Schizophrenia as a Transformative Evaluative Concept: Perspectives on the Psychiatric Significance of the Personal Self in the Ethics of Recognition[1]

Anna Bergqvist

Psychiatric diagnosis serves many functions in the struggle for recognition, such as access to public mental health systems and legal compensation, but it is not necessarily well equipped for the task of self-understanding (Tekin 2019) and re-configuration of personal values in the recovery process – and the likelihood of optimal outcome that is geared to the individual person's quality of life (see May *et al* 2020). Call this the *transformative* dimension of recognition in the complex journey from diagnosis to therapeutic empathy in the doctor-patient relationship.

Patients who are diagnosed with a serious and enduring mental health condition often find it difficult to make sense of themselves in relation to their psychiatric diagnosis. Specifically, they have problems with distinguishing their 'self', or 'who they are', from their mental disorder or diagnosis (Radden 1996; Sadler 2007; Dings & Glas 2020). I argue that what marks out an "owned" and, conversely, "disowned" experience (and behaviour) as such is the wider context of the subject possessing it seen as a *whole person* as characterised by a sense of oneself as an agent (Marcel, 2003). A variety of phenomenological and theoretical considerations strongly suggest that the psychiatric significance of the concept of selfhood is helpfully understood holistically by the five aspects of agency, identity, trajectory, history and perspective that give us the sense of unity and control that generates the subjective sense of self (Neisser, 1988; Sadler 2017). Although there are a few proposals in the psychological literature about therapeutic integration that resemble this claim (Freud 1914; Radden 1996; Tekin 2016), few have made a general case in

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philosophy of psychiatry for thinking about *values* in understanding the psychiatric significance of the personal self in this way. This commentary is intended as a first step in that direction.

The contribution of Gilardi and Stanghellini is particularly illuminating in demonstrating the significance of the personal self and the role of narrative identity in coming to terms with medication and related personal values in the therapeutic process. Consider the dynamic reflection on recognition and therapeutic empathy in the philosophical dialogue at play:

> 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 everyone else. (p. 14).

In what follows I will set to one side the complex question of cure in schizophrenia to allow better focus on the interplay of *values* and *relational agency* in examining the implicit task of self-ownership in psychiatry. When Gilardi tries to make sense of his experiences he seems to be examining the relationship between his diagnosis and who he is. How should we understand this? Gilardi and Stanghellini argue that optimal treatment outcome in psychotherapy 'cannot simply be measured as a diminishing of diagnostically significant symptomatology assessed by some rating scale' (p. 5). The simple reason for assenting to this claim is the recognition that therapeutic success also involves complex existential issues surrounding self-ownership, personal identity and responsibility in the recovery process, where the notion of self-ownership is framed *relationally* as an ongoing mirroring process between self and others for the future (Jopling 2000; Tekin 2011; Bergqvist, 2018).

So far, so uncontroversial. The harder question that remains is how to balance patient values and those of the social context of their environment in assessing diagnostic treatment goals; as the authors put it, "should we declare victory upon schizophrenia when a patient is fully integrated [in society] and his symptoms under (drug?) control, never mind his underlying grief?"

(p.16) Gilardi and Stanghellini's central question as to whether the clinician must always follow through on the idiosyncratic value of the patient in the move from diagnosis to therapeutic empathy invites further reflection on the role played by narrative identity and the concept of self in recovery (see Schechtman 1996; Goldie 2012; Zahavi 2014). I have argued elsewhere (Bergqvist 2020) that we rethink the idea of the "point of view" of the individual patient and the wider context of the treatment situation as something that makes relevant facts available *to* the practitioner's clinical judgment (as opposed to being a determinant of meaning as such). How should we understand this?

The relation between the first-personal aspect of the doctor-patient relationship and what we may think of as the wider humanistic aspirations to effect empathy in clinical practice is, I think, helpfully understood by comparison with Matthew Ratcliffe's (2017) suggestion that we understand empathy as a form of open-ended *exploration* in therapeutic intervention. The central claim is that the distinctive notion of empathic exploration or 'openness' in engaging with the other person's point of view goes beyond cognitive understanding or recognition of the patient's condition because, and in so far as, it involves interpersonal acknowledgement of the suffering of a person as such in the clinical encounter.[2] As Giladri and Stanghellini's conversation show, settling the treatment outcome in isolation from the person's life-world not only fails to acknowledge part of the patient's suffering. In ignoring the shape of one's life-world, an important aspect of the first-personal sense of *being understood as a person* may also be undermined; acknowledging suffering as part of the wider practical context of a person's life *as* the person they are is, I claim, also an important aspect of the first-personal sense of being understood as a

[2] Ratcliffe's (2017) account of empathetic openness as a source of knowledge about patients' experiences of illness and health in psychopathology is offered as an alternative to Goldman's (2016, 2011) deployment of the simulation theory of mind in cognitive science. Following Goldie (2011), Ratcliffe argues against the simulation theory on the grounds that even if empathy, directing one's attention towards the other person, involves a quasi-like perception of what the other person experiences, such empathetic apprehension of the other person operates in conjunction with an importantly different '*second-person experience*' of illness. Due to the limitations of scope, I take no stand here on the plausibility of Goldman's version of the simulation theory as such.

transformative tool in recovery – of being visible and present to the other *as* me as such in the existential context of vulnerability.

The importance of the patient's status of being understood (or not) speaks directly, I maintain, to a key motivation for thinking of narrative as tool for the development of a positive therapeutic relationship in a context of trust and, where necessary, empowerment for positive change. What my account adds to this familiar claim about therapeutic empathy is that, while such choices are revelatory or expressive of a distinctly first-personal stance, they do not constitute or *determine* self-hood and self-interpretation in fixed way. On my use of the idea of narrative structure in self-understanding, the relevant sense of 'narrative' is instead treated as a transcendental condition, as opposed to a feature of the object of evaluation itself. And the reason is that one can also adopt a second-personal stance on one's own experience and address oneself, where the relationship between the first- and the second-personal narrative perspective *on* experience and self-understanding is itself a dynamic and open-ended evaluative process. Such reorientation of focus makes available a new perspective of the narrative task of self-understanding in schizophrenia as a potentially transformative concept in the ethics of recognition, conceived as a dialectical movement in giving uptake to the other.[3]

[Word count: 1110 excluding notes; 1290 including notes]

[3] I borrow the term "uptake" from Austin's (1975) speech act theory. My use of the term in accounting for the significance of narrative understanding and perspective taking in our capacity to talk together owes much to the analytic origin of a descriptive rather than prescriptive methodology of ordinary language philosophy, but I am not able to defend this claim here. For further discussion, see Nyquist Potter 2019.

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