recovering from schizophrenia. From the vantage of a person with schizophrenia, the real problem is not so much (or exclusively) what people call “symptoms,” but *isolation*—not feeling allowed to talk about your condition, including your strange experiences, feelings, values. But my grief is never-ending and far from over.

CONCLUSIONS

Rather than a conclusion, this is a list of questions arising from our dialogue.

DIALECTICAL RECOGNITION

In which ways can recognition be achieved by patients like Lorenzo? What are the mainstays of the dialectical-recognition approach to persons with mental disorders? Is dialectics (i.e., a dialogue—*dià-légesthai*) always possible or indeed good for every patient? What are the conditions under which the clinician can build up a shared vocabulary with the patient? Is it always possible to find such a vocabulary? Are there any patients for which a “rhetorical” approach, based on the “almighty” clinician, is a better way forward for the therapeutic process?

VALUES

What roles do the different values of the clinician and the patient play in the therapeutic care of persons with schizophrenia? How far can ordinary language philosophy be helpful in trying to shed light on the values of the patient and in building up a shared vocabulary with him? In what way can clinical phenomenology shed light on the patient’s experiences and emotions from which his values stem? Must the clinician always follow through with the values of the patient and extricate them, or must he, at some point, look for

an integration between these values and those of the social context the patient lives in? Given the idiosyncratic values (stemming from the underlying lack of common sense; Stanghellini, 2006) of the schizophrenic person, is it always the case for the clinician to nudge him toward a better and possibly full integration into society (i.e., the person’s social networks), possibly risking losing all his peculiarities, or does he, at some point, need to acknowledge not just the impossibility of doing so, but also its undesirability? In which ways the clinician’s recognition of the patient’s values may help him achieve recognition from his neighbors, if possible and desirable? How can the clinician, eventually based on values-based practice, build up a practice to assign the correct weights to the various people surrounding the patient and how hard should he try to push him to tear recognition from these people? Must the schizophrenic person be brought into integration in societal groups (at any costs?) or should he instead be guided to build up a capacity to balance his idiosyncratic values and experiences with the burdensome demands of society? In the end: should we declare victory upon schizophrenia when the patient is fully integrated and his symptoms under (drug?) control, never mind his underlying grief?

DIAGNOSIS

Are there any doubts about the diagnosis of schizophrenia in Lorenzo’s case? What does his story tell the psychiatric community about schizophrenia at large? Does his narrative defy current diagnostic taxonomies? Are there any recognizable comorbidities (just one possible example: a fitter diagnosis of schizoaffective disorder, given his continuous flirt with what seems like bipolar depression)? Does not Lorenzo’s case study bring about the simple fact that “symptoms” are just the surface of the problem, whereas we should try to develop interview practices focusing on deeper phenomena that might emerge from careful phenomenological analysis?

PSYCHOPATHOLOGY

What is the psychopathological core of Lorenzo’s condition? How far this core vulnerability is a

source of pure grief for him and thus should be reduced to a minimum, or alternatively how far could it be used to usher him out of his isolation-dominated grief toward a more fulfilling lifestyle? How far Lorenzo's pro-active hermeneutical stance *vis-à-vis* his core vulnerability can be used by the clinician as a tool to help him carry out his hurtful journey? Given his story, how can the underlying syndrome be separated from his biography, and should it? How are Lorenzo's disembodiment (Laing, 1959), with his construction of a "false self" (Laing, 1959), and the installation of his overt symptoms like the voices related to each other? Given that when he is deprived of his voices by psychotropic drugs his thinking capacities decline too, how can the relationship voices-thinking be understood? And the one between intellect/reflection and intuition (Bergson, 1903, 2010)? Can his core vulnerability be illuminated by the fact that the source of his sorrow is, supposedly, his heightened self-consciousness (Minkowski, 1925, 1997; Kretschmer, 2013; Sass, 1992a)?

CURE

Lorenzo says "drugs don't cure, meaningful relationships do." Is it too a naive approach for a clinician to abide to? How far can this extremely personal model be applied?

How can a psychotherapeutic model based on the Hegelian principle of the *Aufhebung*—to retain what it is worth saving at the same time as getting what is not forlorn, but kept it always as foreshadow—be constructed in a way useful to address either specific, targeted patients or, indeed, every patient? Which is the proper setting for raising questions and carry on the therapeutic process? What kind of institutional design should the mental health-care system take to capture even these below-the-radar schizophrenic cases and treat them with the importance and the recognition that the patients' grief demands? As Lorenzo finally mean to say: what institutional setting is best designed to let hope spring out of self- and other-recognition in a waterfall at the end of a rainbow?

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