Response

The Schizophrenic Person as a Moral Agent

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We are happy for the opportunity to reply to so many commentaries, all of which seem to have appreciated our work and the ideas that it brings to the field of mental health and, in particular, of philosophy and psychiatry.

We are glad to acknowledge the wide spectrum of topics posited by our commentators and at the same time the recognition of the thematic issue of our project: that the mentally ill is still a person, and that this humane dimension of his existence must be brought to the fore in psychopathological studies and kept always in the fore in the therapeutic process. We are also glad to have encountered appreciation for the fact that long gone is the time when the clinician could have afforded to be the plenipotentiary in the therapeutic relationship, and that a more equal geometry of relations with the patient is not only useful but probably necessary for therapeutic success, intended as a "success [that] also involves complex existential issues surrounding self-ownership, personal identity and responsibility in the recovery process" (Bergqvist, 2021).

We agree that the clinician's acknowledgment of the patient's suffering and the patient's first-personal sense of being understood are *transformative* tools in recovery (Bergqvist, 2021). The person's constitutive vulnerability needs to be recognized as a transformative resource in the healing journey through a genuine dialectic movement which is not finalized in removing this vulnerability, but rather in reassessing its meaning and potentiality in a completely different way (Brencio, 2021). Therapeutic success is always embedded into a plural dimension in which the I–Thou relationship is the pre-condition of the We-ness of existence (Binswanger, 1993). Recognition (being seen, heard, believed, and validated) is essential in a therapeutic process. But, as Flanagan (2021) writes, we would not leave this to just the therapeutic relationship, since patients are really longing for and asking for recognition more generally from others—not just from clinicians. The question is: How could philosophy and psychiatry contribute to the recognition of persons like Lorenzo in the social world? We have a dream: Can philosophy and psychiatry, and more specifically clinical phenomenology, help not just patients like Lorenzo to be recognized—but support relatives, neighbors, citizens, and all people belonging to our shared social environment recognize "mad people" like Lorenzo as *members* of this community and as *resources* for better living in our society?

Another point stressed by more than one commentary is the audacity of Lorenzo's will to be recognized as schizophrenic, embracing his "illness" to the point of making it the start of his core identity, and not refusing it, distancing himself,

treating it like a diagnosis on equal footing with another medical condition. Some commentators seem to be more impressed, some more doubtful; and both for good reasons! Schizophrenia is to Lorenzo an identity apparatus, rather than an illness or a diagnostic label. Banicki (2021) gets it right as he writes "It is for that reason, as it seems, that he prefers to say: "I think I am psychotic, I think I am *schizophrenic!* [emphasis added]," rather than satisfy himself with a conventional phrase such as 'I have the diagnosis of schizophrenia.'" There is currently a debate about how one should appropriately address persons like Lorenzo: "persons with schizophrenia," "schizophrenics," "schizophrenic persons," "persons (or patients) with a diagnosis of schizophrenia," and so on. Most contemporary experts would reject the term "schizophrenic" used as noun and prefer "person with schizophrenia." Yet, as argued by Sass (2007), the contemporary consensus downplays how schizophrenia may not merely hijack but actually transform the self; how schizophrenia may grow out of a particular personality structure, thus representing the culmination of a personal trajectory or mode of being; how schizophrenic modes of being can sometimes involve, often in paradoxical ways, certain forms of intentionality, self-awareness, commitment or even quasi-volitional choice (Stanghellini & Ballerini, 2007).

This is not merely a nominalistic problem, or an issue of political correctness; rather, it points to a crucial issue—the way "normals" actually see people like Lorenzo from a third-person perspective, the way people like Lorenzo see themselves from a first-person perspective, and finally the way they ask to be seen by the "normals." Flanagan understands how embracing his identity as a "schizophrenic" was for Lorenzo, rather than negative being "labeled," being liberated and validated, and in fact made him feel heard for the first time in many years. To put it even more clearly: affirming to *be* schizophrenic is to Lorenzo not just a way to say that he does not want to get rid of his voices, or other "psychotic" symptoms. Schizophrenia is a way of *being-in-the-world*, that is a way of living and a world-view to Lorenzo and other persons like him. The only way of being-in-the-world that is (at least at present) meaningful to him, given his feelings, perceptions, desires, habits, etc. and the way he makes sense of these experiences.

Both Flanagan (2021) and Fulford (2021) stress the *atypicality* of Lorenzo as a patient as rated by DSM standards. This issue can involve, on one hand, a true peculiarity of Lorenzo as a person and henceforth as a patient. But don't we believe that every patient is indeed special? As we are not fans of *corpora* like the DSM or the ICD, or probably in wrong use of these: to a clinician's eye, every patient should indeed be atypical. The fault lies perhaps in psychiatry itself, as correctly put by Fulford: as well as Lorenzo, also "psychiatry is schizophrenic: believe it or not" Fulford argues that psychiatry is suffering a loss of what by extension we might call common sense. Just as, that is to say, at the heart of Lorenzo's schizophrenia is a loss of a "secure sense of his *personal* identity, so psychiatry is schizophrenic in the sense that it has lost a secure sense of its *professional* identity." Aren't the DSM and similar diagnostic manuals but counter-phobic objects used by clinicians to secure their fragile personal identity? Yet the "fault" is not (merely) in the manual itself, but in the use some make of it. Even if the conceptual schemata used in standard psychiatric clinical practice are indeed deeply flawed, as Banicki correctly points out, it is still true that conceptual schemata must be carried out and forth by somebody. They are neither brought down from the sky, nor the maximum perimeter inside which the clinician can move to help the patient. Is, in the end, up to the clinician to *responsibly decide* if he wants to be a typewritten copy of his or her diagnostic manuals, or a moral, embodied person dealing with another moral, embodied person in a meaningful relationship. Also, we can't understand how such conceptual schemata could be reformed in purely theoretical terms (as Banicki suggests) as to be able to fit in every patient that is, by definition, out-of-the-ordinary. How could psychiatry achieve the feat of building schemata on purely conceptual levels that are complete and are never put into question by an out-of-the-ordinary patient? We would like to think that the clinician is engaged in a relationship with himself/herself regarding his/her own framework and methodology, and more self-conscious about the limits intrinsic to every

possible and imaginable conceptual schema that the clinical community could ever write down. We cannot but agree with Fulford's point that what Lorenzo went through during the first ten years or so of his illness, with clinicians downplaying his psychotic symptoms and refusing to address the depth of his grief because he was "too intelligent to be schizophrenic," is simply *bad practice*. Fulford correctly points out that the dialogue between LG and GS "is co-productive (it is a dialogue between equals); it is positive (it is concerned as much with LG's strengths as with his needs and difficulties) [. . .]; and it is recovery-oriented (it is aimed not at symptom control but rather at rebuilding a good quality of life as defined by what matters to LG as an individual)." What, in the end, is important, is that LG and GS "speak the same language." It is *this* that helps to bring conceptual schemata, even if flawed, to the ground, even to the "battleground," and gives LG and GS a chance to overcome schemata flaws.

Last but not least, Myers (2021) acknowledges perhaps the most basic and important aspect of what is going on with Lorenzo as well as with other patients: the *anthropological* level. All this is so important that is worth quoting it in full: "when one has the intention and resources to exercise three key capabilities: autobiographical power, or some control over the way one's life story is told; the ability to be recognized by others as a "good" and valued person, or the social basis of self-respect; and the opportunity to try (and fail) at having meaningful relationships with others (e.g., close friendships, marriage, employment, volunteer roles) (Myers, 2016). Another way of looking at it would be to see the world as a *stage* [emphasis added], so that autobiographical power is one's ability to at least be the editor of the play about one's own life, the social basis of self-respect is one's ability to convince one's audience that one is who one is trying to be, and that peopled opportunities are the right to practice one's role, to try and fail and try again with trusted others [. . .]. There are two unusual things about this piece. First, it is co-authored by the doctor and patient, and their voices are presumably present both in the transcript and the analysis. Second, the patient (LG) *wants* to be labeled as a schizophrenic. . . . Thus, LG asserts his ability to narratively re-envision himself in the psychiatric domain, switching between famous psychiatrists and diagnosticians to make his case. Here, he is reclaiming his autobiographical power in a most unusual way—as a person who is capable of labeling himself [. . .]. Careful, empathic listening and space for experimental narrative re-envisioning are crucial. Here, GS offered LG the opportunity to replenish some of his sense of autobiographical power—"I am a schizophrenic!" Next, GS gave him the tools to take the stage in the role of "schizophrenic" both in the clinic *and* in academic audiences that read this journal, thereby offering him a chance to narrate his own diagnosis. The written form of this piece may be well-received, and it may not be, but this piece *is* the peopled opportunity LG needed to move toward being a moral agent—to speak his truth back to a psychiatric audience who may or may not accept that he has the ability to do so. These are powerful ways of helping LG recover because they promote moral agency, which is a driver of mental health recovery [. . .] However, this is an excellent example of how patients' decisions to use and not use treatment, to engage and disengage in care, to take or not take medications, often hinge on how well they feel their doctor is working alongside them to replenish lost moral agency and intimate connections with others.

The remarks by Myers's moral agency theory are paralleled by the psychopathological interpretation of schizophrenia by Italian psychiatrist Ferdinando Barison, for whom "theatricality" was a basic feature of the schizophrenic *Lebenswelt*. We can't know if Myers is familiar with Barison's theory, but their intuitions go hand in hand.

Barison dedicated many years of his life to the study of the schizophrenic form of life trying to apply the principles of his hermeneutic phenomenology to this investigation, that is, trying to grasp not only the core of this psychopathological condition, but also and, above all, the uniqueness and unrepeatability of the being-in-the-world of every schizophrenic person.

Barison's approach to mental illness, in many ways innovative, persuaded him to consider schizophrenia as a *different and alternative way of being*: an *aliter* (Barison, 1951). The schizo-

phrenic is not the sick person, or rather he is not only the sick person: he is the human being who presents himself in one of the multiple forms and possibilities of life, distorted and strange as they can be. From this point of view, Barison's thought represents a whole new way of considering being schizophrenic, which ceases to be that set of deficits, disordered and meaningless elements that standard psychiatry has always thought: a *minus*. The clinician's hermeneutical interpretation of the condition of the schizophrenic is then "an addition to the schizophrenic "thing""; it represents "the truth of that third universe" that modifies us and the thing in itself called "schizophrenia"—a universe that, as we have seen, is the convergence of the schizophrenic being of the patient and the being of the clinician (Tamburini & Sbraccia, 1991).

For Barison through hermeneutics, it is possible to reach a goal that in no other way can be achieved: to grasp the *schizophrenic positivity*. It consists of the creativity that the schizophrenic person demonstrates to possess when he "*stages*" what, in the eyes of a non-sick observer, may seem like a theatrical performance. The act of the schizophrenic—for example the greeting—is in fact charged with expressive behaviors (such as repeated bows or an immense emphasis) which for the observer are "false," because they are excessively sentimental, out of place, exaggerated; in this case the schizophrenic's way of greeting and the deformation of reality he operated become "something absurd that recalls art" and that is attributable to the theater.

To Barison the core of schizophrenia is what Binswanger called "mannerism" (Binswanger, 1959). The creativity of the schizophrenic, therefore, lies precisely in this: In expressing himself through manneristic theatricality "whose evident purpose is to annihilate the expressive reality, to escape direct meaning by continuously diverting the expressive accent on a cascade of parasitic behaviors whose expressive efficacy is in turn emptied of meaning " (Gozzetti, 1998). Hence the idea that being schizophrenic can be considered such only when it reveals its truth artistically or, better, theatrically. It is "as if the schizophrenic aimed to deny all human reality to take refuge in the absolute, in a disinterested theater without spectators, in which to represent his unreal existence." The exasperation of the expressive conduct (which is therefore rich in accessory feelings, extraneous and "distant" from the act itself) causes the behavior of the schizophrenic person to assume the character of unreality: his creative, theatrical and manneristic behavior destroys reality properly, he dictates and creates a new one, apparently "senseless" and, therefore, "incomprehensible." This destruction takes on the character of a *rebellion against reality*. Reality is experienced dramatically by the schizophrenic person because it is too painful. The adoption of manneristic conduct is "a protest against reality and at the active way of living the unreal" (Barison, 1951).

The mannerist theatricality of the schizophrenic person is thus a form of human existence and "the creativity of the schizophrenic ultimately becomes his extraordinary ability to be schizophrenic" (Barison, 1951).

The deficits, deficiencies, and distortions which are part of the schizophrenic "thing," while demolishing a part of reality, are the cornerstones on which the schizophrenic person creates his new universe. The different, alternative way of perceiving and experiencing the world—enriched with new, original, and "bizarre" elements, which create another reality, far from the one properly defined as such—makes schizophrenia a *plus*.

Finally, the way of expressing himself of the schizophrenic person challenges the observer's ability to relate to the "strange" schizophrenic and can represent for the observer an opportunity and a resource to question and change his own being in the world.

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