Vulnerability in schizophrenia: a phenomenological anthropological approach

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Abstract**:** Vulnerability, or simply put "the possibility of being hurt", is not only considered a constituent aspect of human experience, illuminating essential aspects of who we are as individuals interacting with others, but it is also crucial in the manifestation of mental illness. In this paper, the specific vulnerability of patients with schizophrenia in the domain of intersubjectivity is analysed. This analysis is the result of several qualitative empirical studies and from the practice of psychotherapy. Three domains in which disturbances of intersubjectivity are manifested are described, which have been chosen because they seem relevant for psychotherapeutic purposes. Firstly, "de-personalization" is described, which implies difficulties in recognizing a sense of authorship or agency in self-experience. Secondly, "de-synchronization" is described, which refers to unilateral self-centered forms of referentiality, namely as "solipsistic" self-referentiality. In the third part, "de-contextualization" of symptomatology is described, which excludes the spatio-temporal dimension of personal history. In the conclusion, essential aspects of a "personalized" experience are revealed, emphasizing the treatment of the patient as an *individual person*, which might be a challenge to traditional, rather "impersonal" (and "ahistorical") accounts of phenomenological psychopathology.

Keywords**:** phenomenological anthropology, vulnerability, schizophrenia, intersubjectivity, self-disorders, psychosis

1. Introduction

A phenomenological approach to psychopathology traditionally consists in describing general structures of experience such as corporeality, temporality, spatiality, and intersubjectivity, and their disturbances in mental disorders. In schizophrenia, for instance, all these structures are disturbed in some form, which has generally been attributed to a disorder of the pre-reflective self-awareness (Sass, 1992; Sass & Parnas, 2003; Parnas & Handest, 2003; Parnas & Sass, 2003, 2008; Parnas et al., 2005; Raballo, Sæbye, & Parnas, 2009; Fuchs, 2010, 2013). However, this focus on the structural disturbances, although important for diagnostic purposes, does not make it possible to approach the patient as an *individual person*. In other words, the phenomenological approach to psychopathology remains to a certain extent *impersonal*, since it aims at phenomenalizing the structural abnormalities common to all patients suffering from the same mental illness, and not the way in which each patient with a particular mental illness is *personally* coping and dealing with it.

A more encompassing "anthropological" approach allows moving beyond purely diagnostic purposes to broaden the focus on the patient as a whole person. Thus, a phenomenological anthropological approach does not place the focus of interest on abnormality as such but on the "conditions of possibility" of human experience in general, being it labelled as normal or abnormal (Kraus, 2015: 316). Rather, the interest of a phenomenological anthropological approach concerns the question of how mental illness is possible in human beings at all or, more precisely, what constitutes their particular vulnerability. From this approach, vulnerability, or simply put "the possibility of being hurt", is not only considered a constituent aspect of human experience, illuminating essential aspects of who we are as individuals interacting with others, but it is also crucial in the manifestation of mental illness.

The experience of oneself as an individual person emerges through patterns of meaningful interactions with others (Husserl, 1970; Maturana & Varela, 1996; Varela, 1990; Varela, Thompson & Rosch, 1991; Schutz & Luckmann, 1973). This implies that a person's experience can - to a certain but perhaps decisive extent - be understood in terms of the meanings emerging through perspectival, situational and contextualized encounters with others. It is in the encounters with others that certain meanings may acquire disturbing qualities for a person's integrity, giving rise to different forms of alienation. Vulnerability as it is experienced in different cases of mental illness refers to this inherent particular condition of a person being confronted to disturbing, unacceptable or unbearable meaningful encounters with others.

The specific vulnerability of patients with schizophrenia in the domain of intersubjectivity is analysed in this paper. This analysis is the result of several qualitative empirical studies and from the practice of psychotherapy. Three domains in which disturbances of intersubjectivity are manifested are described, which have been chosen because they seem relevant for psychotherapeutic purposes. Firstly, "de-personalization" is described, which implies difficulties in recognizing a sense of authorship or agency in self-experience. Secondly, "de-synchronization" is described, which refers to unilateral self-centered forms of referentiality, namely as "solipsistic" self-referentiality. In the third part, "de-contextualization" of symptomatology is described, which excludes the spatio-temporal dimension of personal history. In the conclusion, essential aspects of a "personalized" experience are revealed, emphasizing the treatment of the patient as an individual person, which might be a challenge to traditional, rather "impersonal" (and "ahistorical") accounts of phenomenological psychopathology.

2. De-personalization

Patients with schizophrenia manifest a progressive "depersonalisation" of their experience culminating in psychosis (Fuchs, 2013: 245). Depersonalization implies

a subjective distance of the patient towards his own experience. Self-recognition is not possible to continue anymore, so the experience appears to the patient in an "unfamiliar" fragmented form. Gradually, the patient's subjective experience becomes externalised, losing its tacitly given sense of "personally belonging": "thoughts, actions, or feelings are lived by the patient as not being mine, of being alien, automatic, independent, arriving from elsewhere" (Jaspers, 1997: 121). The latter implies a progressive "passiveness" of the patient with regard to his own existence in general.

Frequently, there is a transition from experiencing thoughts on a quasi-perceptual level to external auditory hallucinations. In the beginning, patients hear their own thoughts not with their ears, but as their own voices inside their heads. Progressively, thoughts lose their familiarity, and patients now start to hear other voices inside their head (which no longer appear to them to be their thoughts). In full-blown psychosis, the experience is externalized, and the voices are heard as coming from the outside, thus acquiring the characteristics of a hallucination. The patient regards as an external reality, which is, in fact, part of his own fragmented experience (Irarrázaval, 2015: 4).

Furthermore, when the patient describes the thoughts not as his owns, he does not mean that he is not actually experiencing the thoughts, but rather that someone or something else is inserting the thoughts in his head, so he does not *recognize* himself as the author or agent of his own experience (Gallagher & Zahavi, 2012: 233). Such misattribution to others for being responsible of generating the patient's experience (like in thought insertion) involves difficulties in recognizing a (minimal) sense of oneself in one's own experience overtime, namely "sameness".

The "subjective" character of experience would remain constant, even in the anomalous manifestations of the acute phases (Zahavi & Kriegel, 2015: 11). However, a patient with schizophrenia may state that he lives his experiences not as his owns, that he feels like another person or a machine devoid of all subjectivity (Fuchs, 2006: 37). In these cases, the ex-

perience is lived by the subject with the quality of *what it is like "for-him"* (Nagel, 1974: 442), that is, from the patient's viewpoint, as lacking his own subjectivity, although the experience does not lose its constitutive condition of being *subjective*, in the sense that there is still a *subject* who lives such anomalous experiences.

3. De-synchronization

Persons experience themselves and the world on the basis of self-referential meanings generating in "open" interactional coordination with others. This *meaningful* dimension of intersubjectivity is dynamically "enactive" as meanings emerge from the interaction and "mutual incorporation" of the persons involved (Fuchs & De Jaegher, 2009: 482). Making sense of one's self and the world emerges through our own emotional-affective meaningful processes so, for instance, the world sometimes acquires a dangerous, threatening or desolated quality, and sometimes becomes a calm or beautiful place. In this way, there is always expected to find certain consistency between how a person makes sense of herself and how she makes sense of the world.

In schizophrenia, the interruption of intersubjectivity would lead to a "shutting-off" the *reciprocity* of meaning-making processes normally co-constituted with others. In acute phases, patients not only see the world through the framework of their delusions but this view is also irrefutable to them. This implies a difficulty in entering into an open interaction that incorporates the perspective of the other person (Fuchs, 2015: 200). Besides, there is a loss of the ability to realize, as we normally do, that material things cannot actually generate meanings or messages, for example, self-referential messages patients discern from what they have heard on the radio, watched on television, or read in the newspapers.

There is a "solipsistic" self-referentiality (unnoticed) in experience in acute states. For instance, in cases of paranoid-type schizophrenia, this leads to the patient's *unilateral* anticipation of others as threatening, dominant or humiliating. Thus,

the pervasive fear experienced by the patient becomes the predominant external threat, which acquires the characteristics of a delusion. The patient experiences a constant fear of being harmed (or killed) by others; somehow it is his own vulnerability to experiencing fear which makes the world and *the others* become unreliable or threatening for them (Irarrázaval, 2015: 4).

4. De-contextualization

Pathological experiences are usually described as phenomena that are divorced from the life context in which they are manifested. In fact, acute phases of schizophrenia manifest themselves as "de-contextualized". Patients' accounts concentrate on (or are limited to) the disturbances of self-experience or body alienations. In other words, patients' accounts lie outside the time-space dimension of the social context and exclude personal history: they are in themselves "unhistorical" (Jaspers, 1997: 281).

However, from a more encompassing approach, symptoms are embedded in the person's life, thus their contents and meanings can only be understood within the context of that life. The articulation of the patients' life stories allows for the spatiotemporal dimension "re-ordering," as well as for the understanding of the schizophrenic psychosis as an indication of the broader life situation that affects the patient, incorporating a social horizon. In this way, this approach enables to connect the manifestation of the acute episode with the patient's vulnerability, revealing disturbing, unacceptable or unbearable meaningful experiences in different encounters with others. Even more, it is possible to identify a continuity in the experience of vulnerability regarding the main personal meaning configured early in life, for instance: a sense of abandonment, ridicule, powerlessness, etc. (Irarrázaval & Sharim, 2014: 265).

The psychotic episode frequently manifests itself when the patients are planning to return to their studies or work after years of extreme isolation. In their attempt at becoming socially involved, they are suddenly confronted with their own experience of the "vulnerability of being-with-others", triggering the psychotic episode as a symptom of this impediment or "limit situation". Thus, it is the patients' *personal vulnerability* what eventually leads to psychosis, together with the culmination of the intersubjective interruption (Irarrázaval & Sharim, 2014: 265).

5. Conclusion

From a phenomenological anthropological perspective, an investigation into something that is essentially pathological reveals at the same time key aspects of normal experience. For instance, "3-de" disturbances of intersubjectivity in schizophrenia have been described, namely as de-personalization, de-synchronization, and de-contextualization. In turn, *agency, meaning-making reciprocity,* and *spatio-temporality*, have been revealed as essential aspects of a "personalized" experience, which normally manifest as inseparable anthropological constituents of the human being-with-others.

Furthermore, the essential aspects of a personalized experience should serve as focus of psychotherapy, not only for persons with schizophrenia, but as principles for psychotherapy in general: 1) to recover the patient's agency by recognizing his/herself as responsible (for being the author or agent) of his/her own experience, 2) to recover the patient's reciprocity in meaning-making processes by incorporating the therapist's second-person perspective, and 3) to recover the spatio-temporal dimension by contextualizing the patient's experience in his/her life story.

Recognizing the patient as an individual person appears necessary for psychotherapy, since recovery requires not only the reduction of symptoms through pharmacological treatment, but also a change in the patient's attitude towards his

own disease condition. In his ill condition, a patient is *passively* suffering from a disease, so an important goal for psychotherapeutic recovery would be for the patient to take an *active attitude* towards his illness, that is, to recover the sense of *being an agent*: a person who is able to *recognize herself as responsible (for being the author or agent) of her own experience*.

The psychotherapist accompanies the patient, and assumes a second-person perspective, being fully present "here and now" in the interaction. Moving the focus of therapy towards understanding the patient's experience of vulnerability is the key to clarifying how to improve and recover his psychological wellbeing. In psychotherapy, the patient learns healthier ways of coping and dealing with his/her disturbing, unacceptable or unbearable meaningful encounters with others. Thus, vulnerability is not only considered a constituent aspect of human experience, but also crucial as much for the manifestation of mental illness as for its recovery.

Paradoxically as it might seem, symptomatology distances the patient from the life situation affecting him, yet the articulation of the life situation affecting the patient would enable to "freeing" himself from symptomatology. The articulation of the patient's life story would recover the continuity of his sense of being an agent, as well as it would contextualize its interruption in different life situations. By exploring the way he copes and deals with the disturbing interpersonal experiences, the patient would learn to reflect on them, as well as on "healthier" ways of coping and dealing with his experience of vulnerability of being-with-others. In this sense, psychotherapy confers to the patient's experience of vulnerability a "therapeutic" value.

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