

MINIMIZING STIGMA, IMPROVING CARE:
AN INVESTIGATION INTO EMPATHY AND NARRATIVE
FOR UNDERSTANDING THE LIVED EXPERIENCE
OF SCHIZOPHRENIA

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Abstract

This dissertation explores a phenomenological account of empathy and narrative-based medicine. Its objective is to offer a sustained critical discussion of the benefits of a phenomenological account of empathy and narrative-based medicine for understanding the experiences of persons diagnosed with schizophrenia, improving therapeutic relationships, minimizing the stigma of mental illness, and supporting people with schizophrenia in their recovery.

Part one of this dissertation critically examines the nature of empathy and highlights the challenges that impede our ability to understand the experiences of persons with schizophrenia. Schizophrenia has historically been viewed as a condition which defies empathic understanding. This view, endorsed by Karl Jaspers, has been influential in shaping current depictions of schizophrenia in Anglo-American medical literature and informing how clinicians interact with those who are diagnosed with this condition. The dissertation makes the argument that Jaspers' approach is limited and sets the theoretical basis for a more robust account of empathy in the conceptualization of relations with persons with schizophrenia.

Part two of this dissertation defends a phenomenological account of empathy, developed by Edith Stein, and presents it as an alternative to simulation theories of empathy. Simulation theories of empathy involve using one's own cognitive resources to replicate the experiences and mental states of others by imagining being in their situation. But one problem with this approach is that it runs the risk of co-opting their experiences and substituting our own, which is morally problematic. In response, Stein's theory offers a solution by recognizing that empathy involves appreciating someone's experiences *as it is for them* and thus it avoids the assimilation of the experiences of others.

Part three of this dissertation explores applications of Stein's theory of empathy and examines narrative-based medicine as a model of therapy. The narratives of persons with schizophrenia offer crucial insight into their lived experience of illness. By engaging with the lived experiences and narratives of others, caregivers can learn improved ways of understanding and supporting people diagnosed with schizophrenia as they restore a sense of self that has been harmed due to the effects of stigma that portray mental illness negatively.

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Disclosure

Previous drafts of this dissertation have been presented at numerous academic conferences, and the publications that have emerged from those conferences have further refined my thoughts throughout this dissertation. Portions of this dissertation have been expanded upon, and modified from, my other peer-reviewed publications which are cited appropriately in the Bibliography.

Statement of Positionality

This research focuses on finding ways for caregivers to implement Stein's theory of empathy and the principles of narrative-based medicine into practices of care to help improve the therapeutic relationship between themselves and persons diagnosed with schizophrenia. But it is necessary to clarify that I am neither a trained mental health practitioner, nor am I someone who has lived experience with schizophrenia. Although I approach this topic from a philosophical perspective, I believe that, as a scholar with a disability, I can nevertheless use my position as a researcher to help advocate for improving the experience of care received by persons with schizophrenia.

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General Introduction

1. Project Objectives and Aims

This dissertation has three main research objectives. The first objective is to defend a phenomenological account of empathy. This will be achieved by refuting simulation theory, which maintains that empathy is the result of understanding the mental states of others achieved by replicating their mental states within ourselves. More broadly, I am arguing against theories of empathy which claim that it is possible to fully understand the other's experiences directly.

The second objective is to explore narrative as a legitimate source of knowledge and to discuss the advantages of narrative-based medicine for persons with schizophrenia. As the shift towards cognitive science and objective models for understanding mental disorders continues to expand, it potentially jeopardizes the importance of narratives and the subjectivity of the person's lived experience of illness. Narratives, on the other hand, can offer valuable insight into the lived experience of mental illness and the information acquired from first-hand experiences can help improve treatment options.

The third objective is to explore the broader applications of empathy, phenomenology, and narrative within the healthcare setting to improve therapeutic relationships, to help support people with schizophrenia in their recovery, and to reduce the stigma surrounding mental illness.

2. Rationale and Significance

The rationale for pursuing this project is because schizophrenia remains among one of the most stigmatized mental disorders. Since stigma impacts a person's life on a variety of levels, addressing the topic of stigma involves critically addressing some attitudes or beliefs that have promoted stigma in the first place. For instance, if therapists maintain the belief that empathizing

with persons with schizophrenia is impossible precisely because schizophrenia has historically been conceived of as a mental disorder that defies empathic understanding, it can lead to further instances of marginalization and alienation for persons living with this condition.

Another reason for pursuing this project is in response to current models for understanding mental disorders. As indicated above, a predominant approach in psychiatry consists of developing and adopting more biological-based approaches to understand mental illness which, in many ways, threatens to silence the voices of individuals by paying less attention to the phenomenological aspects of their lived experiences with schizophrenia. Personal narratives may not be deemed as important because gaining a better understanding of the complexities of the brain should provide all the necessary information about the nature of mental illnesses. This form of reductionism of the experience of mental illness into brain states, I argue, blurs the uniqueness of experience that is captured through exploration of first-person narratives.

In terms of the significance of pursuing this topic, the first benefit of this research is that it defends a conception of empathy that overcomes some of the historical limitations of engaging with people diagnosed with schizophrenia. For instance, one of the earliest supporters of empathy for understanding someone's experiences of mental disorders within the clinical setting is Karl Jaspers. But although he did advocate for empathy to be used as a diagnostic tool in psychiatry, Jaspers famously states that the utterances of people with schizophrenia are completely unknowable and empathizing with their subjective experiences is impossible. By contrast, the Steinian theory of empathy that I develop is beneficial, in particular, because her theory demonstrates that empathy with persons with schizophrenia *is* possible at a basic level. Establishing the *possibility* of empathy, even on a basic level, serves as a foundation that can

lead to more refined conceptions of care that are appropriate for improving the health and well-being of persons diagnosed with schizophrenia.

Secondly, this research explores a theory of empathy that seeks to avoid the pitfalls that standard theories of empathy experience, most notably simulation theory. Unlike simulation theories of empathy, which maintain that we can know another person's experiences by engaging in a complex, imaginative process of simulating the other person's mental states within ourselves, Stein's phenomenological approach allows for differences between individuals to exist and it does not allow for any appropriation or co-opting of the experiences of others.

Thirdly, this approach can help reconfigure therapeutic relationships between caregivers and care recipients. Empathy is a skill that is beneficial in healthcare contexts. Exploring the applications of Stein's theory of empathy as a method of engaging with others within a mental health context, and critically examining the role that narratives can play in facilitating this process of empathy, can serve as a starting point that can lead to improved treatment options.

3. Methodology

The primary methodology of this dissertation consists of an in-depth textual analysis of primary sources. Specifically, I explore Jaspers' *General Psychopathology* to introduce the problem of empathy. I draw upon numerous works of contemporary simulationists to provide a potential solution to the problem of empathy. I then examine Stein's *On the Problem with Empathy* to critique simulation theory and offer a phenomenological alternative to address this concern. The philosophical investigation of this project that focuses on the possibility of empathy with persons with schizophrenia, as well as highlighting the benefits of empathy and narrative for improving therapeutic relationships and reducing stigma, is followed by a deep dive investigation of

secondary sources of autobiographical accounts written by persons with schizophrenia. While extensive qualitative interviews with persons diagnosed with schizophrenia, or with caregivers responsible for treating them, were not conducted, the insights gained from these first-hand narrative accounts provide a fruitful source of qualitative data to support this investigation.

3.1 A Note on Terminology

As noted in the project aims, one goal of this dissertation is to help address the problem of stigma associated with mental illness. To aid in reaching that goal of minimizing stigma, I intend to demonstrate the utmost respect for persons living with schizophrenia. While some of the authors explored and historical sources cited throughout this dissertation may use clinical and diagnostic terms like “schizophrenic,” “schizophrenic patients,” or “the mentally ill” to describe people diagnosed with this condition, language choice can contribute to a sense of dehumanization and lead to further instances of harm that I try to avoid as much as possible.¹ As a result, the terminology “person with schizophrenia” will be used as much as possible because this person-first language is inclusive and the most appropriate for the aims of this project.

Moreover, although one focus of this investigation is on finding ways to improve therapeutic relationships between “patients” and “caregivers,” describing this relationship using these terms highlights an imbalance in power with respect to both parties in this relationship. To that end the term “patient” will be replaced with “care recipient” as much as possible to help consciously shift one’s thinking away from viewing this relationship as a hierarchy where the caregiver or therapist is in a dominant and authoritative position. Similarly, despite the differences in terms of the roles and responsibilities that a “therapist” as compared to a “nurse”

¹ For more on the evolution of terminology of how persons with mental illness self-identify, see Reaume (2002). And for more background into the concept of Mad Studies and its emergence from the psychiatric consumer/recovery movement, see Beresford (2020) and Rashed (2020).

or “doctor” or a “psychiatrist” has in the treatment process for persons diagnosed with schizophrenia, I frequently use the term “caregiver” as a catch-all term to refer to any health or mental health practitioner who is involved in the care of persons with mental illnesses.

Ultimately, I maintain that therapeutic relationships should be collaborative, reciprocal, and viewed as a partnership where both parties work together to achieve shared goals. Although the medical professional is in a dominant position as matters *currently* stand, reconfiguring these relationships into becoming more collaborative requires conscientious shifts in thinking of how therapy should be conceived and how those seeking treatment ought to be seen.

3.2 The Value of Narrative as a Source of Knowledge

As indicated above, one of the aims in this project is to argue for the importance of personal narrative as a viable source of knowledge. Rather than immediately being dismissed as anecdotal and offering no legitimacy in terms of their epistemic value, narratives can be valuable sources of knowledge because they speak to the lived realities of a person’s experience with illness and how that person perceives themselves in the world. As sources of knowledge, narratives can be philosophically significant in that they can help reveal shared experiences and emphasize recurring themes of injustice that highlight a need for reconceiving therapeutic options currently available for those living with this diagnosis. As a pedagogical tool for caregivers, engaging with these narratives can foster empathy and can help caregivers to reach out to care recipients, regardless of their condition and impairments in their capabilities. For people diagnosed with schizophrenia, the act of creating and sharing one’s story provides meaning and context to make sense of their illness experience (Lindemann Nelson 1997/2001; Toombs 1987; Carel 2016).

That being said, acknowledging narratives should not imply that they are a substitute for standard approaches to treatment, nor is it meant to undermine the importance of systematic knowledge production. But their omission from standard treatment options, and the lack of significance placed on the value that personal narratives can have on knowledge production, leaves a void that can impact the ability for caregivers to empathically engage with others in order to improve the quality of therapeutic options available. Thus, I argue that narratives offer a way to complement traditional approaches to epistemology.

3.3 The Role of Narratives for Minimizing Stigma

Part of the issue with the stigma of mental illness is that the life stories of individuals often become obscured. Just like a photo filter on a camera lens, the public's view of persons with schizophrenia is often distorted due to stereotypes and misunderstandings. But even within the healthcare sector many mental health consumers feel as if they are viewed through a pathologized lens which influences how caregivers interact with them. The refusal to acknowledge the legitimacy of these narratives reinforces the stigma surrounding mental illness. For as long as their narratives are discredited due to their diagnosis, these practices of epistemic harm and injustice will continue. But showcasing these narratives can give voice to those who have been marginalized and to challenge the stigma that is linked with "mental illness."

To contextualize this philosophical investigation, personal narratives are examined to acquire first-person descriptive accounts of the lived experience with schizophrenia and to gain deeper insight into how stigma impacts someone's life (Estroff 1989; Blaska 1991; Deegan 1988/1993/1996; Unzicker 1989; Leete 1989; Walsh 1996; Lovejoy 1982; Saks 2007; Jordan 1995; Watson 2015; Hanley 2016; Houghton 1982). I argue that engaging empathically with

personal narratives dispels stereotypes about schizophrenia that create separation and reinforce stigma. By revising master narratives that portray people with schizophrenia as occupying phenomenologically alien worlds, the aim is to extend this analysis beyond the clinical setting to transform the image of schizophrenia and to address public misconceptions about mental illness.

3.4 Situating Theoretical Concepts in Practice

Another feature of this methodology is to situate theoretical concepts in practice. For example, take the concept of “empathy” which is a main focus in this dissertation. The scholarly literature on empathy is quite expansive as the concept of “empathy” has been applied to several distinct fields, ranging from cognitive science, to education, to healthcare, and to philosophy (Given 2008). But in order to talk about empathy and examine its function on the moral, social, and practical level, the presumption within many philosophical traditions is that it is first necessary to discuss all of the theoretical aspects of a concept before exploring its practical applications. However, focusing solely on the theoretical conditions necessary for empathy to become operationalized fails to capture the historically grounded layer of the concept in question.

To illustrate with an example, in *A Theory of Justice*, one of John Rawls’ significant contributions to political, social, and legal philosophy is how he helped transform how the concept of “justice” is discussed within philosophical discourse.² Prior to Rawls, the philosophical and legal investigations into the concept of “justice” began, first, by providing a comprehensive account of the theory of justice and then examining how that theory of justice applies to the scholar’s time period. According to some theorists, “justice” is an immutable and fixed concept that can be uncovered through rigorous analytical reflection, and it is the role of the philosopher to uncover what justice is through these rigorous intellectual activities.

² Many thanks to Idil Boran for providing this excellent example.

But while that was the standard approach *at that time*, Rawls rejects this line of thought because justice does not exist in isolation. “Justice” is defined in relation to society and, as a result, there cannot be a search for a universal theory of “justice” that exists outside of the condition of society. On its own, a theoretical account of justice will never be able to fully capture the historically grounded layer that manifests itself in a *real* world, situated within a *real place*, and governs the interactions of *real people*. Furthermore, it is not necessary to provide a full account of what justice is in order to recognize justice in action. To understand what “justice” is requires examining how it is viewed now and what it means in these circumstances.

Thus, the methodological approach adopted in this project is more broadly aligned with the Frankfurt School of critical thinking which seeks to anchor intellectual discussions within their appropriate social context. This anchoring is crucial for making sense of the subject matter and for providing critical perspectives on the subject matter in question. Although this analysis shifts away from universal ethical approaches, such as deontology or utilitarianism, it cannot be reduced to the label “relativist” or “contextualist.” This approach involves anchoring ourselves within this structure of real people with real lives where our actions have real consequences.

Moreover, unlike other approaches which may attempt to investigate empathy only as a theoretical concept or may limit the scope of the investigation into exploring *only* the epistemological question of “What does it *mean* to empathize with someone in the first place?” this research is primarily concerned with the *practical applications* of empathy and provides a philosophical investigation into improving relationships between caregivers and care recipients with the goal of minimizing stigma. Since the stigma of mental illness remains quite prevalent within North America and many Western Industrialized nations, the insights gained from persons diagnosed with illnesses are sources of knowledge that warrant showcasing. And it is through

this consciousness-raising endeavour of demonstrating the healing benefits of narrative that new ways of reconfiguring relationships and new strategies for reducing stigma can emerge.

Finally, given the real-world implications of this investigation, it is important for the reader to recognize the interdisciplinary nature of this work. It is crucial to recognize the importance of engaging with fields outside of philosophy but fields which, nevertheless, can inform philosophical analysis and provide fruitful contributions to this discourse. I will be engaging with the literature of areas including nursing, bioethics, critical disability studies, social work, and the history of the anti-psychiatry, ex-patient, consumer, and survivor movements to provide a critical philosophical analysis of these topics, albeit in an interdisciplinary way.

3.5 Applications of Phenomenology

A third point to keep in mind is how the concept of “phenomenology” will be utilized throughout this analysis. As I will argue in the discussion of phenomenological accounts of empathy below, the key feature of any phenomenological investigation is to examine experiences directly without any prejudgment. But while the focus of early phenomenologists, such as Edmund Husserl, was on exploring and understanding the objective and universal structures of experience, the concept of phenomenology expanded into other areas, such as healthcare, nursing, and other fields where the qualitative and experiential aspects of experience are more prominent.³ And it is this understanding of phenomenology that will inform the philosophical foundation of this project.

That said, the conceptual framework of this project is not dependent upon a theoretical exploration of Husserlian transcendental phenomenology. Rather this analysis endorses an

³ For instance, within nursing, phenomenology can be conceived as “participatory” and “nonhierarchical [*sic*]” and can demonstrate increased levels of sensitivity towards vulnerable populations within the health care setting (Dinkel 2005, 9). By bracketing biases and prejudgments concerning their patients, the applications of phenomenology can help caregivers better understand the lived experience of mental illness and help promote recovery options for them.

applied phenomenological approach to address the concept of mental health. Whereas Husserl views the goal of phenomenology to uncover the pure forms of experience, moving away from these essentialist discussions can also be fruitful as it expands these important concepts into areas that the original theorists never envisioned (e.g., through applications in health and the social sciences).⁴ Similarly, although the focus of phenomenological investigations is on the first-person subjective experiencing of phenomena, this emphasis on lived experience should not be confused with mere “opinions” or “interpretations” of certain phenomena that remain relativistic (Given 2008, 618). Rather than a methodology of understanding that seeks to be purely neutral in its analysis and universal in terms of its scope of application, phenomenology offers an alternative mode of thinking that is “*distinctly existential, emotive, enactive, embodied, situational, and nontheoretic [sic]*” (Given 2008, 616, emphasis added). The emphasis on the existential, embodied, and context-specific features of experience make it a prime candidate for applications in fields such as mental health care and nursing (McCamant 2006, Earle 2010, Caelli 2000; Munhall 1994; Beck 2013; De Chesnay 2015; Holloway et al. 2010).

4. Background Themes and Perspectives

This section outlines three main areas of debate identified within the literature review that serve as the theoretical background of this project. The themes and issues emerging from these competing perspectives will be addressed in greater detail across several chapters.

4.1 Medical Model of Illness vs. Social Model of Illness

⁴ The goal of phenomenology is to describe phenomena as experienced by someone. Phenomenology, on its own, does not motivate us to care about the experiences of others in any therapeutic way. But the strength of a Steinian approach lies in opening up possibilities for raising awareness of new understandings of phenomena.

One topic of debate in this literature concerns the nature of mental illness and how it should be conceptualized. As a socially constructed category, “mental illness” is very diverse and presents itself among the population in a variety of ways that make it incredibly difficult to confine to a specific concept. But within the scope of this dissertation, I argue that there remains a split between two conceptual models of understanding “mental illness” that has been a source of disagreement between mental health professionals and mental health consumers: the *medical model* of illness and the *social model* of illness.

4.1.1 Medical Model of Illness

The medical model of illness views schizophrenia purely as a “brain disorder” and focuses primarily on symptoms and treatment of those symptoms directly. The medical model promotes the idea that there is ‘something wrong with the patient’ and that the sole purpose of treatment is to alleviate the person’s symptoms. Under a medical model, the primary method of treatment involves medical intervention in order to relieve patients of their suffering. For instance, to treat a person with schizophrenia, various psychopharmaceutical options will be prescribed to help the patient restore “normal” cognitive functioning. Proponents of a medical model maintain that the responsibility of the caregiver is to “fix” the person and to use their medical expertise to help their patients overcome their illnesses. The medical model has been the predominant approach in psychiatry and remains the primary method of treating persons diagnosed with mental disorders.

4.1.2 Social Model of Illness

By contrast, the social model of illness examines the broader social and structural factors that contribute to someone’s experience of illness. Rather than viewing illness *only* as a medical

problem requiring a medical solution, the social model highlights the various ways that society enforces the category of illness onto individuals and certain groups of people. The social model is used as a theoretical framework in fields, such as critical disability studies, to highlight the functional limitations that are imposed upon people which leads to injustice and impediments to accessibility (Engel 1977; Beresford 2002; Goering 2015; Gosselin 2019; Hogan 2019).

While not neglecting the real symptoms that someone is experiencing, the social model expands the scope of investigation by examining the additional layer of systemic barriers and challenges persons with illness or disability experience daily. For instance, imagine someone who requires a wheelchair for mobility. Although the cause of this person's need to use a wheelchair may be attributable to underlying medical complications (e.g., a person with Multiple Sclerosis who develops weakness in their legs), the lack of accessible ramps in public spaces, the lack of elevators in subway stations, and the lack of automatic doors in places of business are examples of how external factors reinforce and give preference to certain ways of being in the world. And it is precisely how this person is capable of navigating through these structures that can contribute to one's sense of belonging in society. For this analysis, I approach schizophrenia through the framework of the social model. The shift away from the medical model paved the way for other movements to emerge, such as the anti-psychiatry movement in the 1960's and 1970's and the shift towards humanistic approaches to psychiatry (Laing 1964; Szasz 1974; Goffman 1961), as well as the emergence of the mental health consumer/recovery movement in the 1980's and 1990's that will be discussed in subsequent chapters (Davidson 2003).

However, unlike some prominent figures in the anti-psychiatry domain, like Thomas Szasz, who denies the *existence* of mental disorders and claims that mental diagnoses are *only* labels of psychiatric oppression, I maintain that "mental illness" does exist and that the

symptoms of mental illness can have a significant impact on someone's life and well-being. But treating mental illness and, ultimately, supporting people in their recovery cannot be done only from a medicalized perspective. The social aspect of mental illness, and the social stigma of "mental illness" that reinforces systems of oppression, must also be examined, and ultimately challenged. While medication can provide relief to someone and allow them to function daily, medication, *on its own*, is insufficient for supporting people on their road to recovery. Multiple approaches to recovery including medication, engaging in rehabilitation, reintegration into the community, fostering relationships, re-establishing a sense of agency and responsibility, and the presence of empathic caregivers are all necessary for recovery efforts to be successful.

4.2 Evidence-Based Medicine vs. Narrative-Based Medicine

As noted in the previous section, the distinction between the medical model of illness and the social model of illness rests on a disagreement on how best to conceptualize mental illness and there is a tension on what it means when someone is given a diagnosis of mental illness. But there also is a disagreement on how best to conceptualize *treatment options* for persons with mental illness. Although they are not mutually exclusive, the two main approaches for how medicine should operate are *evidence-based* approaches and *narrative-based* approaches.

4.2.1 Evidence-Based Medicine

Evidence-based medicine (EBM) serves as the foundation for diagnostic medicine and treatment. The foundation of EBM rests on standardized clinical trials which aim to present neutral and objective features of illness that can be identified and treated appropriately. Similar to the medical model of illness, the goal for EBM is for the caregiver to *cure* the patient using all the

diagnostic tools and medical knowledge available. Through applications of EBM, the therapist examines a person's symptoms and medical history, diagnoses them according to established diagnostic categories, and monitors their progress over the course of their illness and recovery.

According to analysis done by Guyatt et al. (1992), the key characteristic of evidence-based medicine is that it “de-emphasizes intuition, unsystematic clinical experience, and pathophysiological rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research” (Guyatt et al. 1992, 2420, cited in Reiss and Sprenger 2020). As a model of how medicine and care is delivered to people with schizophrenia, I argue that EBM aligns more closely with the medical model of illness primarily because the role of the therapist, under an EBM framework, is to treat the person's symptoms directly. Like the medical model of illness, the procedures used by EBM to alleviate symptoms are primarily achieved through medical intervention in hopes of restoring the person back to a state of health.

4.2.2 Narrative-Based Medicine

Unlike EBM, narrative-based medicine (NBM) probes into the broader context of meaning that the experience of illness has for the person seeking medical care. Instead of focusing on treating symptoms as mere medical anomalies, a narrative approach aims to provide a clearer sense of the meaning of illness and how it impacts the person's life (Charon 2001/2005/2008; Charon and Montello 2002; Frank 1998; Martinez 2002; Childress 2002; Connelly 2002; Kleinman 1989/2017; Rosti 2017; Young 2009; Chung and Slater 2013; Davidson and Solomon 2010). For instance, mainstream approaches to psychiatric treatment are typically characterized as unidirectional, where the therapist is the one who holds epistemic authority. These approaches are hierarchical and presume that the therapist is in the best position to accurately judge the other

person in this therapeutic exchange. The narrative approach, by contrast, seeks to expand the relationship between caregivers and care recipients to open more possibilities for uncovering meaning as a joint process. Unlike EBM, NBM emphasizes relationships that promote communication, active listening, respect, acknowledges the importance of self-reflection, and demonstrates empathy. Precisely because of the added emphasis on mutual dialogue, I maintain that NBM is more *horizontal* and *collaborative* as a mode of treatment, rather than the *hierarchical* and *unidirectional* nature of EBM.

With these distinctions in mind, it is important to clarify that exploring the benefits of NBM does not mean a refusal of the objective, empirical, and rigorous nature of EBM. Rather, the subjective and intersubjective nature of NBM complements the strict objective nature of EBM. This exploration of an additional experiential component of the person's experiences, combined with standard approaches to medicine, offers a holistic picture of the person and of the impact of illness on their daily life. Shifting one's attitude to become more open-minded can help people with schizophrenia to feel better supported and be able to talk about their experiences of illness. But given the historical injustices and discrimination that persons with mental illness have endured, this shift requires careful attention and care to help improve and regain trust between caregivers and care recipients. I argue that NBM has potential benefits for minimizing the stigma of mental illness and supporting people with schizophrenia in their recovery.

Appreciating the benefits of narrative-based approaches for the purposes of empathizing with the experiences of persons diagnosed with schizophrenia should not be equated with an endorsement of any sort of anti-science or anti-intellectual position. As discussed in later chapters, the value of EBM in many areas of medicine cannot be understated and the choice between EBM and NBM should not be construed as a strict "either or" dichotomy. Rather, the

value of NBM in some areas of medicine is that it can help overcome some of the limitations of EBM and can *fill in the gaps* that EBM leaves behind. For areas of care, such as mental health, a person-centered approach afforded by practices of NBM can be particularly helpful for overcoming or alleviating the experience of discrimination and stigma.

4.2.3 Can Theory Ever Truly Be “Objective” and “Neutral”?

As noted above, the attractiveness of EBM lies in the belief that this approach to medicine offers one of the most *objective* and *neutral* methods of treating people experiencing any kind of illness. But this raises two key questions which warrant further exploration: why are these values important to preserve? And is it even possible for a theory to remain truly objective and neutral?

According to Little (2016), value neutrality means striving to overcome and minimize personal and subconscious biases when analyzing data, as well as “avoiding skewing data in order to match a predetermined outcome that aligns with a particular agenda, such as a political or moral point of view” (Little 2016, 85). Within the history of sociology, for instance, prominent scholars, such as Max Weber, strongly advocated for researchers to strive for value neutrality in order to preserve the authenticity of any sort of investigation. For Weber, personal values could distort one’s interpretation of the area of investigation and, thus, these personal biases should be temporarily suspended to better understand the data collected.

The link between adhering to the principles of objectivity and value neutrality and contemporary approaches to medicine, such as EBM, is clear. Precisely because therapists are tasked with identifying, classifying, and diagnosing mental disorders in those under their care, it is necessary to establish fair, impartial, and value-neutral approaches to psychiatry to ensure that persons with mental illness are not unjustly discriminated against or diagnosed on a whim.

But although the call for neutrality and objectivity within psychiatry *is* important to ensure that therapists are removing as much personal bias as possible when making a diagnosis, there are many external sources that can influence a therapist's judgment including the type of training they received, the theories that they personally commit to, cultural biases, etc. (Parascandola 2003, 3).⁵ For example, Thomas Kuhn famously noted how scientific observations are always theory-laden and that it is impossible to completely remove oneself from theoretical assumptions and presuppositions that influence *how* those observations are interpreted in the first place (Kuhn 1970, cited in Reiss and Sprenger 2020). Furthermore, because psychiatrists and caregivers work within an existing paradigm of psychiatry that has already set the standards of practice to guide these researchers, establishing a truly “value-neutral” and “objective” approach in psychiatry (or any field) is an idealized goal that can never be fully actualized in practice.

Part of the reason why “objectivity” and “neutrality” are striven for within the domain of psychiatry is because, as Gupta (2014) and Rashed (2020) note, the history of psychiatry is one of seeking legitimacy as a medical science. Unlike other areas of medicine which have a long history and various measures in place for evaluating, diagnosing, and treating physical ailments, the treatment of mental illness possesses several complexities that are involved in tracing the origins of these mental disturbances. Moreover, until the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952, which provided standard criteria to aid

⁵ In “The Americanization of Mental Illness” Watters (2010) notes how the proliferation of ‘Westernized’ mental disorders, such as depression, post-traumatic stress disorder (PTSD) and anorexia, have spread globally alongside the Western idea that mental illness is primarily rooted in biology. But focusing *solely* on biology without exploring the impact of social and cultural influences into the conceptualization and treatment of mental disorders is problematic. This is because culture and context can offer justifications for the emergence of particular disorders over time. For instance, Summerfield (2001) notes that the rise of reported cases of PTSD cited in psychiatric literature after the end of the Vietnam war does not necessarily *prove* that PTSD is an objectively-verifiable mental disorder. But it does give an indication of how social and cultural beliefs influence the definition of mental disorders in ways that are just as important as the psychopathological factors (Summerfield 2001, 95-96; Watters 2010).

in the classification of mental disorders, the decision to label someone with a mental disorder was left largely to the discretion of the trained psychiatrist.

But the decision to determine what precisely counts as “delusional,” “abnormal,” or “schizophrenic” or not and, more pressingly, who has the power to decide who is “delusional,” “abnormal,” or “schizophrenic” is an issue that calls into question the neutrality and objectivity of these approaches.⁶ As Watters (2010) notes, those who are responsible for attending to persons with mental illness “inadvertently help to select which symptoms will be recognized as legitimate” and, as a result of this influence, he notes that “the forms of madness from one place and time often look remarkably different from the forms of madness in another” (Watters 2010). Since there are no universally agreed upon criteria for understanding the nature of mental illnesses, particularly in relation to cultural variations, and since the meaning of mental illness can change over time, the quest for seeking a unified theory of mental disorders is misguided.

With this context in mind, it is plausible to suggest that if psychiatrists and caregivers are professionally trained in a tradition that has historically marginalized persons with schizophrenia, and if they approach persons they *perceive* to have the defining features of “schizophrenia” as perceived through the lens of that psychiatric paradigm, then the attitudes embedded within those practices can carry with them attitudes that have further increased marginalization and discrimination and reinforce stigma.

4.3 Simulation Theory vs. Phenomenological Accounts of Empathy

The third background issue that is addressed throughout this dissertation is how to understand the concept of “empathy.” If you were to ask someone, “What is empathy?” the likely response you

⁶ For more on the discussion of objectivity and value neutrality in the sciences and social sciences, see Smedslund (2016); Little (2016); Parascandola (2003); Mazur and Watzlawik (2016); Reiss and Sprenger (2020). And for further discussion on the objectivity and validity of psychiatric diagnoses, see Caplan (1995) and Boyle (2002).

might hear is that empathy involves “putting *yourself* in the shoes of someone else.” Empathy is typically viewed as the ability to identify with the experiences of others, and it indicates an opportunity for engaging with another person on an emotional level and cognitive level. As Derntl and Regenbogen (2014) note, most models of empathy contain three core components: (1) the ability to recognize emotions in oneself and others, (2) the ability to share the emotional states of others and respond to these affective states in others, and (3) a perspective-taking ability which allows the empathizer to imagine the perspective of the other to understand them (Derntl and Regenbogen 2014, 70). These core features are exemplified through simulation theory.

4.3.1 Simulationist Approaches to Empathy

Simulationists view the role of empathy as means to understand the experiences of others and, more specifically, to use simulation to *predict* their behaviour (Goldman 2000/2002/2006; Gordon 1995a/1995b/1995c; Coplan and Goldie 2011; de Vignemont 2010; de Vignemont and Singer 2006; Heal 1995a/1995b/2003; Frith 2015; Frith and Johnstone 2003). Using ourselves as the model for cognition, simulation involves replicating the mental states of others to understand what they are experiencing. Simulation theories are attractive because they provide an objective basis for understanding the minds of others. Since they are designed to be neutral, evidence-based, and informed by principles of rationality, objective approaches like simulation theory are deemed preferable because they serve as a theoretical foundation for gaining future knowledge.

It is important to clarify that simulation theory is not precisely a theory of *empathy*. As I will highlight in Chapter 2, simulation is primarily developed to make sense of the experiences of others to predict their behavior in certain situations. Given the same inputs, the same outputs should be the result. But it is this notion that it is possible to recreate another person’s

experiences within oneself that I take issue with as a theory of empathy. The element I am targeting is the claim that it is possible to simulate another person's experience within myself, as that falls into the same trap as theories of empathy which Code (1995) describes as "*I know just how you feel*" types of empathy. And the "*I know just how you feel*" type of empathy is the default approach of empathy that, I argue, is problematic in the therapeutic context.

But, as our understanding of the brain and cognitive sciences improves, the benefit of simulation is that we can get a better understanding of how the brain processes information and that information can be used to aid our understanding of the biological features of mental disorders. This increased knowledge of *how* symptoms of mental disorders are generated can result in the creation of new and more targeted forms of medication to help relieve a person's suffering (Marcsisin et al. 2017, 239). More importantly this knowledge can be a source of reliable and verifiable information to gain a truer understanding of another person's experience.

4.3.2 Phenomenological Accounts of Empathy

However, an alternative model of empathy that stands in contrast with simulation is a phenomenological conception of empathy. As indicated above, phenomenology is the method of investigating and understanding conscious experiences. Phenomenology is a qualitative research method which allows for the examination, exploration, and description of subjective human experience for the purposes of understanding (Dinkel 2005). Within the cognitive sciences, Hipólito and Martins (2018) argue that phenomenology is used to designate a first-person description to capture the "what it is like"-ness of experience (Hipólito and Martins 2018, 60). Instead of being conceptualized purely as a kind of "introspective psychology" of the self,

phenomenology aims to assess the qualities of the experiential phenomena and is concerned with providing a detailed description and analysis of experience (Hipólito and Martins 2018, 59-60).

While the starting point for phenomenological investigations is our own conscious experience and reflection, there is no single phenomenological perspective that is universally agreed upon by phenomenologists or other scholars. For example, Husserl (1977) aims to uncover the universal structure of what it means to be a conscious being that has experiences. Husserl argues that phenomenology is a method which allows us to identify phenomena and identify the *essences* of those phenomena as perceived in experiential consciousness. For Husserl, the notion of “essences” means something similar to a rule or formula for the constitution of a class of phenomena—not how the word is normally used in philosophical discourse. His aim is to develop a science of explanation for conscious experience and develops the method of phenomenology to describe these experiences of the world as fully as possible.

As his doctoral student, Stein (1964) expands on Husserl’s project but develops key insights in several significant ways that are appropriate for this project. Specifically, Stein expands on Husserl’s conception of empathy. In her doctoral thesis, *On the Problem of Empathy*, Stein defines empathy as the non-primordial, or indirect, grasping of the other’s primordial, or direct, experience. Her theory of empathy involves a sense of *feeling with* and *being with* the other rather than *simulating* what it is like to be the other. For Stein, empathy allows us to understand the experiences of others *with them* as they are experiencing them for themselves.

But whereas other approaches of empathy maintain that empathy requires first-person replication of the other person’s experiences, or direct access into the minds of others to understand their mental states, Stein maintains that empathy is *not* a feeling of oneness with another, nor does it involve simulating another person’s thoughts and feelings and then

projecting it back at them. Instead, her account involves a degree of “phenomenological appreciation” of someone’s experience “*as it is for them*” which is achieved through a distinctive kind of “other-directed attitude” (Ratcliffe 2012, 486-487). As Zahavi (2010) notes, empathy entails by necessity a difference between the person who is engaging in the act of empathy and the person who is “the subject of the empathized experience” (Zahavi 2010, 294).

Although Stein’s theory of empathy originally was intended for face-to-face encounters, that does not necessarily entail that it cannot be applied to the context of written narratives. The reason why Stein’s theory does not need to be limited to face-to-face encounters is due to the fact that there are numerous mediums through which empathizing with another remains a possibility. For example, long before the era of digital correspondence and social media, pen pals who frequently write to each other is one method of interpersonal engagement but one which is not confined to face-to-face encounters. Even if you never meet your pen pal, the act of reading their stories and experiences, and sharing your own experiences with someone else, is a reciprocal action which can facilitate empathy and can build interpersonal relationships with them.

But whether it is writing to a pen pal and building a connection with them over time, talking on the phone or listening to a voicemail, communicating with them via texting or instant messaging, or speaking with them on Skype or Zoom, all of these methods of engagement are not, strictly speaking, “face-to-face encounters.” And, as a result, some may argue that these types of situations fall outside of the original scope of Stein’s theory of empathy. However, I think it would be misguided to suggest that these modes of engagement preclude empathy from occurring especially when several technological advances (which perhaps Stein could have never envisioned at the time of her writing) have made connecting with others easier than ever before. That being said, without question, Stein’s approach to empathy teaches us how to empathize with

others immediately present before us and understanding this empathetic process is important in a variety of situations. But I argue that her framework can be broadened and apply to other modes of engagement, such as written narratives, which is the focus of this research.

Empathy involves a feeling of *being with* another person, of relating to her as a person, and an “openness to phenomenological difference” that is “integral” to a “person-oriented second-person experience” (Ratcliffe 2015, 236). Building off the work of Stein and other contemporary phenomenologists, I understand empathy as a relation of *being with* and *feeling with* the other rather than viewing empathy as *being as if* and *feeling as if* the other as per simulation theory. Moreover, unlike simulation theory, I do not view the purpose of empathy to predict the behaviour of the other person or to replicate their experiences. When we empathize with someone we are concerned with another person and “not about a kind of experience she is having, where *who* has the experience does not really matter...” (Ratcliffe 2015, 245; de Vignemont and Jacob, 2012). The significance of attending to narratives is that they constitute meaning for the person with schizophrenia by allowing her to make sense of her experiences.

Simulation offers good insight into how the mind works but that does not mean that narratives should be displaced. Given the recent push towards developing biological models of mental disorders, coupled with the common belief that narratives are unreliable and not legitimate sources of knowledge, the worry of simulation is that, if left unchecked, it could *potentially* lead to further displacement of subjective narrative accounts of experiences of mental illness.⁷ Even if these models become so sophisticated and provides better understanding of the mind, I argue that empathy involves *more* than just examining experiences divorced from the broader context of the person’s life. It is the *person* who is having those experiences that matters

⁷ For further discussion on the perceived unreliability of testimony, see Gupta (2014) and Svenaeus (2017).

and I argue that Stein's theory offers a way to gain access to their experiences. The role of empathy is to facilitate connection with others and to learn more *about* them *from* them.⁸

It is fair to say that simulation theory does not *completely* isolate experiences from the context of the person who is having them, nor is simulation theory *fundamentally* opposed to narrative approaches towards mental illness. Simulation theory requires context because to ask the question, "What is it like to be in another person's shoes?" requires thinking about the other person's shoes and what their situation entails. But narratives may not be given the priority or emphasis they warrant as epistemic sources in these frameworks. Simulation can be very useful in some situations, and it can help us understand the context of another person's situation. But nothing can replicate or work as a substitute for the experience of another. And simulation, presumably, should be achievable without engaging directly with the other person. Thus, while it is one thing to think about what it is like to be in another person's shoes, thinking about what it *might be like* is not the same as what *it is like* for the other person. For as long as empathy is viewed as "putting yourself in someone else's shoes," and reinforces the mindset of "*I know just how you feel*" there is a key experiential element missing that, I argue, Stein's theory of empathy can accommodate. Empathizing with others—particularly members of historically marginalized groups—in morally appropriate ways requires engaging with them on their own terms. A phenomenological investigation into the lived experience of schizophrenia, aided by engaging with narratives, helps caregivers gain an awareness of the other and provides a better understanding of what it is like to live with schizophrenia.

⁸ One of the aims in this project is to push back against wholly objective, impersonal, "view from nowhere" models of knowledge and focus attention on the lived experiences of illness. Analogously, it is useful to make a parallel to Thomas Nagel's reflections on *qualia* on the topic of "what is it like to be a bat?" While we can imagine what being a bat *might* be like, given the knowledge and understanding we have about bats, we can never *know* what it is like *to be* a bat. Similarly, it is not possible for someone to *know* what it is like to have schizophrenia unless they, too, have experienced it directly. I argue that there is a qualitative aspect of experience that cannot be captured via simulation.

5. Short Chapter Description

I close this introductory chapter with a short chapter description for the remainder of this project. Chapter 1 traces the history of psychiatry and explores how schizophrenia has traditionally been understood and treated. Specifically, it examines the defining features of schizophrenia that impedes the ability for therapists to empathize with persons with this condition. A major figure discussed is Jaspers whose influence on psychiatry is revealed through an examination of his account of phenomenology and empathy. Despite the benefits of empathy as a therapeutic tool in psychiatry, Jaspers maintains that empathizing with persons with schizophrenia is impossible. I argue that Jaspers' account is insufficient, and that an alternative account of empathy is required.

To overcome the difficulties associated with empathizing with persons with schizophrenia as outlined by Jaspers, Chapter 2 examines simulation theory as a model of empathy. As previously noted, simulation involves using one's own cognitive resources to reconstruct the other person's mental states to gain a deeper understanding of their experiences and behaviour. Three versions of simulation are discussed: Goldman's analogical inference simulation, Heal's co-cognition simulation, and Gordon's personal transformation simulation. Despite the benefits that simulation has towards understanding the experiences of others, all three versions risk potentially co-opting the experiences of others, which is problematic as it can undermine the value and legitimacy of the other person's narrative and subjective experiences.

Chapter 3 articulates Stein's phenomenological account of empathy as an alternative to simulation theory and demonstrates its therapeutic benefits. In response to Jaspers, it is argued that her phenomenological account demonstrates that empathy with persons with schizophrenia is possible. Moreover, unlike simulation, Stein's account preserves the distinction between the self and the other and does not result in a co-opting of the others' experience. It is argued that

Stein's approach is appropriate for responding to the lived experience of schizophrenia as it opens room for caring attitudes to emerge in these relationships.

Chapter 4 defends Stein's account of empathy against objections. Although empathy is typically required for caring about others, the moral significance and necessity of empathy has recently been called into question by several scholars. The first objection is that the emotional component of empathy is problematic because emotions are insufficient for guiding morality. The second objection is that empathy is not something that can be taught, therefore it cannot be something that needs to be advocated for in contexts such as health care. A final objection is that empathy leads to emotional fatigue and burnout, a problem inherent within many aspects of health care. While these objections are strong, they are problematic for specific kinds of empathy, such as simulation. I argue that Stein's theory is uniquely positioned to respond to these objections and overcome them in ways simulationist theories of empathy fall short.

Chapter 5 explores the therapeutic potential of engaging with personal narratives of illness authored by persons diagnosed with schizophrenia. Narratives are important for constituting our sense of self but one reason why the narratives of people with schizophrenia are often dismissed stems from the stigma of mental illness. Shifting the negative views about schizophrenia requires raising awareness about the realities of living with these diagnoses. Drawing on numerous first-person accounts, I argue that narratives provide insight into ways of cultivating Stein's conception of empathy in more refined ways. Empathizing with others creates opportunities for connection and this can help support people in their recovery from illness.

Chapter 6 investigates the implications of both Stein's theory of empathy and the use of narratives in the context of mental health care. It begins with a discussion of the distinction between evidence-based medicine and narrative-based medicine. It then examines the broader

implications of narrative-based medicine within a recovery model of care. The chapter closes with a discussion of the numerous benefits for both caregivers and care recipients in adopting narrative-based approaches to medicine for improving the therapeutic relationship with persons with schizophrenia.

Finally, the dissertation closes with a brief conclusion reiterating the main research contributions set forward at the beginning of this chapter. It offers a critical reflection on the preceding discussion and highlights additional research questions that emerge from this analysis.

Chapter 1 - Historical Approaches to Understanding Schizophrenia and the Limits of Empathy

This chapter provides an historical overview of the concept of “schizophrenia,” and a detailed description of contemporary understandings of this disorder. One question that arises in this investigation is: why is schizophrenia a challenge for empathy? To address this question this chapter explores the historical works of Emil Kraepelin and Eugen Bleuler and highlights their influence on contemporary conceptualizations of schizophrenia. Then, through a close look at the works of Karl Jaspers, this chapter offers a conceptual framework for articulating the problem of empathy that will be addressed in subsequent chapters.

1. The History of Schizophrenia: Kraepelin and Bleuler

“Schizophrenia” is an umbrella term that encompasses many aspects of psychosis within it. According to the American Psychiatric Association’s *Diagnostic and Statistical Manual Fifth Edition* (DSM-5), the symptoms of schizophrenia include: *diminished emotional expression*, including both a lack of facial expression as well as an aversion to eye contact; *avolition*, which is a decrease in motivated self-initiated and purposeful activities; *alogia* or diminished speech output; *anhedonia* or a decreased ability to experience pleasure; and *asociality*, which is the lack of interest in social interactions (DSM-5, APA 2013/2018). Other symptoms of schizophrenia include delusions; auditory and visual hallucinations; depression; incoherence in speech (“word salads”), disorganized thoughts; catatonic behaviour; impaired social functioning and social withdrawal; neurocognitive impairment; poor quality of life; decreased perspective-taking abilities; and problems in forming goal-directed behaviours leading to difficulties in performing the activities of daily life (Kruse and Schulz 2016, 3-4; Marcsisin et al. 2017, 49; McLeod et al. 2014, 115; Bargenquast and Schweitzer 2014, 233; Derntl and Regenbogen 2014, 72, 77).

Another feature of this condition is that people with schizophrenia may lack insight into their condition and this perceived lack of awareness is typically viewed as a symptom of schizophrenia rather than a coping mechanism for dealing with their diagnosis (Derntl and Regenbogen 2014, 72). But because many people diagnosed with schizophrenia may not believe that they have an illness, the DSM notes that this increases the likelihood of non-adherence to treatment and, consequently, results in higher relapse rates, increased number of involuntary treatments, and an overall poorer sense of psychosocial functioning (DSM-5, 2013/2018).⁹

1.1 Kraepelin's Classification of "Dementia Praecox"

In the late 19th century, Emil Kraepelin provided the conceptual framework for identifying schizophrenia and was the first person to classify schizophrenia (which he identified as *dementia praecox*) as an illness that is distinct from other psychiatric disorders (Andreasen 2011, 4; Marcsisin et al. 2017, 6). *Dementia praecox* is a chronic disease of "progressive functional deterioration", and it emphasizes severe cognitive decline for the person afflicted with it (Kruse and Schulz 2016, 5, 8). As Northoff (2015) notes, Kraepelin characterized *dementia praecox* as the "peculiar destruction" of the "inner coherence" of the individual's "personality" coupled with a "disunity of consciousness" and being reminiscent of an "orchestra without a conductor" (Northoff 2015, 85). For Kraepelin, *dementia praecox* is fundamentally a degenerative brain disorder with no cure and no possibility for recovery.

According to Kruse and Schulz (2016), Kraepelin's influence on the history of psychiatry emerges from the ability to categorize mental disorders based on their nature and his proposal of

⁹ The descriptions of mental illness outlined in the DSM have informed how psychiatrists and other mental healthcare professionals conceptualize persons with various psychiatric diagnoses. While the DSM's descriptions are by no means exhaustive, researchers have compiled a list of symptoms that are typically common for people who are diagnosed with schizophrenia.

a new classification of mental disorders (Kruse and Schulz 2016, 5). He distinguishes between two categories of mental disorders: episodic and chronic. Depression or anxiety, for example, are episodic mental disorders because people diagnosed with these conditions can experience periods of remission over time. Schizophrenia, however, is characterized as a chronic disorder precisely because the projected course of the illness is defined as being incurable and gets progressively worse over time resulting in “a deteriorated state” of mind (Andreasen 2011, 4).

For people perceived to have schizophrenia, symptoms such as alogia, anhedonia, affective blunting and other abnormalities in cognition and emotion regulation were understood as the main identifiers of this disorder. But Kraepelin was not preoccupied with specific symptoms of schizophrenia. Instead, the category of “schizophrenia” is what distinguishes it from other mental disorders (Andreasen 2011, 4). Although definitive diagnostic tests were not readily available at the turn of the 20th century, Kraepelin was one of the first theorists to emphasize the importance of understanding the “natural course and outcome” of schizophrenia which allowed it to be distinguished from other mental disorders (Kruse and Schulz 2016, 5).

1.2 Bleuler’s Theory of Schizophrenia (“Split Mind”)

Unlike Kraepelin, Eugen Bleuler maintained that the chronicity and inevitable deterioration of the mind of the person suffering from this disorder was not guaranteed. For Bleuler, schizophrenia is best conceptualized as a “disorder of the personality” which is caused by a “splitting” of the mind and resulting in a “dissociation” of the self where the sense of an “I” never remains completely intact (Northoff 2015, 85). By focusing instead on this dissociative quality rather than its chronicity, Bleuler moves away from describing the disorder as *dementia*

praecox to *schizophrenia* ('split mind'). This splitting and fragmenting of the mind was seen by Bleuler as the crucial aspect of identifying someone with this condition (Andreasen 2011, 5).

Bleuler's account of schizophrenia identified a series of core symptoms that were present in all instances of schizophrenia. More importantly, these are symptoms which occurred *only* in schizophrenia, and which distinguishes it from other mental disorders. These symptoms include disordered thoughts and speech, ambivalence, the flattening of a person's affective states and responsiveness, social withdrawal from reality, and preoccupation with one's thoughts (Kruse and Schulz 2016, 5; Andreasen 2011, 5; McLeod et al. 2014, 117; Marcsisin et al. 2017, 6). Due to the focus on symptoms, rather than generalized categories, Bleuler's definition was broader in scope than Kraepelin's narrow definition and, consequently, psychiatrists adopted the method of identifying the key symptoms which allows for more accurate diagnoses (Andreasen 2011, 6).¹⁰

1.3 Kraepelin and Bleuler's Legacy: Schizophrenia and a Distorted Sense of Self

As highlighted in the list of symptoms found in the DSM, it is evident that the influence of both Kraepelin and Bleuler shaped how schizophrenia was defined by psychiatrists in the early part of the 20th century. Following the tradition of Kraepelin and Bleuler, schizophrenia remains characterized as a disorder resulting in a "fragmentation" and "disruption" of one's experiences as well as an impairment of one's sense of self (Ratcliffe 2012, 486-487). According to Northoff, a person's sense of self that is disrupted due to the presence of a "disturbed ipseity" in which there is a dissociation within the person where they feel like their sense of self is no longer their own (Northoff 2015, 85-86; Molas 2020, 26-27). Similarly, Parnas et al. (2005) argue that the

¹⁰ For more on the history of schizophrenia that emerged from the tradition of both Kraepelin and Bleuler, as well as how different iterations of the DSM treated the condition of "schizophrenia," see Boyle (2002).

core features of schizophrenia include an “inner void” and a “lack of identity” since the individual feels disconnected from themselves and others (Parnas et al. 2005, 244).

According to Hirjak et al. (2013), people with schizophrenia suffer from disembodiment and often feel like their experiences do not belong to them but are being had by someone else (Hirjak et al. 2013, 1). Because of this lack of a firm sense of self, some people with schizophrenia view themselves as “passive spectators” of their own bodies (Hirjak et al. 2013, 6).¹¹ Due to this sense of lack of self and connection to the world and experiences, people with schizophrenia seem distanced and feel as if their experiences are no longer meaningful and would experience the world in a “mechanical way” as a result (Northoff 2015, 86).

For Raballo and Parnas (2012), the presence of schizophrenia reflects a “profound change” in the “structure of subjectivity” for people diagnosed with this condition, as well as a “fundamental shift” in the sense of being a “self-coinciding subject, endowed with a stable first-person perspective and vitally engaged in the world” (Raballo and Parnas 2012, 578).¹² Due to this change in the person’s subjectivity, Stotz-Ingenlath (2000) explains that people with schizophrenia lose their connection to reality and how they experience the world is difficult to articulate to others (Stotz-Ingenlath 2000, 157; Salvatore et al. 2014, 216). Moreover, the refusal to accept their diagnosis, as indicated earlier, leads several theorists to suggest that people diagnosed with schizophrenia are unable to give an objective assessment of their values and beliefs, and this makes engagement with them more difficult (Roe and Davidson 2005, 90; Roe

¹¹ One instance of this is “alien thoughts” (Pickard 2010). Alien thoughts are disembodied experiences through which people with schizophrenia deny ownership of having had those experiences.

¹² For Fuchs (2013), the symptoms of schizophrenia could be due to a breakdown of the person’s intentional structure and that this disturbance of intentionality may be traced back to a lack of “pre-reflexive self-awareness” (Fuchs 2013, 246). Several studies examining the connection between theory of mind (ToM) and schizophrenia suggests that people with schizophrenia exhibit these neurocognitive limitations and, in particular, there is an impairment of intentionality (Sprong et al. 2007). In this situation, the fragmentation of intentionality results in feelings of alienation, depersonalization, and disconnect from the subject and her experiences. For more on the theory of mind and schizophrenia, see Bora et al. (2009); Bora (2017); Bozikas et al. (2011); Harrington et al. (2005); Peyroux et al. (2014); Konstantakopoulos et al. (2014); and Russell et al. (2006).

and Kravetz 2003, 419; Davidson and Solomon 2010, 93). Thus, it can be challenging for a person diagnosed with schizophrenia—and who contests their diagnosis by maintaining that there is nothing “wrong” with them—to engage with health care professionals who insist that the person is mistaken about their beliefs. Disagreement with the psychiatrist about the diagnosis can be interpreted as an indication that the illness is worse than initially thought.

As a result of these perceptions that have persisted throughout the history of psychiatry, Graham (2010) maintains that schizophrenia is seen as being constituted by “incapacities” in the rational operation of “fundamental psychological faculties” in the person’s mind that prevents someone from properly leading a decent life (Graham 2010, 131-132).¹³ The presence of schizophrenia presents unique challenges to living that are not experienced by others without this condition. Moreover, living with a diagnosis of schizophrenia brings a host of suffering and existential anguish that significantly impacts the quality of life and well-being of many people living with it.¹⁴ Given these limitations and challenges to understanding those who exhibit signs of this diagnosis, how is it possible to make sense of the experiences of people with schizophrenia? One way is by appealing to both phenomenology and empathy as evidenced through the work of Karl Jaspers.

2. Jaspers and the Role of Phenomenology in Psychopathology

As discussed in the previous chapter, phenomenology is a method of investigating and understanding conscious experiences. Although phenomenology has historically been viewed as a method for studying the structures of consciousness as experienced from a subjective point of

¹³ These basic psychological capacities include: a sense of bodily and spatial self-location; a sense of historical and temporal self-location; world comprehension and a sense of a general self; the ability to participate in communicative acts with others; the ability to care for others and emotionally engage with them; a sense of responsibility for self; and recognition of opportunities present to oneself in everyday life (Graham 2010, 147-149).

¹⁴ For more on the quality of life for people with schizophrenia, see Skantze et al. (1992) and Sidlova et al. (2011).

view, within a therapeutic context Thoma (2014) notes that the phenomenological method can be used as a tool to help therapists make sense of and to help classify the subjective experiences of their patients. This method not only helps therapists understand what the other person is going through, but it helps persons diagnosed with schizophrenia to better understand their experiences as well (Thoma 2014, 85; Marcsisin et al. 2017, 49).

One of the earliest psychiatrists to endorse phenomenology into the practice of psychiatry is Jaspers (1963/1968). In his article, “The Phenomenological Approach in Psychopathology,” Jaspers maintains that phenomenology is a descriptive empirical psychology of real experiences which allows for a method of visualizing and understanding mental phenomena as experienced by patients (Jaspers 1968, 1314; Walker 1994; Wiggins and Schwartz 2013). For Jaspers—whose work in psychopathology is inspired by Husserl’s phenomenological method and other early phenomenologists—phenomenology can help clinicians to engage with their patients and to make sense of their descriptions of their mental disturbances. But whereas Husserl was focused on uncovering the essence or essential features of experience, Jaspers’ focus was on the description of experiences as articulated by the other person. Through phenomenological investigation into the experiences of others, Jaspers explains how it is possible for therapists:

to describe the inner experiences of patients as phenomena of consciousness. Not only hallucinations, but also delusions...could, *on the basis of the patients’ own descriptions*, be described so clearly that they became recognizable with certainty in other cases (Jaspers, quoted in Berrios 1993, 215, emphasis added).

Because the purpose of this approach is to describe mental phenomena in as *neutral* terms as possible, the experiences of others only become accessible to the observer “second-hand” through their own presentation (Jaspers 1968, 1313). Since the therapist cannot have direct access to the other person’s mental states within the context of a clinical encounter, the individual must describe their experiences as accurately as possible to help facilitate the

therapist's understanding. The role of the therapist is to guide the interlocutor into gaining a clearer understanding of their experiences and to ask for clarifications so that they can describe their experiences as descriptively as possible.

Within the context of a clinical encounter, Jaspers maintains that a therapist can share in the other person's experiences, but this ability must happen "spontaneously" without the therapist having to "take thought over it" (Jaspers 1968, 1315). In other words, sharing in the other person's experience happens almost naturally and witnessing their experiences becomes self-evident to the therapist that facilitates their understanding of the other person's experience. To reiterate, the process of sharing in the other's experiences must happen without any initial interpretation from the therapist. It is necessary for the person diagnosed with a mental disorder to descriptively retell their experiences so that the therapist gets a fuller picture of what precisely the other person is experiencing. And it is through this investigation into the phenomenological experiences of the other that occurs in therapeutic dialogical exchanges and diagnostic interviews that Jaspers explains how things which go unnoticed in prior engagement with the person's mental experiences can become recognized.

2.1 Advantages of Jaspers' Phenomenological Approach to Psychopathology

A strength of Jaspers' approach is the use of phenomenology to focus on what is experienced without relying too heavily on theories of the mind to explain those experienced phenomena.¹⁵

Jaspers argues that it is difficult to develop an objective science of psychology to curate all mental phenomena, and to reduce subjective mental states to an objective science, because

¹⁵ If the goal in psychology is to provide a system that allows for a fully conscious understanding of mental processes, then it would be necessary to devise a scientific system of measuring and quantifying mental disorders which can be presented in "definite terms and forms" (Jaspers 1968, 1315). But he argues that "we must realize also that psychology cannot hope to approach this scientific ideal..." (Jaspers 1968, 1315). What Jaspers is highlighting is the difficulty of devising comprehensive and definitive categories to delineate various mental disorders. And since no unified system can exist, alternative methods for making sense of these phenomena must be developed.

experiences vary drastically from person to person.¹⁶ Since psychology cannot hope to approach this scientific ideal, it must find alternative approaches for understanding others and their experiences. A phenomenological investigation into another's experiences is one way to do this.

Another key insight of Jaspers' phenomenological approach is that he stresses the importance of not considering mental phenomenon in isolation and divorced from other features of the person's life. Rather these phenomena must be understood within a broader context of the person's life and other experiences (Jaspers 1968, 1315). According to Jaspers we understand others not by "analysing their mental life" in abstract theoretical considerations. Instead, we understand others by "living with them" in the context of "events, actions and personal destinies..." (Jaspers 1968, 1315). But in order to understand others in this direct and meaningful manner, we must gain an appreciation of the person's psychic phenomenon by "looking at its genesis, the conditions for its appearance, its configurations, its context and possible concrete contents..." (Jaspers 1968, 1316). This exploration into the origins of mental phenomena serves as the foundation of Jaspers' theory of understanding.

2.2 Genetic and Static Understanding of Mental Phenomena

In his highly influential work within the history of psychiatry, *General Psychopathology*, Jaspers distinguishes between two types of understanding used to grasp the mental experiences of others: *genetic understanding* and *static understanding* (Jaspers 1963, GP 27).¹⁷

Genetic understanding focuses on how particular anomalous experiences are situated within the person's broader psychological history.¹⁸ According to Jaspers, genetic understanding

¹⁶ Despite the infinite variation of experience we can have, he notes that phenomenology is "definitely orientated towards the perceptible and the concrete, not the abstract" and thus it is problematic for understanding certain phenomena, such as delusions, since they cannot be perceived from an outsider's perspective (Jaspers 1968, 1320).

¹⁷ All references to Jaspers' *General Psychopathology* are abbreviated to *GP* with the appropriate page number.

denotes the ability of “perceiving the meaning of psychic connections and the emergence of one psychic phenomenon from another” (*GP* 27, 307; Oulis 2014, 3; Herpertz 2014, 182; Bizzari 2018, 40; Adeel 2015, 18; Aragona 2016, 40). As Lalumera (2018) notes, genetic understanding describes how ‘delusional’ and ‘abnormal’ contents, and consequent behaviours, emerge from other psychological contents within the person’s psyche (Lalumera 2018, 243-244).

Genetic understanding is useful in psychopathology because the therapist gains a better sense of the emergence of a variety of mental health issues experienced by the other person. For instance, if someone experiences trauma at a young age, which then manifests in post-traumatic stress disorder (PTSD) in adulthood, the connections between this person’s past experiences and their current situation can be traced to understand *why* they are feeling this way or behaving in this manner. Based on the traumatic events experienced firsthand, the emergence of the symptoms of PTSD in adulthood can become understandable from the therapist’s perspective.

Static understanding, by contrast, attempts to grasp at the psychic states as individually experienced by the other person (*GP* 307). The genetic mode of understanding is such that it can be done externally from an outsider’s perspective (i.e., the therapist can piece together how these phenomena fit within the other person’s broader set of beliefs). But Jaspers maintains that static understanding “denotes the presentation to *oneself* of psychic states, the objectifying to *oneself* of psychic qualities” and is done internally through phenomenological reflection (*GP* 27, 307, emphasis added). According to Häfner (2015) and Oulis (2014), static understanding is the intuitive reproduction and description of another person’s conscious mental phenomena. The

¹⁸ To clarify, “genetic” may invoke the language used by geneticists and eugenicists to suggest that the presence of schizophrenia is determined by hereditary traits that are passed along genetically from generation to generation. But Jaspers does not use “genetic understanding” in this manner. Rather he uses it to demonstrate genuine understanding of the other person’s experiences. The word “genetic” refers to the origin of something and only recently has it become associated with discussions regarding DNA and heredity matters. Jaspers is using it in its original sense which may cause confusion.

static mode of understanding aims to describe how symptoms appear from the first-person perspective of the person diagnosed with schizophrenia (Lalumera 2018, 243-244). The static mode involves the *re-experiencing* of another person's mental experiences and it occurs "without any human prejudices or pre-conceived theoretical assumptions" (Oulis 2014, 2-3; *GP* 27).

Recalling the example of the person suffering from PTSD, the static mode of understanding would allow the therapist to understand *what* the other person is experiencing because, based on that person's descriptions of their experiences, it should be possible to know *precisely what they are feeling* in that moment. The static mode of phenomenology claims to describe the fundamental and objective "structures of consciousness" which gives rise to these experiences associated with mental disorders, such as schizophrenia (Bizzari 2018, 40; Lalumera 2018, 243-244).¹⁹ Being concerned with addressing the person's mental experiences directly, this type of understanding is closely linked to Jaspers' account of empathy.

2.3 The Role of Empathy in Jaspers' Psychopathology

As indicated previously, under Jaspers' phenomenological account, the process of gaining access to another person's subjective mental experiences is indirect because mental phenomena are not directly observable and can only be inferred by engaging with the other person's words or behaviours. For Jaspers, since we can never directly perceive the first-person experiences of another, we can only make "some kind of representation of them" and there must be an "act of *empathy*, of understanding" which comes from the other person's own self-descriptions (*GP* 55,

¹⁹ As indicated earlier, phenomenologists like Husserl were interested in describing the structures of consciousness and were not necessarily interested in the specific content of the experience or even the *person* having the experience. Rather the focus is on the pure or transcendental *forms* of experience. Husserl's project is to effectively "map out" the structure of experience: how do we experience time? What are the rules determining the constitution of a physical object? How are different experiences synthesized across time and different modalities of experience (e.g., perception, memory, imagination) understood?

emphasis added). Empathy allows a therapist to see the causal connections between a person's abnormal mental phenomena and the rest of their psychic activity. For Jaspers, the aim of empathic understanding is not to "grasp an ineffable subjectivity" of another but to discover a set of what Lalumera describes as the "objective structures of experience *as accessed from a particular perspective*" which, in this instance, would be the perspective of the person diagnosed with schizophrenia (Lalumera 2018, 243-244, emphasis added). In other words, the aim of Jaspers' theory of empathy is to appreciate how the person with schizophrenia—from their unique perspective—experiences psychic phenomena which would be deemed "abnormal" or "delusional" as per currently existing diagnostic standards and models.

Empathy plays an important role in forging connections that govern the relationship between caregivers and care recipients in a therapeutic environment. But as noted earlier, to empathize, the therapist must suspend their prejudgments of how they perceive the other person and receive their descriptions as openly and neutrally as possible. Preconceived notions of what schizophrenia is will inevitably influence the perception of the other and can, therefore, distort the diagnostic procedure. To relinquish all prejudices, then, Jaspers recommends a "quiet absorption" into the "facts of psychic life" without the "adoption of any specific attitude attributed to them" (*GP* 17). According to Jaspers, empathy is achieved by "transforming oneself" into the other individual's psyche by "participating in the other person's experience, not by any intellectual effort" and through this process a therapist can share the other person's experiences and gain an "essentially personal, indefinable and direct understanding" of their experiences (Jaspers 1968, 1315; Sass 2013, 98).²⁰ However there are three categories of

²⁰ On face value the act of transferring oneself has the *potential* for opening ways of understanding others. But this approach has similar issues that are found in simulation theories of empathy that will be discussed in Chapter 2.

empathic understanding that emerge from his account: full understanding, partial understanding, and the “un-understandable” (GP 27, 307; Oulis 2014, 6).

The first category of empathic understanding is *full understanding*. Full understanding results from having shared a similar experience with others. If someone informs their doctor that their joints hurt from arthritis, the doctor can *understand* what it is like provided they have arthritis and can relate to the pain that the other person is feeling. Even if the experience of arthritic pain is not uniform across all sufferers of this condition, the doctor would be better able to appreciate the kinds of challenges their patient is experiencing when complaining about arthritis pain. The second type of understanding is *partial understanding*. Partial understanding involves an experience that a therapist *may* have experienced herself but is not completely identical to the situation experienced by the other person. For example, if someone is grieving the death of her sister, the therapist can acknowledge the sadness the patient is experiencing even if the therapist has not lost a sibling herself. This is because the therapist is able to recognize the various emotional states the other person experiences in their grieving and can sympathize with their situation of losing a loved one. The third category, the “*un-understandable*,” is best demonstrated through primary delusions of schizophrenia and indicates a challenge for empathy under Jaspers’ approach.

3. Why Does Schizophrenia Defy Empathic Understanding?

This section explores three reasons why persons with schizophrenia seem to defy the reach of empathic understanding under Jaspers’ account: (1) the presence of primary delusions of schizophrenia, (2) the emergence of the delusional atmosphere, and (3) the inaccessibility of the other person’s phenomenological experiences.

3.1 The “Un-Understandability” of Primary Delusions

A core element of Jaspers’ theory of empathy involves making sense of another person’s mental states by putting oneself in the shoes of the other person. Through this lens, people with schizophrenia appear to defy empathic understanding due to the incomprehensible nature of the content of their *primary delusions*. Primary delusions are one of the fundamental symptoms outlined in Jaspers’ analysis of schizophrenia.²¹ According to Garety and Hemsley (1994), one central feature of primary delusions is that people who experience them are “irretrievably lost in untruth” and their beliefs in their delusions are firmly held despite subsequent reflection and external criticism (Garety and Hemsley 1994, 3, 9). Kraus (2014) identifies three characteristics of primary delusions that emerge from Jaspers’ analysis and which distinguish them from other normal beliefs a person may have about the world. First, primary delusions are felt with “incomparable subjective certainty” regarding the truth value of the experience (e.g. someone could firmly believe that they are the target of a global assassination plot; that their spouse is a doppelganger; or that the living person is actually dead) (*GP* 410, 282). Second, there is an unwavering insistence on the belief even if presented contrary evidence (*GP* 104). The third element is the impossibility of the content of the delusional experience to be true.

An example from Chaudhury and Kiran (2009) illustrates how a delusional belief is distinct from a normal belief. A normal belief would be something like “When I see dark clouds in the sky, and when I see the grass is wet, I believe it was raining.” This qualifies as a ‘normal belief’ because it can be verified that rain likely occurred if there is a strong overcast and a wet

²¹ Jaspers makes a further distinction between primary delusions and secondary delusions. Primary delusions are more entrenched and are judged to be “incomprehensible and meaningless” as they are the “causal by-products” of a “dysfunctional brain,” whereas secondary delusions possess meaningful content for the person experiencing them and are, on some level, understood by others (Gorski 2012, 79; Radden 2011, 58; *GP* 98). Unlike primary delusions, secondary delusions have an identifiable antecedent in the psyche and the origins of these beliefs can be traced by seeing how these false beliefs are situated within that person’s broader belief system (Maher 1999, 551-552).

ground. Moreover, it is a reasonable connection made between these two events that are linked together in the person's belief system.

A primary delusion, by contrast, would be something like "When I see dark clouds in the sky, and when I see the grass is wet, I believe that Canadian Prime Minister Justin Trudeau is an android." In this example, there is nothing to ground the person's belief or to make the connection between "dark clouds" and "wet grass" with the belief that "Prime Minister Justin Trudeau is an android." On the surface, this statement is nonsensical and there appears to be no way to parse out further information about the meaning of this person's belief. But while this example differentiates the distinction between a normal belief and a delusional belief, there remains a further distinction between primary delusions and mere false beliefs which adds an additional layer to the problem of empathizing with persons with schizophrenia.

3.2 The Distinction Between False Beliefs and Delusions

While they share similarities, it is helpful to differentiate between delusions and false beliefs. A false belief is an unreasonable belief for someone to have, especially if they are presented with evidence that supports the contrary. False beliefs emerge due to insufficient or incorrect information about a situation or topic. But one feature of false beliefs is that the person who holds them can possibly be persuaded into thinking and believing otherwise.

For example, suppose you are out for a walk in your neighbourhood, and you run into a family who just moved into your area. After meeting up with the parents and introducing yourself to them, suppose their young son turns to you and exclaims "My Daddy says the Earth is flat! I think the Earth is flat, too!" Although he is still just a child, for the sake of argument, let us classify your neighbour (and his son) as flat-Earthers. A flat-Earther is someone who believes that the Earth's surface is flat and not spherical as is recognized by the majority of the scientific

community. Regardless of anything else this young child believes, given the knowledge that we have of the planets in our solar system, it is clear to recognize that the young boy possesses a *false belief* about the ‘shape of Earth.’ To justify the true belief that the world is not flat, one can appeal to the principles of astronomy and appeal to scientific knowledge to demonstrate that the Earth is spherical. There are grounds to convince him that the beliefs are mistaken and should be modified in light of information supported by evidence.

Delusions, on the other hand, share similarities with false beliefs because they, too, are fixed beliefs based on incorrect inferences about reality which are firmly held despite evidence to the contrary. But, unlike false beliefs, the nature and specific content of those delusions are often so outlandish that they defy credibility and are not accepted by other members of that person’s community (DSM-5; Graham 2010, 195).²² Whether they are longstanding in nature, or emerge spontaneously within a person’s mind, delusions affect how a person interacts with others in the world and influences the kinds of choices they make and actions they perform. Whereas individuals with firmly-held false beliefs may be persuaded to change their views once they are presented with sufficient counter evidence, Graham maintains that people experiencing delusions may be “incurably committed” to maintaining them and make no effort to rid themselves of these beliefs because they “over-identify with their delusions, [become] blind to their harmful consequences” and fail to realize that the persistence of these thoughts indicates that they are not thinking properly (Graham 2010, 243).²³

²² This distinction is important as otherwise religious beliefs would qualify as “delusional.”

²³ This element of incorrigibility seems to be one of the distinguishing features that is necessary for some belief to be constituted as a “delusion.” It could be argued that, like false beliefs, a person can eventually be talked out of delusion. Moreover, as several first-hand accounts of persons living with a diagnosis of schizophrenia can confirm, they are aware that certain beliefs can be considered delusional as they are uniquely distinct from their other perceptual experiences. But I think that it is more difficult to talk someone out of a delusion than a false belief.

Another way a delusion can be distinguished from a false belief is that false beliefs are akin to what Jaspers calls “over-valued ideas” (*GP* 107). For Jaspers, over-valued ideas describe the convictions people have which are “strongly toned by affect” and which are understandable in terms of “the personality and its history” (*GP* 107). He explains that over-valued ideas must be distinguished from delusions proper because over-valued ideas are “isolated notions” that “develop comprehensibly” out of a given person’s background and situation and are thus capable of being understood via empathy (*GP* 107).

For instance, for a white person raised in the Southern United States during the 19th century, it is reasonable to suggest that their beliefs and values on certain topics, such as the moral permissibility of slavery, attitudes towards racism, and the meaning and significance of the Confederate flag, would be significantly different from the beliefs and values of someone born and raised during the 21st century. In the latter context, it is reasonable to suggest that the person would recognize that practices of slavery and attitudes of condoning racism are morally wrong and that the Confederate flag represents a period of history in the United States in which these morally inappropriate attitudes and practices were endorsed.²⁴ But, in the former context, the person might *genuinely believe* that there is nothing morally inappropriate with adhering to these specific beliefs because they *make sense* and are therefore *understandable* within the context of the environment they grew up in.

However, while false beliefs can be contextualized in this manner and can be understood by examining how these particular beliefs can emerge within an individual or her community, Jaspers argues that primary delusions, by contrast, are the “vague crystallizations of blurred delusional experiences” which possess “diffuse, perplexing self-references” which “*cannot be*

²⁴ However, given the incident of Trump supporters raiding the United States Capitol Building in Washington, D.C. on January 6, 2021, and groups of people proudly waving the Confederate flag during this event and at similar rallies, there are still plenty of white supremacists who continue to perpetuate this view even in recent times.

sufficiently understood in terms of *the personality* or *the situation*” of the person experiencing them (GP 107, emphasis added). Moreover, Jaspers maintains that primary delusions are “*un-understandable*” and “closed off” to acts of empathy precisely because the origin of these experiences cannot be traced to other phenomena in the person’s psychological history (GP 578, 106). Since primary delusions of schizophrenia effectively appear out of nowhere, and because they leave no trace of their origin to connect them to other mental states, it is difficult to make sense of them and thus impossible to empathize with someone experiencing them (GP 587).

3.3 The Delusional Atmosphere and the Challenge for Empathy

Whereas false beliefs emerge from incorrect information about reality, primary delusions of schizophrenia emerge from a “*transformation in our total awareness of reality*” and originate in alterations of our “ordinarily taken-for-granted sense of things as ‘there’, where nothing presents itself in that way anymore” (GP 95; Ratcliffe 2013, 232). According to Jaspers, individual reality is embedded in a “general reality” that has been “structured and amplified” for us through the “traditional culture” we have experienced all our lives (GP 94). Our beliefs emerge against the backdrop of a shared social world, and, for healthy individuals, our conception of reality emerges from this shared social world (Ratcliffe 2013, 223). Moreover, our shared interaction with others influences our beliefs about the world and contributes to our sense of belonging in the world.

But given the difficulties that emerge due to the symptoms of this disorder as discussed at the beginning of this chapter, a second barrier to empathizing with persons diagnosed with schizophrenia that Jaspers identifies is the emergence of the “*delusional atmosphere*” (GP 98). The delusional atmosphere is described as an altered state of perceptual awareness which distorts the perceptual reality of the person submerged in this state. For Ratcliffe (2013) the delusional atmosphere involves a partial loss of “consensus reality” which shares similarities to what

Stanghellini (2004) labels as impairments in “common sense” (Ratcliffe 2013, 223). Common sense refers to the shared and agreed upon facets of life and is the “constitutive element” of the perception of reality and is the “true pillar” of “normal mental life” (Stanghellini 2004, 13).²⁵

While living with schizophrenia often makes it difficult for someone to fully articulate their experiences to outsiders, Ratcliffe notes that the emergence of the delusional atmosphere makes it difficult for persons diagnosed with schizophrenia *themselves* to navigate the world as their sense of reality in this altered state is unlike anything they have experienced before. And for therapists attempting to empathize with those they are treating, the delusional atmosphere adds a layer of difficulty to understanding because the presence of this atmosphere results in an “all-encompassing change in the shape of experience and thought” (Ratcliffe 2013, 232).

According to Jaspers, when someone is embedded deep within the delusional atmosphere their perception of their environment is “somehow *different...perception is unaltered in itself*, but there is *some change*, which envelops everything with a subtle pervasive and a *strangely uncertain light*” (GP 98, emphasis added). Within this delusional atmosphere, Ratcliffe highlights that it is quite common for people with schizophrenia to describe feeling:

alive, dead, *distant*, detached, dislodged, *estranged*, *isolated*, *otherworldly*, *indifferent to everything*, overwhelmed, suffocated...*lost, disconnected...not oneself*, out of touch with things, out of it... (Ratcliffe 2008, 68, emphasis added)²⁶

²⁵ Stanghellini draws an analogy between common sense and a chessboard. Whereas ‘healthy individuals’ are chess pieces that follow the rules and expectations defined by the nature of the game, people with schizophrenia remain *outside* of the board and are disconnected from others and social norms. While healthy people adhere to social norms and strive for centricity, Stanghellini argues that people with schizophrenia are the embodiment of “extreme eccentricity,” as they are removed from ordinary social interaction (Stanghellini 2004, 13-16). But it is important to note that this eccentricity should not necessarily be viewed in negative or stigmatizing terms.

²⁶ This description of the delusional atmosphere bears resemblance to Bleuler’s (1950) discussion of the symptoms that persons with schizophrenia experience. As Bleuler explains, persons with schizophrenia: “have no more contact with the outside world live in a world of their own. They have *encased themselves* with their desires and wishes...they have *cut themselves off* as much as possible from any contact with the external world” (Bleuler quoted in Parnas 2012, 1122, emphasis added).

Furthermore, within the delusional atmosphere, Jaspers explains how everything the person experiences might appear “*mysterious, intriguing and new*” but things might also look “*odd in a disturbing, menacing way*” (Ratcliffe 2013, 237-238, emphasis added). When someone finds herself wandering through the delusional atmosphere, the socially accepted reality “totters” and people become “adrift” as their sense of reality becomes reduced to an “immediate and shifting present” (GP 104). This lack of a firm grip of reality, coupled with a fragmented sense of self and identity that is characteristic of this mental disorder, is another reason why empathic engagement with persons with schizophrenia is near impossible under Jaspers’ framework.

3.4 The Inaccessibility of the Other Person’s Phenomenological Experiences

A final reason why persons diagnosed with schizophrenia appear to defy empathic understanding under Jaspers’ account is due to the inaccessibility of that person’s phenomenological experiences. From a phenomenological perspective, Jaspers maintains that primary delusional experiences are “radically alien” to the “healthy person” (GP 196). As Jaspers argues, regarding primary delusions, “[w]e cannot really appreciate these quite *alien modes of experience*, they remain largely *incomprehensible, unreal and beyond* our understanding” (GP 98, emphasis added). While it is hard enough to empathize with someone who is experiencing a physical illness, Karp and Tanarugsachock (2000) note that it is even more difficult for someone to understand another person whose mind is presumed to be “thoroughly inaccessible” as persons with schizophrenia appear to be according to the dominant models of psychiatry (Karp and Tanarugsachock 2000, 13-14; Molas 2018b, 53-54).

Moreover, if ordinary social interaction requires us to take each other’s roles to understand each other, then meaningful engagement with persons with schizophrenia is often “short-circuited,” as they appear to inhabit “phenomenological worlds” that are “inaccessible” to

outsiders (Karp and Tanarugsachock 2000, 7). This task of engaging with the other in a meaningful manner is nearly impossible with people suffering from primary delusions and feeling adrift in the delusional atmosphere because, as Frith and Johnstone (2003) note, "[t]he profoundest difference...seems to exist between that type of psychic life which we can intuit...and that...[which] is not understandable and which is truly distorted and schizophrenic" and thus we "cannot empathize, we cannot make them immediately understandable, although we try to grasp them somehow from the outside" (Frith and Johnstone 2003, 124; *GP* 98).

To sum up the main limitations of empathizing with persons with schizophrenia outlined thus far, the presence of primary delusions and the emergence of the delusional atmosphere make it more difficult for someone to fully understand the experiences of persons with schizophrenia. The presence of delusional beliefs disturbs the notion of common sense for the person diagnosed with schizophrenia and, as a result, this disruption impacts the person's ability to accurately judge their experiences of reality in the world (*GP* 96; Thoma and Fuchs 2018, 22). Delusions transform how that individual experiences and engages with the reality of the external objective world and gives it a "new meaning" (*GP* 98; Kraus 2014, 117-118). However, despite this perceived disconnect from reality, delusions are regarded as of "vital necessity" for the person with schizophrenia because, as noted by Garety and Hemsley, without them they would "inwardly collapse" (Garety and Hemsley 1994, 3). The delusional belief helps to constitute the reality that the person with schizophrenia lives in and, because of the nature of their mental disorder, these beliefs appear 'natural' to the person experiencing them.²⁷ Therefore, empathizing with persons with schizophrenia remains a limiting case under Jaspers' account.²⁸

²⁷ Interestingly, delusions can serve a beneficial purpose. In a 2012 interview on TVO's *The Agenda with Steve Paikin*, entitled "Schizophrenia: Sentence or Diagnosis?" Dr. Elyn Saks indicated that the presence of her psychotic experiences served as a safeguard to external threats. She argues that delusions and hallucinations can emerge to protect the person from trauma and other psychological harms experienced in their lives. In other instances, people

4. Limitations of Jaspers' Phenomenological Approach

This section overviews the limitations of both Jaspers' phenomenological approach and his account of empathy in preparation for the next chapter, which will discuss the shortcomings of Jaspers' approach and how it can potentially be resolved by turning to simulation theory.

4.1 The Difficulty for People with Schizophrenia to Describe Their Experiences

Jaspers maintains that the therapist's ability of empathizing with others is a skill that must be developed over time. Moreover, he suggests that cultivating empathy is necessary to prevent misunderstanding of the person's descriptive account of their subjective experiences.²⁹ Since the goal of phenomenology is to provide detailed first-person descriptions of experiences, Jaspers stresses the importance of fostering a dialogue between caregivers and care recipients and of allowing persons diagnosed with mental illnesses opportunities to articulate their experiences in a non-judgmental and supportive environment.

describe hearing voices that manifest themselves through the form of supportive figures who provide comfort during extreme hardship (Goude 2020). Thus, the delusion (while not *real*) still has benefits and the thought of exploring the embedded meaning behind those experiences should be entertained and not immediately dismissed.

²⁸ But just because someone is experiencing primary delusions does not mean that their other cognitive functions are also impaired. Many people with schizophrenia are aware that some of their experiences are delusional and this ability to differentiate "normal" from "abnormal" phenomena provides caregivers with opportunities to connect with others and recognize that they are not lost causes. Pickard (2010) notes that people with schizophrenia acknowledge that these thoughts are different and are capable of recognizing the distinction between "real reality" and "delusions." In fact, according to Sass (1994), many people with schizophrenia experience their delusions as having "a special quality or feel" that distinguishes them from "real" beliefs and that they have an insight into their own condition and recognize that their experiences are divorced from what "normal" people experience (Sass 1994, 3). While primary delusions are un-understandable, some theorists contend that there is an element of rationality present even in delusional thoughts. What may be understood as "false, but reasonable" beliefs to have, Maher (1999) argues that the presence of delusions reflect the person's attempt at making sense of bizarre perceptual experiences but that the cognitive processes used to make sense of these bizarre experiences are "not significantly different" from the persons without this condition (Maher 1999, 550; Garety and Hemsley 1994; Oltmanns and Maher 1988). If Maher is correct in saying that delusions are false but based on a kind of rationality from the perspective of a person with schizophrenia, there is room for understanding to emerge.

²⁹ Jaspers does not offer much guidance on how therapists, specifically, can help cultivate these empathic attitudes for understanding the experiences of their patients. But, as I will argue in subsequent chapters, a narrative-based approach to care can help facilitate interactions between caregivers and care recipients.

However, as Parnas et al. (2005) note, some people with schizophrenia may be hesitant to discuss their private experiences with someone else because they may not have shared these descriptions before.³⁰ Given the incomprehensible, and often times frightening and surreal nature of delusions, one limitation of Jaspers' approach is it may be difficult for someone with schizophrenia to accurately describe their experiences in a way that makes it easy for a caregiver to fully understand. As a result, they may rely on metaphoric language to supplement those descriptions of phenomena that may be very difficult to describe in any other way.

Moreover, even if they can describe their experiences of certain phenomena at one time during a therapeutic encounter, there is no guarantee that the person will be able to reliably and consistently repeat their description to a therapist on subsequent encounters (Parnas et al. 2005, 237). This inability to grasp at potentially shifting phenomena and describing it can make the therapist's role of making sense of their experiences and of treating the person more difficult.

4.2 The Willingness for People with Schizophrenia to Engage in Therapy

Relatedly, Jaspers' approach requires that people diagnosed with schizophrenia are willing to cooperate with their therapist and feel safe to disclose these phenomena in the first place (Oulis 2014, 4). But due to the long history of unjust forms of treatment administered to people living with mental disorders, and due to the equally damaging consequences surrounding the social stigma of being diagnosed with a mental illness and labelled "schizophrenic," the reluctance of some people to engage with therapists and fully disclose their experiences is understandable.

Within the history of psychiatry, for example, many male therapists often dismissed women's traumatic accounts of abuse in their past as delusional and, thus, their reports of their

³⁰ As I argue in Chapter 4, persons with schizophrenia may also choose to keep their experiences private to avoid the brunt of social stigma and the negative judgments from others.

lived experiences are undermined and not taken seriously (see Ussher 2011; Masson 1988). As I will note in greater detail in Chapter 5, many people living with schizophrenia who reflect on their experience of receiving psychiatric care emphasize that numerous therapists and caregivers often dismiss their legitimate health concerns as merely “delusional” or as another symptom of their condition.³¹ For instance, if someone with schizophrenia complains of bodily aches and pains, Schulze and Angermeyer (2003) explain that they are more likely to be viewed with suspicion from their caregiver as opposed to someone who makes similar complaints but does not have this diagnosis (Schulze and Angermeyer 2003, 310).

Furthermore, within the broader conceptual framework of the medical model of illness, the therapist may view the other person’s complaints as an indication that their current medication dosage is insufficient and may prescribe more to “fix” them and rid them of their “delusions.” Because of repeated instances of not being taken seriously, many people diagnosed with schizophrenia and other mental illnesses learn to hide their symptoms and are often afraid to speak about their experiences to avoid further harmful treatments, such as isolation from others, or increases in medication which can have damaging side effects.

Given the longstanding influence of Kraepelin, Bleuler, and Jaspers for their role in how schizophrenia is conceptualized in modern psychiatric practice, many therapists are trained to recognize any abnormality in thought or behaviour as suspect and to label these occurrences as defective or as a product of the mental disorder. As I will argue later on, one of the downsides of traditional or typical approaches to therapy is it can reinforce the belief that the reports of people with schizophrenia are meaningless and therefore not necessary for further engagement. This is

³¹ What is required, then, is a shift in the attitudes and approaches from caregivers to one which acknowledges how schizophrenia can impact the person’s life in ways that need to be treated with increased sensitivity and care. I return to this point in later chapters.

morally problematic as it can further reinforce the power imbalances on who is to be believed and who is not believed on a psychiatric ward.

Moreover, even if someone's reports of their experiences of delusions are cryptic and difficult for a therapist to grasp and understand in a literal sense, the individual may be conveying information that is important to them. Despite the metaphoric nature of some descriptions of first-hand experiences, caregivers should not be too quick to dismiss the legitimacy of those descriptions. There are times when someone says something such that caregivers do not understand what the other person means. Therapists, like everyone else, sometimes fail to grasp the meaning of what their interlocutor is saying. This failure to grasp the meaning of what their interlocutor is saying is a normal part of dialogue, and occurs with everyone, not just persons who are diagnosed with schizophrenia. Furthermore, this inability to fully understand another person all the time does not suggest that empathy with them is impossible. It is important to remember that even if some of the person's utterances appear nonsensical, exercising humility and recognizing that sometimes one cannot fully know what someone else means is an exercise in restraint that caregivers should aim to cultivate.³²

4.3 The Applicability of Phenomenology as a Method for Understanding Others

While cultivating a phenomenological attitude is important for therapists to help better understand another person's experiences, a third issue, raised by Langenbach (1995), is the applicability of phenomenology for understanding the experiences of others. Since the phenomenological method—in the tradition of Husserl and Jaspers—involves a first-person reflection on the experiences an individual is having *to herself*, it seems unclear how this first-person method of investigation can be used to gain access and empirical insight into the mental

³² Many thanks to Geoffrey Reaume for this important suggestion and addition to my analysis.

states of *someone else*. According to Oulis (2014), the worry of using a first-person method of reflection to investigate the subjective experiences of a third party is that, in this scenario, the therapist could conflate their own experiences with the experiences of the other person, and this can result in a *misrepresentation* of their unique subjective experiences (Oulis 2014, 5).³³

As noted earlier, engaging in the act of empathy consists of taking up the mental perspective of another person and imaginatively putting oneself into that person's frame of mind for the purposes of gaining a better and clearer understanding of their subjective experiences (Graham 2010, 189). Although Jaspers maintains that accessing another person's mental experiences *is* possible through indirect methods, such as diagnostic interviews, he also maintains that therapists should strive for “the unprejudiced direct grasp” of the mental experience *as it is experienced* by the other person directly (Oulis 2014, 3; *GP* 27).

That said, another difficulty in assessing the effectiveness of Jaspers' approach stems from a confusion as to whether his understanding of empathy involves direct or indirect access to the mental states of others. Given the presence of delusions, one of the key difficulties in empathizing with people with schizophrenia is trying to understand their experiences and get a sense of what schizophrenia is like from a first-person perspective (Scheff 2012; Prinz 2011). According to Karp and Tanarugsachock (2000), caring for others presumes efforts “to feel *what they feel*, to try to see the world *from their standpoint*, and to *take their role*” which is made possible through acts of empathy (Karp and Tanarugsachock 2000, 13, emphasis added). But the problem of accurate role taking is that it is difficult to understand what they are going through,

³³ The risk of co-opting someone else's subjective experiences is a charge laid against simulation theories of empathy and it is something that they will have difficulty overcoming. But I am not arguing that a successful account of empathy must involve fully direct access to the mental states of others. If anything, this represents an idealized form of empathy and this line of thinking hinders our grasp of what it means to engage with others in a supportive manner. I do not need to have in-depth direct access to your mental states to empathize with you. Given that our access to the minds of others is limited, we need to foster interpersonal relationships of trust and establish genuine dialogue first with persons diagnosed with schizophrenia before they are willing to share their experiences.

especially if caregivers have never experienced the feelings of “intense isolation, the hopelessness and despair of depression...or the terror accompanying paranoid delusions” that are common with schizophrenia (Karp and Tanarugsachock 2000, 13-14; Molas 2018a, 730-731; Molas 2018b, 53).³⁴

While the purpose of empathy under Jaspers’ account is for the therapist to gain direct access to the experiences of others in order to better understand and make sense of the meaning of their disturbed mental states as they are experienced first-hand, Hollan and Throop (2008) explain that this “first-person-like” knowledge of others typically found in empathic exchanges is “rarely, if ever...an unambiguously good thing” (Hollan and Throop 2008, 389; Molas 2018b, 53). Part of the reason for this is that there are some experiential factors that cannot be replicated in the mind of someone else, regardless of the strength of one’s imagination or the degree of one’s empathic abilities. But, more pressingly, presuming that one can *fully know* and *fully understand* the experiences of others runs the risk of subsuming their experiences into oneself, which is problematic. I will return to this point in greater detail in the following chapter.

5. Conclusion

Overall, Jaspers’ methodological approach for understanding the experiences of others has the potential for helping make sense of the unique mental phenomena present in various mental disorders. If the aim of phenomenology is to provide a description of experiences, as articulated from the first-person perspective, then by suspending preconceived notions about patients and

³⁴ But it is important to be mindful that not all delusions are terrifying in this manner, nor should all experiences of persons with schizophrenia be cast in the same light. As indicated in an earlier footnote, some people report hearing positive and encouraging voices in their head. The 2016 documentary, “Surviving Schizophrenia,” contains interviews with mental health experts and advocates, such as Dr. Elyn Saks, Debra Lampshire and Dr. Paris Williams. For one individual, her delusional experience took the form of a nurturing mother-figure that provided her with a sense of security and comfort.

allowing them to articulate their experiences as fully and as descriptively as possible, Jaspers' methodological approach provides a way for therapists and caregivers to empathically engage with persons diagnosed with mental illness and to learn more about their experiences.

But this approach is problematic because, on Jaspers' view, it is important for the therapist to actively *recreate* the other's experiences so that they can understand them. While this approach may be achieved for certain kinds of understanding, when it comes to those he designates as "un-understandable"—namely persons with schizophrenia—it creates an epistemic barrier between caregiver and care recipient that impedes empathy from occurring. But more pressingly, it sustains a power imbalance within this dynamic that can lead to further instances of marginalization by reinforcing the belief that empathy with these individuals is impossible.

The influence of Jaspers on the history and development of modern psychiatry—and the insights that emerge from his approach to treating persons diagnosed with a variety of mental disorders—cannot be understated. Applications of the principles of phenomenology and empathy play a major role in engaging with and supporting persons with mental illness. But, despite his significant insights, Jaspers' account brings us no closer to understanding the experiences of persons with schizophrenia. As noted earlier, schizophrenia remains defined as a disorder that results in the loss of a firm sense of self, a splitting and fragmenting of one's mind, and a distortion of one's sense of reality which make empathic engagement more difficult, if not impossible. Although Jaspers provides a good starting point for engaging with others, given the limitations outlined above, exploring the role of empathy in applied therapeutic contexts requires a more robust conception of *how* empathy operates and how it can be used to better understand persons diagnosed with schizophrenia. An alternative approach to empathy must be explored and one potential candidate is simulation theory.

Chapter 2 – Simulationist Accounts of Empathy: Strengths and Limitations

This chapter provides an in-depth discussion of simulation theory as a potential answer to the problem of empathy raised by Jaspers in Chapter 1. Three variations of simulation theory are explored: Goldman's analogical inference simulation, Heal's co-cognition simulation, and Gordon's personal transformation simulation. After highlighting the numerous benefits that all three versions of simulation have towards understanding the experiences of others, including persons diagnosed with schizophrenia, the chapter closes by raising several criticisms against simulation as an account of empathy.

1. Background to Simulation Theory

Before exploring simulation theory as a method of understanding the experiences of others, it is helpful to situate simulation theory within the broader discussion about metacognition and theory of mind (ToM) within the cognitive science and philosophy of mind literature.

1.1 The Role of Metacognition and Theory of Mind (ToM) in Simulation Theory

According to Salvatore et al. (2014), metacognition includes the ability to think and reflect upon one's own mental states, such as memories, desires, and current emotions. Metacognition also consists of the ability to think about and infer the mental states of other people. Finally, metacognition allows for thinking about oneself and others within a larger social context (Salvatore et al. 2014, 216; McLeod et al. 2014, 124; Combs et al. 2014, 163; see also Dimaggio and Lysaker, 2010; Dimaggio et al., 2007; Lysaker et al., 2013; Semerari et al., 2003).

Metacognition is the ability to make sense of mental states and this concept plays a crucial role in the development of a comprehensive theory of mind (ToM).

As McCleery et al. (2014) note, ToM refers to the ability to make inferences about the thoughts, beliefs, and intentions of others and allows us to discover the potential meaning behind another person's actions (McCleery et al. 2014, 53). Also known as "mindreading" and "perspective-taking," ToM is the ability to simulate in one's own mind the mental states of others in order to attribute intentional states to them. ToM not only allows us to make sense of the mental states of others, but it also provides the ability to critically evaluate one's own subjective mental states from an objective point of view (Fernandes and Roberts 2014, 152-153).

As indicated in the previous chapter, an impediment to understanding persons diagnosed with schizophrenia is the impairment in ToM as their condition results in a fragmentation of their experiences. As a result, it is argued that people diagnosed with schizophrenia have difficulty in making sense of their own subjective experiences which can impede practices of empathy. However, the ability to infer and make sense of the mental states of others is a core feature of both *theory-theory* and *simulation theory*.

1.2 The Distinction Between Theory-Theory and Simulation Theory

Within the cognitive sciences and philosophy of mind literature, there exists two broad categories for making sense of the experiences of others: theory-theory and simulation theory. Theory-theory is a theory of mind which presumes a shared background of theoretical knowledge and rationality that both parties have access to which facilitates mutual understanding between them (Henderson 1995). Theory-theorists endorse a folk psychological approach that allows us to understand others and ascribe propositional attitudes and beliefs toward them (Ratcliffe 2006; Churchland, 1990/1991). According to proponents of this view, nature and our evolutionary development provided humans with the ability to infer states about others to

understand them. But a core element of theory-theory is that we have the ability to appeal to universal laws of rationality to make sense of the behaviour of others.

Standing in contrast to theory-theory is simulation theory. Rather than appealing to a universal theory of rationality or having a vast understanding of human psychology in place, proponents of simulation theory maintain that understanding another person and predicting their behaviour involves using *our own* cognitive system. Simulation theorists argue that grasping the thoughts and experiences of another can only be accomplished by “integrating” that person’s thoughts into one’s own “subjective cognitive system” (Kögler and Stueber 2000, 5-6; Davies and Stone 1995a, 3; Michlmayr 2002, 10; Gordon 1996). By appealing to our own cognitive faculties we place ourselves in the other person’s situation and imagine the world from their perspective (Kögler and Stueber 2000, 8-9). Because it involves using one’s own cognitive system, simulation theory is characterized as a “process-driven” procedure rather than a “theory-driven” procedure since it involves more than appealing to a general psychological theory (Goldman 1995a; Stueber 2006, 113).

With this distinction in mind, the remainder of this chapter will focus exclusively on evaluating the strengths and weaknesses of simulation theory as a theory of empathy. But even within this theoretical framework there are two main variations of simulation worth exploring.

1.3 Implicit Simulation vs. Explicit Simulation

As indicated in the previous chapter, empathy is an important tool that therapists employ in order to better understand the experiences of others within a clinical context. For Coplan (2011), empathy requires a complex imaginative process of taking another’s perspective by “simulating” the experience of being in the other person’s situation and then reflecting on what emerges from

that imaginative exercise (Coplan 2011, 9; Heal 1995a, 47; Stueber 2006, 111; Molas 2018b, 53). As a theory of empathy, simulation can be further divided into either *implicit* simulation or *explicit* simulation (Goldman 2006; de Vignemont 2010; Goldie 2011; Ratcliffe 2012).

Implicit simulation—sometimes called “lower-level” empathy or “mirror” empathy—is a view which maintains that it is possible to perceive what another person is experiencing involuntarily without actively recreating their emotional and mental states through a complex imaginative process.³⁵ For instance, if you are walking around your neighbourhood and a smiling jogger runs past you, you can look at her face and *see* she is happy and infer that she is in a good mood. Based on her facial cues and other information you perceive in this brief encounter, the attribution and belief that she is in a good mood occurs almost immediately and further reflection or deliberation is not required in order to confirm the nature of her emotional and mental states.

By contrast, explicit simulation—sometimes called “re-enactive” empathy or “reconstructive” empathy—involves a more complex process of using one’s cognitive resources to *replicate* the experiences of the other person within ourselves in order to facilitate understanding. According to Stueber (2006), it is only through re-enactive empathy that we can conceive of another person as being a rational agent who acts for a reason (Stueber 2006, 20-21). These higher forms of empathy are intellectual processes of understanding and making sense of the experiences of others by appealing to our own imaginative capacities. This replication and simulation of the other person’s mental states (and how they would react in a particular situation given a particular set of stimuli) in our imagination then allows us to gain a deeper understanding of her behaviour (Meneses and Larkin 2012, 156; Ratcliffe 2012, 474-475).

³⁵ As I will argue, in the context of mental health care, it is problematic for caregivers to try and simulate the other person’s experiences because they will never get a fully authentic understanding of their experience from a first-person perspective. At best, caregivers can rely on narratives that reflect the individual’s lived experience and see what can be learned from those narratives (written or verbal).

2. Three Models of Explicit Simulation Theory

With these preliminary distinctions in place, the remainder of this chapter will focus on three versions of explicit simulation that claim to provide ways to fully understand the experiences of others: (1) Goldman's analogical inference simulation, (2) Heal's co-cognition simulation, and (3) Gordon's personal transformation simulation.

2.1 Goldman's "Analogical Inference" Simulation

The first model of simulation, proposed by Alvin Goldman (2000; 2002; 2006), is a form of *analogical inference*. Goldman's analogical inference simulation theory is comprised of three phases: the matching phase, the simulation phase, and the attribution phase.

During the matching phase the "simulator" introduces "pretend-beliefs" and "pretend-desires" derived from themselves in their own mind to initially match the perceived intentional state of the "target" of simulation. In the simulation phase, the simulator uses her own cognitive resources to process these pretend-beliefs in a way that mirrors the internal cognitive processing system of the other person. Finally, in the attribution phase, the simulator projects the presence of these mental states to the target (Stueber 2006, 120). At the end of this three-stage simulation process, the simulator (or empathizer) should have a fairly good sense of what the other person is experiencing based on how the simulator would respond or feel in response to similar inputs.

To illustrate Goldman's analogical inference simulation with a concrete example, suppose a therapist is trying to understand a person's description of living with chronic depression. During the matching phase, the simulator (the therapist) would first introduce pretend-beliefs about feeling lonely and desolate to match the perceived mental state of the target (the person diagnosed with chronic depression). Now that the therapist is holding these beliefs of *what it is like* to be depressed, he would then use his *own* cognitive resources to see what it is

like to be living in this state of mind and what can be learned from this mental exercise (the simulation phase). The therapist might ask himself “If I were chronically depressed, I would feel hopeless and aimless and I would be looking for ways to ease my pain.” After going through this process of simulating *what it is like* to be chronically depressed, the therapist then makes an *analogical inference* that the other person would also be feeling this way (the attribution phase). This gained insight can then help the therapist to offer ways for the other person to help manage the symptoms of their depression, or perhaps the therapist can use this information to find alternative treatment strategies to help the other person cope with these feelings of depression.

As a potential candidate for a theory of empathy to be used within the context of mental healthcare, specifically, the strength of Goldman’s analogical inference simulation is that it offers a way to engage directly with others to get a sense of what they are experiencing. Moreover, Goldman’s approach also bears similarities to our common sense and intuitive conception of empathy as “putting yourself in someone else’s shoes.” As a result, Goldman’s theory of analogical inference simulation is easily graspable and often reflects how practices of empathy typically occur in daily life.

2.2 Heal’s “Co-Cognition” Simulation

A second type of simulation, defended by Jane Heal (1995a, 1995b, 2003), prioritizes a form of *co-cognition* with others by thinking about the same subject matter as them (Kögler and Stueber 2000, 10; Nichols and Stich 1998, 502). As Lockard (2014) explains, Heal’s co-cognition simulation maintains that one can know and predict others’ beliefs “primarily by thinking about what their antecedent beliefs imply” (Lockard 2014, 719).

To illustrate with an example from Stueber, suppose a friend asks you “What would you do if you ordered food in a fine dining restaurant and there was a dead fly on your plate?” Heal contends that we cannot appeal to a general theory of psychology to know how to respond in the situation, as per theory-theory, because there are too many variables to consider. Stueber’s justification is that these scenarios are too broad and that a general theory of understanding is unhelpful and cannot give specific guidance.³⁶ Instead, it is more likely that we will imagine ourselves in this situation, reflect on how *we and anyone else* in that situation would feel, and react accordingly.

For instance, we could ask the waiter to take the plate away and bring us another dish, we could ask to speak with the manager, or we could ask for a refund and leave. By thinking about being in a similar situation as another person, we can predict how others will behave in similar circumstances. For Heal, simulation provides the basic tools for predicting another person’s thoughts in a more localized way. It is possible to roughly predict what another person might be thinking about in a given situation because humans share thought processes that are “rationally organized” in a similar manner (Stueber 2000, 147). Thus, given our capacity of thinking about the *same subject matter* as another person, Heal argues that we should be able to understand the other person’s thought processes to a fairly high degree (Heal 2003, 132).

As a second potential candidate for a theory of empathy to be used to better understand the experiences of persons diagnosed with schizophrenia, the strength of Heal’s co-cognition simulation is that it is collaborative and inclusive because it presumes that others think how we do. It is inclusive, in a sense, because by promoting the idea that others are capable of thinking

³⁶ It could be argued that Heal’s position is not simulation theory at all, but rather a kind of theory-theory since, in this example, what we do here is apply our knowledge of social and cultural norms. Based on this knowledge we would then infer how the other person would feel and act in this situation. As Stueber (2000) notes, theory-theorists make broad generalizations and abstract away from specific instances, whereas Heal takes a more context-specific and holistic approach to understanding others (Stueber 2000, 146).

about and experiencing external phenomena in an identifiable way, it can be interpreted as a preliminary step towards minimizing the perceived sharp distinction between “normal” and “abnormal” modes of being. Especially since the presumption is that people diagnosed with schizophrenia are so radically different from neurotypical individuals, Heal’s approach—much like Goldman’s approach—can serve as a starting point for bridging the divide between caregivers and care recipients and this can have positive implications for reconfiguring therapeutic relationships to better support persons living with schizophrenia.

2.3 Gordon’s “Personal Transformation” Simulation

A third version of explicit simulation theory is the *personal transformation* view proposed by Robert Gordon (1995a, 1995b, 1995c). While Goldman maintains that simulation is an inferential process that involves using our own cognitive resources as a model for understanding others, and Heal views simulation as a process of co-perceiving and thinking about the same phenomena with others, Gordon maintains that simulation must be understood as a “personal transformation” of the other into myself achieved through a “recentering of my egocentric map” in which I make “adjustment[s] for relevant differences” that exist between myself and others (Gordon 1995a, 63; Gordon 1995c, 56; Kögler and Stueber 2000, 9-10; Stueber 2006, 120). Whereas the other theories of simulation are introspective and involve *transferring* oneself into the mind of the other, Gordon’s theory of simulation involves imaginatively *transforming* oneself into *becoming like the other* in order to understand them.

For example, imagine your friend is an actor who has been selected as the lead role in a stage production of *Hamlet* and you are helping him prepare for the performance. To help your friend become immersed into the character of Prince Hamlet you might ask him “How would *you* feel if your uncle murdered your father and married your mother?” The motivation behind

this question might be to help reflect on the variety of emotions that would be involved for someone in a similar situation that the fictional character of Prince Hamlet finds himself in.

Under the theory of personal transformation simulation, Gordon might reply that the question to ask your friend is *not* “How would *you* feel in this situation?” but instead “How would *Prince Hamlet* feel in this situation?” If the goal is to fully understand the fictional character of Prince Hamlet’s emotional and mental state in this situation, personal transformation simulation recommends to use one’s cognitive resources and imaginative processes to *become like* Prince Hamlet and then project that simulated character to the audience during the performance. On this approach, based on a recreation of the character’s motivations, intentional states, and behaviours, the actor would effectively *transform* into “Prince Hamlet” to portray an authentic representation of this character. This process is referred to as a “total projection” of ourselves onto the simulated character (Kögler and Stueber 2000, 9-10).³⁷

Without question, Gordon’s personal transformation simulation is more extreme than Goldman’s analogical inference simulation or Heal’s co-cognition simulation. But as a third potential candidate for a theory of empathy that can help therapists better understand the experiences of persons with schizophrenia, Gordon’s personal transformation simulation is beneficial because it allows for a deep and comprehensive understanding of others and their behaviour. As researchers acquire more information about how the brain processes information

³⁷ Similar to Heal’s co-cognition view mentioned in the previous footnote, it could be argued that outside of this very specific case of method acting, Gordon’s process of personal transformation simulation is nothing more than theory-theory in action. And as a result, there is no simulation or “transformation” taking place at all; it is just inference. But it is important to clarify that Gordon does not mean “transformation” in a literal sense. However, by engrossing oneself in the thoughts and behaviors of others, and by drawing upon features of another person’s experience that derive from making inferences from knowledge about that person, their culture, their tastes, and preferences, etc., Gordon’s personal transformation simulation should allow someone to get a good sense of what the experiences of another would be in a particular situation. But even if simulation theory, as a theory of empathy, turns out to simply be a process of inference, this does not mean that it is appropriate within therapeutic contexts. As I will note in the next chapter, Stein does not view empathy as a mere inference about the experiences of another. Instead, she views it as a joint, collaborative process of understanding with an insistence of avoiding a conflation of *my own experiences* into that of another or using my own experiences as a means of understanding *your* experiences. And it is precisely that deliberate other-focused quality that makes her theory of empathy beneficial in areas of care.

and makes sense of a variety of mental phenomena, the strength of Gordon's approach is that it can help therapists gain more reliable and in-depth access to understanding the other person's experiences, particularly if those experiences are difficult to articulate or appear to be nonsensical. Furthermore, if the reliability of the person's narrative or testimony is raised into doubt due to the difficulties of articulating those experiences (as seen in Chapter 1), then the benefit of simulation theory, as a theory of empathy, is that it allows someone to get at the source of another person's experiences and offer a direct and immediate form of understanding.

With these three variations of explicit simulation theory established, the next section will explore some additional benefits of simulation theory as a form of empathy, particularly within the context of mental healthcare.

2.4 Highlighting the Benefits of Simulation Theory as a Form of Empathy

As argued in Chapter 1, schizophrenia has historically been viewed as a disorder that defies empathic understanding. The degree of disorganized thoughts associated with schizophrenia may be so strong that it is incomprehensible for the person having it and can impair effective communication with others. Furthermore, the presence of a fragmented sense of self reinforces the notion that it is an illness that cannot be understood from an outsider's perspective.

With these barriers to understanding people diagnosed with schizophrenia under traditional approaches to empathy in mind, one benefit of simulation theory is that it recognizes that other people share similar mind states as we do, and this awareness can bridge the epistemic gap between persons by ascribing similar mental states to them. Especially as the cognitive sciences continue to develop and offer further information regarding the brain and how the presence of mental illness influences someone's experiences of the world, the benefit of

simulation is it allows for the creation of authentic models of the mind that can provide accurate depictions of *what it means* to experience certain mental phenomena, including (presumably) *what it means* to experience schizophrenia and other types of mental illnesses.

Another therapeutic benefit of simulation theory is that it could help therapists better diagnose and make sense of their patient's symptoms. The current shift in psychiatry towards adopting more neuroscientific approaches towards understanding mental disorders with improved accuracy, such as RDoc, can prove beneficial for improving relationships between caregivers and care recipients.³⁸ But if a therapist can recreate the experiences of others directly via simulation, it might make it easier for them to connect with them and offer insight into their condition that may not be currently possible under existing diagnostic frameworks.

Finally, in addition to simulation being a theory of explanation for how empathy works, "simulations" as practice can serve as an invaluable training tool for therapists to help decrease the divide between themselves and those under their care and to help form more positive relations between both parties based on mutual understanding. If it is possible to replicate the experiences of others, and if we can predict the person's behaviour in response to these stimuli with greater accuracy, then the possibility of creating tailored treatments for people diagnosed with schizophrenia, designed to meet their specific needs, can become a reality.

Despite the variations in its application, the simulation theories of Goldman, Heal, and Gordon have benefits for addressing the problem of empathy for persons with schizophrenia. But although all three approaches appear to provide the conceptual tools necessary for making sense

³⁸ For example, the Research Domain Criteria (RDoc) offers a neuroscientific exploration into mental disorders and seeks to provide a biological reductionist account of mental disorder that makes them easier to identify, diagnose, and potentially treat. For more on the history and definitive features of RDoc, especially as a potential alternative to the DSM, see Lilienfeld and Treadway (2016).

of the experiences of others, there are several problems with simulation theory, as a theory of *empathy*, which undermines its efficacy and applicability in therapeutic contexts.

3. Objections Against Simulation Theory as a Model of Empathy

While the following section illustrates some limitations of specific theories of simulation, it is important for the reader to recognize that these objections are not limited to a specific theory or theorist, and that some objections overlap multiple theories. However, for the sake of clarity, the objections are roughly divided across all three versions of explicit simulation as outlined above.

3.1 The Issues of Goldman's Introspection-Simulation

The following considerations are criticisms of Goldman's version of simulation theory.

3.1.1 Simulation is Too Egocentric and Presupposes an Ideal Knower

Although there are instances where simulation is unsuccessful, Goldman argues that simulation is the “fundamental method” used for arriving at “mental ascriptions of others” (Goldman 1995a, 83). For Goldman, simulation can often produce “close facsimiles” of “naturally-generated states” and, as a result, simulation can be used to make sense of the mental states experienced by others (Michlmayr 2002, 47, 26).³⁹ However, Goldman explains that this process of simulation “does not involve the very same states in the attributor as those undergone by the target” (Goldman cited in Michlmayr 2002, 25-26). Thus, while they are not a perfect one-to-one recreation of the other person's experiences, the results achieved through this process are *sufficiently similar* that they can be used to get a better understanding of the other person.

³⁹ However, one of the problems is that there is no such thing as a “mental state” at all as consciousness is dynamic, always in movement and transition, and never remains static to be isolated and observed. This is one of the most central qualities of consciousness that is important to keep in mind. Many thanks to one reader for raising this point.

But while the aim of simulation is to provide an objective and empirical method of understanding the experiences of others, one of the drawbacks of this approach is that it presupposes an ideal knower that serves as the foundation for simulations to occur. When inferring actions and behaviours onto others based primarily on one's own cognitive framework, the simulating agent's cognitive functioning is taken to be "normal", "standard", or "neurotypical" and perhaps the presence of mental illness is not factored into the act of simulation. And since the simulating agent makes inferences about others *based on his own experiences*, this neurotypical agent is not able to understand what someone with schizophrenia is experiencing precisely because the notion of "mental illness" might remain outside of the scope of the simulation parameters.

Applied to the therapeutic context, then, Goldman's theory of analogical inference (or introspection-simulation) is problematic because the therapist is using himself as the standard model for interpreting his care recipient's experiences.⁴⁰ According to Code (1995), if caregivers attempt to empathize with care recipients by using themselves as a model for interpreting others, it reinforces an epistemic authority that is external from the lived experience of the person diagnosed with the medical condition. Similarly, Goldie (2011) maintains that approaches to empathy that uses oneself as a model for knowing others are problematic because it essentially "usurps the agent's own first-personal stance" towards what they are thinking and feeling and this has the potential of undermining the other person's agency and replacing it with their own (Goldie 2011, 302, 316). By privileging our own cognitive faculties, and using ourselves as the standard for understanding others, simulation can further contribute to this demarcation between 'normal' and 'neurotypical' and those who are labelled 'abnormal' and 'neurodivergent.'

⁴⁰ This criticism is also known as the "isomorphism" or the "interpersonal similarity relation" criterion that is cited as an objection to simulationist accounts of empathy. See Zahavi (2011).

3.1.2 The Possibility of Simulation Without Directly Engaging with Others

As the cognitive sciences continue to expand, it is plausible to suggest that, *eventually*, the possibility of fully understanding the mind in a comprehensive manner can provide detailed explanations of *all* mental phenomena experienced, including the experiences unique to schizophrenia. But another worry with simulation is that if the underlying neurological processes of experiencing mental phenomena are known—specifically the unique phenomena associated with schizophrenia—then it may not be necessary to interact with the other person at all. In other words, if simulation provides all the tools necessary for making sense of any kind of experience someone is capable of having and can potentially allow outsiders the ability to understand those experiences from a detached perspective, then it should be possible to recreate or *simulate* the other's experiences fairly accurately without engaging with them directly. This has negative implications, I argue, because it can potentially undermine the subjectivity of experience that is a core feature of our sense of selves and identity. And if mental health professionals can *understand* what a person is experiencing without engaging with how that person articulates it, and if their understanding is built upon the foundation of the medical model of illness that informs how caregivers approach their care recipients, my worry is that it can result in further instances of depersonalization and dehumanization of persons living with mental illness.

Furthermore, since therapists are primarily trained to diagnose the symptoms of mental disorders as categorized by diagnostic manuals (as per the medical model of illness), another limitation is that therapists cannot ever use simulation to fully understand the lived experience of schizophrenia.⁴¹ If therapists and psychiatrists approach people they perceive to have

⁴¹ This is especially true for newly trained therapists. As Deegan (1993) notes, one worry for how we train psychiatrists and caregivers to engage with persons diagnosed with mental disorders in a caring and empathic manner will require to teach these healers to view their care recipients as more than just their illnesses. Viewing

schizophrenia with simulated models in mind, based on the medical facts and objective features of “schizophrenia,” the worry is that people with schizophrenia will be treated in a depersonalized manner as their sense of self is reduced to a set of symptoms I highlighted at the beginning of Chapter 1. Even though a therapist would know all the medical facts and objective features of schizophrenia, they would not know *what it is like* to live *with* schizophrenia. The result would be an epistemic gap that separates both parties within this therapeutic relationship. This gap reinforces the power dynamic between “patient” and “therapist” and the worry is that the individual’s voice will be marginalized by the dominant voice of medicine.⁴² And if therapists are concerned primarily with a medicalized conception of mental disorders, then their interpretation of the other person’s experiences will come from a focus on *treatment* of their condition rather than on *understanding* their condition and how relates to their sense of self.

3.2 The Drawbacks of Heal’s Co-Cognition Simulation

The following considerations are criticisms of Heal’s version of simulation theory.

3.2.1 The Issue of Replicability of Experience

In response to Heal’s co-cognition simulation, the limitations with her approach stem from the fact that there are certain features of our subjective experiences that cannot be replicated by someone else with full accuracy. To be fair to proponents of simulation theory, a large portion of the simulation literature focuses primarily on *predicting* another person’s behaviour, not

people diagnosed with schizophrenia through the lens of symptoms that need to be remedied is one of the hallmark features of the medical model of illness (Walker et al. 2020).

⁴² Although I will return to this idea later, Toombs (1987) maintains that medical professionals view illness in terms of their objective status as symptoms, whereas care recipients view illness in terms of their subjective status as lived experiences. Because each party approaches “illness” from a different standpoint, there is a “gap” that must be bridged for mutual understanding to occur. I maintain that Stein’s theory of empathy, and engaging with the other person’s narrative, offers one potential way to bridge that gap.

necessarily empathizing with what the other person is experiencing in order *to care* for her. But an individual's experience of the world—and, more importantly for this analysis, one's lived experience with schizophrenia—is mediated by the fact that everyone has a unique way of experiencing and engaging with the world that cannot ever be replicated by anyone else.

For example, imagine you and your friend are watching a movie together. Your experience of watching the film results in feeling an emotional connection to the characters, you enjoy the actors in the film, and you find it easy to become heavily invested in the plot. Your friend, however, does not connect emotionally with the characters, dislikes the actors, and maintains the plot is so ludicrous that it is hard to suspend disbelief and enjoy the film. Here we have two people *experiencing the same phenomenon* and yet have completely opposite reactions.

Despite its simplicity, this example highlights a potential worry about the applicability of simulation theory (of any form) in practice: there is no guarantee that simulation of similar kinds of experiences can consistently or reliably be replicated with a high degree of accuracy all the time. Even if you and your friend talked about the film afterward, and you tried to understand their perspective from their point of view, it would still be very unlikely to be able to *replicate* their experience of watching the film precisely because you are approaching the film from two distinct vantage points. If it is possible for two people to experience something like a film with vastly different interpretations, presumably based on their own tastes and preferences which are unique to them, then it is difficult to see how these factors can be omitted when trying to simulate another person's experience. And even if you tried to simulate their experience without taking their tastes and preferences into account, I still do not think that simulation gets us anywhere closer to how the other person would or could *actually* experience that phenomena in the first place as there is too much variation between yourself and someone else.

3.2.2 Simulation Cannot Recreate the Immediacy of Experience

In addition to the issue of detached engagement illustrated above, another reason why simulationist approaches to empathy are limited is because, as Collingwood argues, they cannot recreate the “immediacy of a qualitative episode of consciousness” that another person has experienced (Collingwood 1946, cited in Kögler and Stueber 2000, 6). This inability to recreate the immediacy of the other person’s experience can lead to the empathizer bringing in more of their own subjective influences into the interpretation of the other person’s experience.⁴³

The purpose of transposing ourselves into the situation of the other via simulation can be viewed as a way of diminishing or eliminating contextual differences that exist between individuals, including cultural, historical, or social factors. On face value, this approach seems promising for applications in a therapeutic context because it should allow the therapist to experience a situation as closely as possible as the person diagnosed with schizophrenia experiences it. And, more importantly, it should allow the therapist to engage with another person’s phenomenological experiences as neutrally as possible in order to understand it without injecting any personal bias into that encounter that would distort or influence the way the experience is understood (Kögler and Stueber 2000, 23). After all, this is precisely the type of approach advocated for by Jaspers that was discussed in Chapter 1.

While the motivation behind attempting to actualize this impartial and neutral approach towards understanding others is well-intended, I agree with many feminist philosophers that this striving towards *removing* cultural, historical, or situated differences is problematic precisely because it can result in further instances of epistemic silencing of the perspectives and situated knowledge of traditionally marginalized groups (La Caze 2008; Benhabib 1992; Young 1997;

⁴³ As I will argue in the next chapter, a phenomenological account of empathy captures this immediacy of the other’s experiences in a direct way.

Code 2006; Molas 2016/2018b). Thus, while the intention of seeking an objective and neutral standard is admirable, the negative consequence is that it can reinforce certain epistemic modes of knowing as ideal, and it can lead to certain groups of people falling in between the cracks since their ways of experiencing the world do not fit these typical epistemological models.

3.3 The Problems of Gordon's Total Projection Simulation

The following considerations are criticisms of Gordon's version of simulation theory.

3.3.1 The Vagueness of the Criteria for Total Transformation

Although Gordon's personal transformation simulation appears to offer an accurate way to understand the experiences of others, Kögler and Stueber note that if we come across a situation where total projection is near impossible, then simulation requires *more effort* on the part of the simulator to adjust for relevant differences between themselves and the simulated person.

But given the nature of primary delusions, and the difficulty that some people diagnosed with schizophrenia may have in articulating these experiences to others, it is quite difficult to "recenter" our egocentric maps and make "adjustments" to account for these differences between my psychological states and the person with schizophrenia. Furthermore, it remains unclear what precisely is entailed by these adjustments. Since Gordon offers no criteria on *how* to adjust for these differences, it is plausible that the likelihood for errors in understanding increases.⁴⁴

⁴⁴ More importantly, the power dynamics between caregivers and care recipients can lead to misunderstandings which can be harmful to the person's well-being. For example, suppose someone is experiencing a delusion and repeatedly says to the nurse "They are coming for me!" Imagine that this person is lonely and would like to be surrounded by others because it helps mitigate the effects of the voices in his mind. If the nurse, who is trying to project herself into the other person's mind, assumes that he is suffering and interprets the nature of his delusion as one of persecution which requires more drastic treatment (e.g. increased medication to calm him down), the misunderstanding results in the person with schizophrenia being further isolated from others, causing more harm to his well-being.

3.3.2 Total Transformation Cannot Lead to Authentic Understanding

In addition to the vagueness of what is precisely needed in order for a total projection to be considered successful under a simulationist framework, when total projection fails (which is quite possible if caregivers are engaging with someone experiencing delusions), Gordon suggests performing a type of method-acting transformation the way actors do in preparation for an acting role. By transforming myself into becoming someone else, as indicated in the Hamlet example above, Gordon's claim is that I can generate a deeper and more thorough understanding of *you* instead of merely imagining *myself* being in *your situation* (Gordon 1995, 57; Goldie 2011, 313).

For example, suppose a teaching hospital is training its residents to better empathize with their patients with physical impairments who require wheelchairs for mobility. To help these residents get a better sense of what it is like to need to use a wheelchair, the residents are asked to remain in their wheelchairs for the duration of the day as they perform their daily duties throughout the hospital.⁴⁵ On face value, these exercises seem harmless and can help raise awareness about the limitations that some people experience daily. By offering clinicians insight into the challenges that emerge when a person is dealing with any type of limitation, the hope is that these simulation activities can foster compassion, empathy, and the realization that there are certain privileges that able-bodied individuals possess but are often taken for granted.

However, in this scenario, this activity is insufficient for truly capturing *what it is like* to be in the other person's situation. The simulator will never *fully know* what it is like to be unable to enter certain public buildings without assistance. The simulator will never *fully know* what it is like to face discrimination in the workplace because of their disability. And the simulator will never *fully know* what it is like to be stared at by strangers on the street, or to be treated in an

⁴⁵ For more on the concept of disability simulation, as well as some criticisms of these approaches, see Nario-Redmond et al. (2017) and Paul (2019).

infantilized manner, the way that some people with physical limitations experience. Although the intention of an activity like this is well-taken, the problem is that the person *pretending* to need a wheelchair has the ability to end the “simulation” and go back to the way things were before. At most, simulation of this sort would allow an able-bodied person to get a temporary sense of what it is like to be unable to move freely without a wheelchair. But it would not allow them to *understand* the other’s experiences or to *empathize* with them in a meaningful manner.

By presuming that we can understand the experiences of the other person to a high degree, simulation theory can be unreceptive to interpersonal differences and may minimize existential differences which exist between people by attempting to experience what the other person is experiencing in the same way (Ratcliffe 2015, 230-231). While the example of the teaching hospital above demonstrates a limitation of simulation for understanding physical conditions, I maintain that simulation is problematic for understanding *mental* illnesses because, as argued above, a therapist will never have a fully authentic experience of another person’s experiences in a first-person manner. This is not to risk further marginalizing persons with schizophrenia by placing them into a special category of “un-understandable” as per Jaspers’ description highlighted in the previous chapter. Rather it is meant to highlight the complexity of mental phenomena and the uniqueness of each subjectivity as a center of experience.

That said, although there may be limitations to simulating the experiences of others using our imaginations, it is interesting to note that technological tools have been designed to recreate the sensation of what it is like to live with schizophrenia and other impairments for the purposes of fostering empathy.⁴⁶ In an investigative journalism piece entitled “Exercise in Empathy:

⁴⁶ One example is the creation of an “aging suit” designed to help wearers experience the physical impairments of old age while navigating public spaces. This suit is designed to add forty years of “age” onto the wearer by using a variety of mechanisms to recreate the challenges that people experience as they get older. For instance, one’s vision is reduced via specially crafted goggles, one’s mobility is restricted through a series of straps and pulleys on the

Hearing Voices,” CNN’s Anderson Cooper is asked to perform a series of cognitive tasks, such as repeating a list of words spoken by an interviewer, and folding an origami boat while following written instructions, while wearing “schizophrenia simulator” headphones designed to simulate the phenomena of hearing voices.⁴⁷ During the completion of these tasks, Cooper’s headphones would periodically interrupt him with dismissive voices and a cacophony of noises intended to *simulate* the auditory hallucinations that people with schizophrenia may experience.

Throughout his completion of these basic tasks, Cooper claims that the voices heard in his headphones made it difficult for him to focus and made the simple and straightforward tasks more challenging to complete. On the surface, something like a “schizophrenia simulator” can be a valuable tool for therapists because it offers a brief *glimpse* into the lived realities that many people with schizophrenia experience and highlights some of the challenges in daily life that those without this diagnosis may not be aware of and do not need to overcome. But, like the wheelchair example mentioned above, while these tools can raise awareness of the challenges that people with schizophrenia face, it does not allow someone to *fully understand* what it is like to live with schizophrenia. It may offer some insight into what the experience of schizophrenia is like, but it is not the same as the kind of experiences a person with schizophrenia has firsthand.

For Gordon, it is important to clarify that we are not transforming and projecting ourselves into the other person but instead a simulated representation of that other person. But an additional worry is that, as a *simulated representation* of another person, the simulated character could be based on stereotypes or narrowly defined characteristics that could misrepresent another

suit’s vest, and gloves and braces are worn to reduce dexterity in one’s joints. The purpose of this suit is to help people *empathize* with the challenges that elderly people have when navigating public spaces. The intention is that raising awareness of these natural limitations of one’s body as we get older can help inspire more accessible public spaces. For more on this aging suit: <https://www.wbur.org/hereandnow/2019/06/03/age-simulation-suit>

⁴⁷ A video of Cooper's experience can be seen online: <https://www.medicaldaily.com/anderson-coopers-schizophrenia-simulator-experience-was-unpleasant-experiment-288400>

actual person. For example, suppose an inexperienced medical student is learning to diagnose instances of schizophrenia. Suppose also that it is his first week of residency and his knowledge of schizophrenia is based on case studies that depict the most severe instances of this disorder. This can lead the therapist to have pre-conceived expectations of what “schizophrenia patients” are and can influence how he approaches those in front of him.

Returning to the schizophrenia simulator example to close this section, it is telling that, at the end of his investigative report, Cooper claims: “I can’t wait to take these headphones off because it’s very depressing, it’s very negative. It makes you feel very, very negative. It’s very creepy, I want it to stop.” While it is possible for Anderson Cooper to *take off* the “schizophrenia simulator” headphones and return to his previous way of life that is free from these experiences, a person with schizophrenia cannot turn off the voices in their head at will. Thus, while Gordon’s attempts to understand the experiences of others through total transformation is ambitious and admirable, it does not provide a complete picture of the other’s experiences.

3.4 The Limitations of Simulation in Therapeutic Contexts

Although there is overlap between the objections raised above, this section explores the limitations of simulation broadly construed and is not targeting any specific theory of simulation.

3.4.1 Simulation Cannot Replicate the Subjectivity of Experience

As previously discussed, the “integration” of another person’s thoughts into our own cognitive systems is all that is required to understand them and their experiences under the simulation framework (Kögler and Stueber 2000, 5-6). But the ability to integrate another person’s thoughts

into our own cognitive systems is problematic because, as argued thus far, there is always *something* that is omitted in this process that leads to an incomplete simulation.

To illustrate with an example, given his upbringing in a life of financial security and near limitless opportunities, former United States President Donald Trump would be unable to simulate being in the position of someone who grew up in poverty, no matter how hard he tries to “integrate” the thoughts of that person into his own cognitive system. While he may be able to *sympathize* with someone who is less financially secure than himself, Donald Trump would be unable to tell a person living in poverty that he *understands what it is like* to be impoverished because he has never experienced it himself.⁴⁸

Part of the reason why we can never fully *know* another person is because, as Ratcliffe (2015) argues, a person is “*intrinsically unknowable* in her entirety” (Ratcliffe 2015, 247, emphasis added). Simulation focuses on specific moments in time, but these individual moments cannot fully capture the whole person who is influenced by their experiences of the world. Our memories, our relationships with others, our socio-economic status, and even our geographic location are all features of our personality which influence the experiences we have and shape how we perceive the world. Since it is impossible to replicate all those other factors in a purely cognitive simulation, attempting to simulate someone’s emotional and mental states in isolation is problematic as it divorces those experiences from the person’s embedded context and history.

According to Michlmayr, simulation requires having enough information about the other person’s mental state for it to be effective as a tool for understanding others (Michlmayr 2002, 59). But attempting to simulate the experiences of others without being able to replicate all these extra-experiential factors, I argue, leaves the outcome of simulation feeling incomplete and

⁴⁸ But as professional psychologist, and niece of the former President, Dr. Mary Trump notes in her book *Too Much and Never Enough* (2020), from a psychological perspective it could be argued that Donald Trump may be incapable of even *sympathizing* with anyone beyond his immediate family. Many thanks to Geoffrey Reaume for this point.

leaves too much room for individual biases to misrepresent the experiences of the other person. As Stueber points out, empathy theorists claim that in learning about other minds we proceed essentially in an “*egocentric* manner” and that finding out about another person’s mind depends on “using *myself* and *my own mind*” as a model representation for the other person’s mind (Stueber 2006, 3-4, emphasis added).⁴⁹ But given that there remains so much variation in lived experience from person to person, I maintain that this “access” is limited because we are relying solely on our own experiences to project feelings and thoughts onto others.

3.4.2 The Inability to Quarantine Personal Biases

A final reason why simulation theory is unsuccessful (and undesirable) as a theory of empathy is due to a failure of being able to “quarantine” our own psychological states so that they do not “interfere” with or “contaminate” the simulation process (Goldie 2011, 313). To an extent, successful simulation requires us to “quarantine” certain beliefs that we have to reason about the beliefs of others (Stueber 2006, 111-113). For example, if I were attempting to empathize with someone who believes that vaccinations cause autism, or that climate change is a hoax, I must first suppress my own belief that vaccinations help keep populations safe and that climate change is a real global phenomena. To understand where this person is coming from, and to get a better sense of why she holds these beliefs, I must withhold my beliefs in order to receive hers for the purposes of understanding her.⁵⁰ While quarantining some of our beliefs can have positive implications for helping to address the problem of stigma and rewrite the harmful master

⁴⁹ Within the tradition of positivist epistemology, there is a presumption that knowledge is mediated through an ideal subject. This ideal knower remains perfectly rational, objective, neutral, and is meant to stand for everyone. For a critique of these traditional epistemological positions, see Code (2006) and Molas (2016).

⁵⁰ Appealing to something like Donald Davidson’s principle of charity, where we ascribe rationality to the other person in order to make sense of them, could be helpful. For a discussion on the principle of charity within the psychiatric context, see Radden (2011).

narratives which currently surround mental illnesses (that I will discuss in Chapter 5), this approach put forward by simulation theorists is misguided for the following reasons.

On the one hand, simulationists are correct to note that if we are going to understand other people, we must quarantine beliefs that interfere in the interpretation of the other person's experiences.⁵¹ For instance, stigmatizing and discriminatory beliefs about people with schizophrenia should be quarantined because those beliefs negatively disrupt our interaction and impede our ability to engage with the other person. But while quarantining *harmful* beliefs is helpful, it should not be used solely for the purposes of *simulating* another person's experiences within ourselves. Instead, it should be done to remain open-minded to understanding her experiences better *as experienced by her*. When empathizing with another person, it is important to exercise restraint, to show humility, and to remain open and receptive to the experiences of the other person. And since the simulation theories discussed in this chapter presume that a full understanding of the other person is possible, I argue that simulation misses the mark as a theory of empathy and fails to address the problem of empathizing with persons with schizophrenia.

4. Conclusion

Despite the variations in the theories listed above, simulation involves using one's own cognitive processes in an "imitative fashion" to gain information about other minds which can then be used to predict or explain the actions of someone else (Stueber 2006, 111-113). Given our imaginative capacities, our cognitive systems allow us to imagine things that extend beyond ourselves. Since all humans have minds that are structured and function psychologically in a similar manner that allow us to perform these imaginative feats, the underlying assumption of simulation theory—as

⁵¹ This notion of quarantine echoes Husserl's argument about the transcendental reduction—and invoking the *epoché*—to suspend judgment and examine phenomena without preconceptions in mind. See Englander (2016)

a theory of empathy—is that we can use our own minds to understand other minds by imagining the world from their point of view (Stueber 2006, 115-116; Heal 1995, 49; Harris 2000).

But, as I have argued throughout this chapter, the main problem I find with simulation theory, of any kind, is that it can result in the empathizer *co-opting* the other person's experience and substituting their own. Because the empathizer may impose their own attitudes and beliefs onto the experiences of the other, the most significant objection is that this general theory of empathy leads to an *assimilation* of the other instead of a *simulation* of the other. On that note, Ratcliffe's insightful analysis raises key points as to why simulation is insufficient to capture the essence of empathy and how it can be used in practice. According to Ratcliffe:

Simulation can contribute to a sense of what another person *might* be experiencing, but empathy demands restraint...To engage with [another person's] experience, an attitude involving *openness*, curiosity, and *reciprocity* is needed. *Imposing* one's own experience on someone...*without listening*, without being open to alternatives, is a *failure of empathy*. First-person experience thus informs empathy, rather than serving as a substitute for it (Ratcliffe 2015, 245-246, emphasis added).

Since all three accounts of explicit simulation theory involve some degree of imposing one's own experience onto someone else, all three fail to grasp the essence of empathy. And since all three accounts of explicit simulation theory fail to grasp the essence of empathy, all three variations fall short of addressing the problem of empathy as articulated by Jaspers in Chapter 1. Overcoming this difficulty of imposing one's own experience onto others requires a theory of empathy that allows for interpersonal engagement to occur yet preserves a distinction between the self and the other. As I will argue in the next chapter, a phenomenological account of empathy, developed initially by Edmund Husserl but further refined and defended by Edith Stein (1964), offers a compelling alternative to simulation theory and a promising solution to the problem of empathizing with persons diagnosed with schizophrenia.

Chapter 3 – An Exploration of Stein’s Phenomenological Conception of Empathy

This chapter explores Stein’s phenomenological theory of empathy (or “sensual empathy”) as an alternative to simulation theory. It is argued that Stein’s theory allows for the possibility of empathizing with persons with schizophrenia on a basic level. This chapter outlines the necessary features that make empathizing with others possible, and the analysis extends to include persons with schizophrenia as well. Finally, it outlines the potential therapeutic benefits and the applications of Stein’s theory of empathy that will be explored in subsequent chapters.

1. Biographical Background of Edith Stein

Before exploring Stein’s theory of empathy in greater detail, given her role in the formation of this dissertation it is appropriate to offer a brief biographical background of Stein’s academic and vocational career to potentially highlight some of the key insights of her approach. Although, academically speaking, she is known for her association with Husserl while earning her doctorate under his supervision, Stein’s contributions and impact extend far beyond academia.

Stein began her doctoral studies in 1913 at the University of Göttingen in Germany. During the outbreak of the First World War, which interrupted her studies, Stein volunteered to be a nurse for the Red Cross in 1915 to work at a hospital that treated persons with infectious diseases. After completing her PhD in 1917 and being unable to secure an academic position at the time (due in part to the effects of sexism and the denial of opportunities for women within European universities during that period), Stein converted to Catholicism in 1921 after being inspired by reading the autobiography of St. Teresa of Avila (Magri and Moran 2017, 12; Szanto and Moran, 2020). Following her baptism and conversion to Catholicism, Stein would teach at

St. Magdelina's College in Germany from 1923 until 1931 and she secured a lecturer position at the German Institute for Educational Theory in 1933.

However, given the rise of the Nazi party in Germany in the 1930's and the implementation of anti-Semitic policies throughout the country, Stein (born into a Jewish family) was removed from her academic position. She then proceeded to join the Carmelite Order of Sisters at Cologne to become St. Teresa Benedicta of the Cross in 1938. Tragically, given the outbreak of World War II and the Nazi's targeting of Jewish people and other groups, Stein died a martyr in 1942 in a concentration camp along with millions of others. She would later be canonized by the Vatican and Pope John Paul II in 1998 (Poe-Greskamp 2014, 194-195; Bordeaux 1959; Herbstrith 1985; Sullivan 2002; *Vatican: The Holy See*).

Although the remaining focus of this analysis is based on the advantages of Stein's contributions from an academic perspective—and as I will argue below, her academic work stands alone with its merits and contribution to the discussion of empathy—without question her desire to attend to caring for others evidenced through her experience in nursing serves as a precursor to fully appreciating her theory of empathy from an applied perspective in healthcare.

2. The Aim of Stein's Project and Criticisms of Historical Views of Empathy

In *On the Problem of Empathy*,⁵² Stein articulates a conception of empathy that builds upon the groundwork of Husserl but expands upon it in several key ways. Stein maintains that empathy refers to the “basic nature of acts in which foreign experience is grasped” and aims to provide a general account of how empathy functions (*OPE* §4).⁵³ In response to the problem of empathy articulated in previous chapters, along with the possibility of gaining access to the experiences of

⁵² References to Stein's text will be abbreviated to “*OPE*” and includes the section indicated by the “§” symbol.

⁵³ As Waltraut Stein explains in the Translator's Introduction of *On the Problem of Empathy*, the purpose of empathy, for Stein, is to provide a *description* of the other (*OPE* viii).

others when our minds are the only ones we have access to, Stein notes that several historical understandings of empathy claim to address this issue: empathy as imitation, empathy by association, and empathy as analogical inference. Before exploring Stein's account in greater detail, it is helpful to examine these approaches of empathy and examine why they are unsuccessful for understanding the nature of empathy.

2.1 Empathy as Imitation

The first theory of empathy Stein discusses, and ultimately refutes, is *empathy as imitation*. Empathy as imitation involves a mimicking of the other person's experiences to understand what they are currently feeling. Reminiscent of the implicit simulation views described in Chapter 2 (specifically "mirror" empathy or empathy as "emotional contagion"), empathy as imitation can occur involuntarily and without requiring the use of many cognitive resources.

While imitation, on face value, appears to be an act of empathy, Stein maintains it is not suitable as an explanation of empathy because the focus is on *our* feelings, not the experiences of the other person. Through acts of imitation, Stein argues that we do not arrive at the phenomenon of foreign experience but at "*an experience of [our] own*" that "*arouses in [us] the foreign gestures witnessed*" (*OPE* §24, emphasis added). Stein maintains that our interpretation of someone else can "arouse imitation in us, but not a feeling" and, as a result, conceiving empathy as an imitation of what we perceive the other person is experiencing prevents us from "turning toward" the other person and "submerging ourselves in the foreign experience" which is the "attitude characteristic" of empathy (*OPE* §25).⁵⁴

⁵⁴ Stein maintains that there is a difference between the mere transference of feeling to another person and the "empathic submersion" in the foreign experience of the other (*OPE* §25). The "*I know just how you feel*" theories of empathy that I reject represents a misunderstanding of empathy and can dismiss the accounts of persons with mental illness and reinforce harmful attitudes that leaves persons with mental illness at risk for further marginalization.

For instance, imagine the phenomenon of babies who cry in the presence of other crying babies. If one baby is crying because she is hungry and tired, and another well-fed and well-rested baby only cries because she is triggered by the crying baby, then the second baby is not *empathizing* with the first baby's hunger and fatigue. Rather, she is merely *imitating* the behaviours and emotions she perceives the other baby to be experiencing.

To that end, the imitation theory of empathy fails to capture or explain a key feature of empathy because it prevents us from submerging ourselves into the foreign experience of others and, instead, limits it to our own sphere of conscious experience. Furthermore, as indicated through the crying baby example, this conception of empathy is limited because imitation is possible without having the same feelings of another aroused in us (*OPE* §25). And because it only provides a sense of what the other *might* be experiencing, Stein maintains that imitation is insufficient for understanding others as we would only have gotten a *knowledge of* their experiences, but not a *givenness of* the foreign experiences (*OPE* §25). This distinction Stein makes between “knowledge of” and “givenness of” is important for understanding how her phenomenological approach differentiates itself from simulation.

Knowledge of involves an acknowledgement that the person is having an experience. By gaining a better understanding of how the brain works, for instance, the appeal of simulation is that we can develop reliable and accurate models for understanding how the mind works and, potentially, how the manifestations of mental disorders materialize, as in the case with primary delusions of schizophrenia. However, regardless of how much “knowledge of” schizophrenia one gains in terms of neuro-biological information about mental processes and brain states, that knowledge, alone, is not the same as empathic knowledge of the experiences of the other.

By contrast, the *givenness* of something involves a feeling of and taking over the experience of the other. *Givenness of* is something like being made aware to me in my conscious experience. What I perceive from the other, and the information I receive from them is what is given to me. *Knowledge of* something involves a basic comprehension of an object or experience on a surface level, whereas I maintain that the *givenness of* some object or experience focuses more on uncovering the surface to get at the essence of something (which is reminiscent of Husserl's claim that the role of phenomenology is to investigate and uncover the implicit meaning of objects, not merely how those objects are represented to us). As Stein notes:

Knowledge reaches its object but does not "have" it. It stands before its object but does not see it. Knowledge is blind, empty, and restless, always pointing back to some kind of experienced, seen act. And the experience back to which knowledge of foreign experience points is called empathy (*OPE* §20).

Because it only provides knowledge of another person's experiences, as a theory of empathy imitation is insufficient for explaining what happens when we empathize with another person.

2.2 Empathy by Association

A second theory of empathy Stein claims is insufficient for explaining the genesis of empathy is *empathy by association*. Empathy by association involves perceiving another person's behaviour and attributing specific beliefs that correspond to that behaviour. These attributions can be based on our own feelings that we exhibited in the past in similar situations. And much like simulation theory, empathy by association can provide meaning to instances of that behaviour in the future.

For example, suppose that while going out for a walk around the neighbourhood you witness a child stomping her feet on the sidewalk. In the present moment, you can infer to yourself that "This child must be angry!" When perceiving this moment, you can reflect on your childhood experiences of stomping your feet and you can remember how you felt at that time

(e.g., angry). And if you were to witness someone stomping their feet in the future, you could infer that the person is also experiencing an emotional state that is similar to that of the child.

While there are some intuitive features of this second approach that help us get closer to understanding what it means to empathize with others, Stein argues that empathy by association is problematic because, once more, you are drawing on *your own* experiences to attribute an emotion to the other person without knowing precisely if they are feeling the same emotion. As Stein explains, even if you perceive that person to be angry, “the other’s fury itself is not given, but *its existence is inferred*. By an intuitive representation, *my own fury*, I seek to draw it near” (*OPE* §26, emphasis added). But even if we associate someone stomping their feet as being indicative that this person is angry, there is no way to guarantee that this state of anger is being experienced by the other person. The child could be *pretending* to be angry in order to fool her parents; she could be playing with her friends and having *fun*; she could be stomping her feet out of *impatience*; or she could be stomping on a spider out of *fear*. With empathy by association, there is simply no way to accurately assess or verify the other person’s mental states.

Stein’s issue with this approach is that *inferring* someone’s emotional experience just is not what empathy is because empathy involves the *perception* or intuition of another person’s experience. Furthermore, Stein maintains that this approach does not capture the essence of empathy because, by drawing on our own past experiences, we are not focusing on what the other person is *currently* feeling in the moment. For Stein, empathy is an immediately experienced act (*OPE* §26). And since we are drawing conclusions about the behaviour and mental states of others based on our own past experiences, empathy by association can potentially lead to projections onto others that are inaccurate and not based on a direct

understanding of the other person's "inner condition" (*OPE* §27-28). Therefore, as a theory of empathy, empathy by association is unsuccessful for understanding the experiences of others.

2.3 Empathy as Analogical Inference

A third form of empathy Stein refutes is *empathy as analogical inference*. Similar to Goldman's analogical inference simulation discussed in Chapter 2, Stein explains that through this approach to empathy we perceive "the foreign 'I' [of consciousness] with its experience innerly just as we perceive our own 'I'" (*OPE* §30). Unlike empathy as imitation or empathy by association, which involves some degree of engagement with the other person, empathy as analogical inference is problematic as a method of understanding the experiences of others because the process leading to the experience of the foreign consciousness is "simply ignored" (*OPE* §29).

Recall that, at this preliminary stage of the phenomenological investigation into understanding others, the only direct access we have is to our own conscious experiences and mental states. As a result, we use ourselves as a model for making sense of the world and assume that other people must also experience the world in similar ways that we do (*OPE* §29). But since we are drawing on ourselves to make inferences about what another person is experiencing, Stein argues this approach is unsuccessful because, like simulation theory, turning toward *our own* experience "naturally means the cessation of the foreign attitude" which is characteristic of any empathic act (*OPE* §36). As a result, empathy as analogical inference cannot be used to understand the experiences of others because the focus is on *ourselves* and *our own* experiences.

Nevertheless, Stein admits that we cannot deny that inferences by analogy do occur and that it is likely that we draw similarities from our own situations when we see glimpses of it in other people (*OPE* §30). But analogical inference is a limited form of empathic understanding because, as discussed in Chapter 2, it provides only a "more or less probable knowledge of the

foreign experience” which Stein maintains is an “empty form” of knowledge that results in an inauthentic and non-genuine form of understanding (*OPE* §30, §36).⁵⁵ Empathy requires something more than any of these traditional theories of empathy can provide. Given the limitations of empathy as imitation, empathy by association, and empathy as analogical inference as methods for understanding the concept of empathy, what is Stein’s theory of empathy and how does her theory overcome the problems that these alternative forms of empathy cannot?

3. Articulating Stein’s Account of Empathy

Before we outline the core features of her theory of empathy, it is important to clarify the distinction Stein makes between *primordial* (original or direct) experiences and *non-primordial* (non-original or indirect) experiences. I maintain that these distinctions are significant for differentiating Stein’s theory of empathy from alternative approaches, such as simulation theory, precisely because these alternative theories seem to strive to recreate the primordially of another person’s experiences within oneself.

3.1 The Difference Between Primordial and Non-Primordial Experiences

Primordial experiences are any phenomena we perceive firsthand and are given to us fully in our perceptual awareness (*OPE* §6; Dullstein 2013, 343). For instance, if I am working in my warm office on a hot summer day and feel the cool breeze from my air conditioner, the cooling sensation is given to me primordially because I am experiencing it directly. But there are also

⁵⁵ By contrast, a phenomenological account of empathy defined as a grasping of the foreign “I” is more authentic because empathy “posits being immediately as an experienced act, and it reaches its object directly without representation” (*OPE* §26). To clarify, Stein maintains that the issue with representation is that it is *recreated* based on the experience we *think* others to be having. If some experience or feeling of the other is represented within ourselves, her claim is that we are using *our own* experience or feeling to do this and, thus, it makes the same mistake as both empathy as imitation and empathy by association.

instances, such as memories or expectations, which are non-primordially given to us (*OPE* §6). For example, I can *remember* a joyful experience I once had, such as being accepted into a PhD program, and I can *anticipate* the joy I will experience once I defend my dissertation. Although both experiences are given to me (in that they have happened and will eventually happen), neither of these examples are experienced primordially because their intentional object (the experience of joy) is not present to me (temporally or spatially). As such the mental states of others, including their thoughts and emotions, are primordially inaccessible and can only be grasped through what Stein calls the non-primordial act of empathy (Dullstein 2013, 343).

3.2 How Does Stein Define “Empathy”?

With those clarifications in mind, “empathy” refers to all acts in which foreign experience is comprehended. Empathy is a process of *being with* and *feeling with* the other person by directly perceiving their experiences, which Stein describes as the “non-primordial parallel to perception” (*OPE* §10; Dullstein 2013, 349; Svenaeus 2018, 742). Stein refers to empathy as a kind of “fellow feeling” that allows us to understand others by participating in their experiences *with* them (*OPE* §14). Although her theory of empathy involves a *feeling into* the experience of others, and focuses on participating in their experiences *with* them, one distinguishing feature of Stein’s theory of empathy is that it does not result in a *recreation* of the other’s subjectivity (*OPE* §12, §16). As Stein argues, the subject of the empathized experience “is not the subject empathizing, but another” (*OPE* §10).

Through acts of empathy, we gain access to another’s experiences, but we never take over the person’s experience. For instance, if we come across a person who is happy or is grieving a loss of a loved one, we can *understand* their feelings based on our understanding of

the concepts of happiness and grief, respectively. But we can never experience those feelings *as experienced by that person* from a first-person perspective (*OPE* §13; Määttä 2006, 5). This is because, as Stein notes, these experiences I feel of the other “does not issue live from my ‘I’” (*OPE* §10). Rather I have a *representation* of the other’s experience even though I do not experience it myself (Dullstein 2013, 345; Svenaeus 2015, 227, 243; Lebech 2017, 113).

3.3 How Do We Grasp the Primordial Experiences of Others Non-Primordially?

To illustrate how we grasp the primordial experiences of others in a non-primordial way, suppose we are watching Game 6 of the 2019 NBA Finals between the Toronto Raptors and the Golden State Warriors. During the game, the Warriors’ top shooting guard, Klay Thompson, tears his left ACL and falls to the ground. Based on his facial expressions, his hands gingerly caressing his knee, and the look of concerned faces from his coaches, teammates, and the fans in attendance watching the game, it is plausible to have the belief that “Klay Thompson is in pain.”

In this example, Klay Thompson’s pain caused by his torn ACL is *primordially given* to him. The sensations he feels are *primordially experienced* and he can even confirm the nature of his pain to reporters and the fans watching at home during the post-game press conference. But, as Burns (2017) notes, another person’s *pain* does not appear to us the way that other perceptual features of his body are perceived. Unlike other phenomena we perceive directly, Stein maintains that we never get an “orientation” where the pain itself is “primordially given” (*OPE* §5). Although we are *aware of* his pain—as indicated he may close his eyes tightly and he may scream “Ouch!”—we have no direct access to his pain in the primordial sense. Thus, we can only grasp his pain in a non-primordial manner (*OPE* §5).

With these core features of her theory of empathy in mind, how does Stein's theory of empathy develop and more importantly, how does Stein's theory differ from simulation theory?

4. Stein's Phenomenological Approach as an Alternative to Simulation Theory

The following sections will outline Stein's theory of empathy in greater detail. In particular, the following sections will explore the three stages of Stein's theory of empathy and present it as a viable alternative to simulation theory for better understanding persons with schizophrenia.

4.1 Stage One: The Emergence of Experience and Direct Perception

Stein's account of empathy develops at three stages. The first stage is the "emergence of the experience", and this stage involves directly perceiving the other person's embodied experience in an intuitive manner (*OPE* §10, §18; Meneses and Larkin 2012, 157). Unlike the kind of perception found in simulation theory, Shum (2012) maintains that the Steinian approach involves a particular kind of "seeing" to the extent that one intuits something that does not belong to one's "sphere of ownness" (Shum 2012, 178). When engaging with someone else during this first stage, Stein explains how "I *intuitively* have before me what *they feel*. It comes to life in *my feeling...*" (*OPE* §18, emphasis added). At this first stage, I am aware that the other person's experiences belong to them, and I become aware of their experiences and that they are feeling *something*, which is knowable to me and others within a certain range of indeterminacy.

For example, suppose I am attending my best friend's dissertation defense. After waiting for her committee members and external examiners to deliberate the outcome, I notice my best friend emerge from the examination room who, with a wide smile on her face, informs me that she successfully passed her defense with distinction. Before she tells me of the committee's

decision, I immediately *perceive* the joy on her face. I can *see* that she looks confident, and it *feels like* all the stress she had prior to the defense has disappeared. In this situation, I am grasping the joy I perceive her to be experiencing. But this grasping at her experience of joy is not a result of a complex cognitive simulation, or by imagining how *I* would feel if I was in her position. Instead, as Meneses and Larkin note, my grasp of her joy is due to a perceptual act which brings her primordial joy into my conscious awareness (Meneses and Larkin 2012, 166).

4.2 Stage Two: Fulfilling Explication of the Object of Experience

After initially grasping the other's experience through my own perceptual awareness, the second stage of Stein's theory is a "fulfilling explication" of the object of experience (*OPE* §10). At this second stage, Stein explains that empathy exhibits the "non-primordial parallel to the having of the experience" (*OPE* §10). In stage two, I gain a better understanding of their experiences by following through with them in an act of the imagination where I am led by the other.

Stage two involves an imaginative "transposal" or "projection" of the self into the other person's experiences (Meneses and Larkin 2012, 170). But unlike the projections used by simulationists to replicate *being* the other person to understand her experiences, Stein's projections focus on exploring these experiences *as if with* the other person as her experience unfolds. Moreover, rather than being conceptualized only as cognitive acts, these projections are experiential, non-intellectual, and intuitive (*OPE* §21; Meneses and Larkin 2012, 170, 175-176).

Returning to the dissertation example, Stein notes that the joy of the other we experience empathically is *numerically* the same as the joy we feel firsthand. But the distinction is that it is "*a different mode of being given*" and thus it is not *qualitatively* the same as the joy the other person is feeling (*OPE* §15, emphasis added). For example, if my friend excitedly tells me that

she passed her dissertation defense, I can *see* the joy in her face and bodily expressions. I can feel happy *for her*, and I can share her excitement *with her*. But I do not feel *her primordial joy* that she is currently experiencing. This is because her feeling of joy is only given to me through the “non-primordial act” of empathy (*OPE* §14). Although her primordial joy is inaccessible to me, I participate in her experience *with her*, as this feeling I am having is “primordial as present experience though non-primordial in content” (*OPE* §9).

In this scenario, the intentional object of my friend’s feeling of joy is successfully defending her dissertation. When I see how happy she is, I have a primordial experience of her joy because I *see it* in her gestures. I have a non-primordial experience of *what her joy is directed at* (namely, her joy from her successful defense) and it is observable to me *through her gestures*. My experience of my friend is primordial (not mediated), but my experience of her dissertation defense is *non-primordial* because I see it through her gestures, not my own. In acts of empathy, I can “see” the intentional object *from her perspective*, but at once removed, through the intermediary of the other person’s gestures, facial expressions, body language, or words.

During this second stage, there is a shift from an “objectifying intuition” about another person’s experiences into a “pre-reflective lived experience” in which one “dwells within the Other’s experience” (Shum 2012, 185). Through my non-primordial experience of others, Stein suggests that I feel “led by a primordial one *not experienced by me* but still there, manifesting itself in my non-primordial experience” (*OPE* xviii, §10, emphasis added). This language of being led by the other, of being “drawn into” (*OPE* §12), of being “guided by” (*OPE* §99), and being “pulled...into” (*OPE* §9) their emotional experiences is made possible through empathy.⁵⁶

⁵⁶ As I will demonstrate in the next chapter, narratives are capable of emotionally pulling a listener or reader into the experience of the narrator and can facilitate empathic engagement between them.

By feeling into the primordial experiences of others, Stein's account of empathy allows for the possibility of better understanding others by engaging in those experiences with the other person.

4.3 Stage Three: Comprehensive Objectification of the Explicated Experience

After becoming aware of the other person's experiences in stage one, and after being pulled into their phenomenological world where we experience *with them* and see how their experiences feel *to them* in stage two, Stein argues that we emerge in stage three with a more comprehensive understanding of the other person's experiences. Stein refers to this third stage as the "comprehensive objectification" of the explained experience (*OPE* §10; Svenaeus 2015, 241; Svenaeus 2017, 163; Burns 2017, 130). During this final stage the empathizer represents the other person's experience by forming an "intellectual interpretation of what was given of it" (Meneses and Larkin 2012, 175-176). According to Stein, stage three involves "interpretatively mentalizing" the other person's experience, which involves a higher-level recognition of the other person's primordial experience (Meneses and Larkin 2012, 166; Määttä 2006, 5-6).⁵⁷ The result is that it allows individuals to get a better understanding of another's experiences and, as I argue in Chapter 5, this understanding allows for connections between individuals to occur.⁵⁸

⁵⁷ One distinction between this third stage of Stein's theory and simulation theory rests on the word "interpretation." Stein never claims that empathy allows us to *fully know* what the other person is thinking or feeling with absolute certainty. Rather, interpretation suggests that this process of understanding others is open-ended and invites more feedback from the empathized individual. Applied to a therapeutic context, then, interpretation allows for more nuanced ways for treating persons with schizophrenia as it does not reduce their experiences to one definitive understanding derived from a medical model of illness. As I will argue in the upcoming chapters, this allowance for multiple meanings plays a key role in the constitution and reclaiming of one's identity through narrative.

⁵⁸ As Määttä (2006) notes, during this process, we develop the feeling of connection towards the other person as we are drawn into their experiences and feel their feelings with them. This closeness plays a key role in therapeutic relationships because care recipients are more likely to be receptive and trusting of caregivers if they sense a connection with them. While this claim may appear to be a presumption that my view of empathy will be received with little resistance, personal narratives reaffirm this desire to be able to connect with others. It is precisely the lack of connection, the perceived sense of distance between caregiver and care recipient, that leaves many persons with schizophrenia feeling abandoned by the mental health care system. These narratives will be examined in Chapter 5.

Returning to the dissertation example once more, after becoming aware of my friend's joy after passing her dissertation defense (stage one), and by feeling her excitement with her as the reality of the moment sinks in for her (stage two), I now have a better sense of how meaningful this experience is for her (stage three). For instance, although her defense only lasts approximately three hours, I can appreciate the hundreds of hours she put into researching and writing her dissertation. I can recognize her hard work and dedication that culminates in a manuscript that shows her merits in academia. And I can also share the excitement as she enters the next stage of her academic and professional career.

Throughout this example of the three-stage process of Stein's theory of empathy, it is important to remember that I am not *imposing* my own beliefs onto my best friend, nor am I attempting to *simulate* what she is feeling based on how *I* would react if *I* was in her situation. Instead, Stein's account of empathy is helpful for establishing connections between people since we are drawn into their experiences and guided by the other person as we navigate their experiences *with them*, not *as them*. This shift in emphasis from the self to the other is key as it allows for a deeper understanding of the meaning of experience for the other person because it is *focused on* the other person.

As an alternative approach to simulation theory, then, Stein's account of empathy is promising because it allows for interpersonal engagement to occur, yet it avoids the problem of co-opting the experiences of others and substituting our own. But even if Stein's theory can overcome some of the limitations of simulation theory, does Stein's theory allow for the possibility of empathizing with persons with schizophrenia? And, consequently, can Stein's theory provide a response to the problem of empathy highlighted by Jaspers in Chapter 1?

5. Is Empathy with Persons with Schizophrenia Possible Under Stein's Theory?

The following section will outline the numerous ways that Stein's theory can be used to empathize with persons with schizophrenia. Specifically, I will demonstrate that it is possible to empathize with persons diagnosed with this condition because persons with schizophrenia are constituted as *living bodies* who perceive the world through their senses and who possess a *zero point of orientation* that reflects their unique perspective of the world. These two features are necessary for the possibility of empathy to occur under Stein's theoretical framework.

5.1 The Distinction Between Physical Bodies and Living Bodies

One way of clarifying how empathizing with persons with schizophrenia remains a possibility under Stein's account stems from the distinction between the physical body (*Korper*) and the living body (*Leib*) and how the living body is constituted within consciousness (*OPE* §45, §47).

The physical body (*Korper*) encompasses all the physical features of bodies, such as tissue, muscles, organs, and other features related to the biology and physiology of human beings. *Korper* means the objective body, as viewed from the outside, especially as understood through the physical sciences. The physical body shares similarities to what Svenaeus (2017) defines as the "medical body" which, in the context of medicine, refers to "a set and system of biological functions in potential disorder" (Svenaeus 2017, 162). The physical body is just an *object* that exists in the world, and, from a phenomenological perspective, there is no way to differentiate physical bodies that move around in the world from other mere objects which exist outside the scope of our perceptual awareness.

By contrast, the living body (*Leib*) is the "expressive body" of the person and serves as the "anchoring point" of the "experienced, meaningful world" (Svenaeus 2017, 169-170). *Leib*

refers to our experience of our own body from the inside. For Stein and many scholars working within the phenomenological tradition, the living body is necessary for all experience to occur and plays a key role in the possibility of empathy with other living bodies. Throughout her analysis, Stein emphasizes the importance of embodiment for consciousness and for the “I” as something which experiences the external world.⁵⁹ Unlike the mere physical body, Stein explains that the living body is “essentially constituted through sensations” and it is our sensations that are the “real constituents of consciousness” belonging to the “I” that make all experience possible (*OPE* §52). We perceive the world through our living bodies, and we receive information about the world through our senses. And it is precisely by highlighting this ability to perceive the world through our senses that differentiates Stein’s theory of empathy from alternative views and serves as the starting point for extending the possibility of empathy to include persons diagnosed with schizophrenia as well.

5.2 Stein’s “Sensual Empathy” and the Constitution of Others as Living Bodies

Because Stein’s three-stage process of empathy involves a “sensing-in” to the other person’s lived bodily experiences, Stein describes her theory as a kind of “sensual empathy” (*OPE* §66). For Stein, sensual empathy is the foundation for the constitution of the other person as a lived body (Burns 2017, 132). Sensual empathy serves as the most basic form of empathy because it allows us to grasp the “fields of sensation” which belong to another person (*OPE* §64, §66).

According to Svenaeus (2018), sensual empathy occurs when one lived body “feels and perceives” the presence of another lived body and “follows its experiences through” in a

⁵⁹ Many phenomenologists stress the importance of the role of the body for understanding the nature of experience. For example, in the *Cartesian Meditations*, Husserl emphasizes the body and embodied consciousness in his account of intersubjectivity. Our sense of embodiment allows us to experience the world and to situate ourselves within it. As Husserl argues, it is our bodies’ corporeality which gives us a location for perception. Similarly, Jaspers argues that the body is a “background for consciousness” (*GP* 88).

“spontaneous manner” (Svenaeus 2018, 748). For Stein, sensual empathy allows us to constitute the other as a subject of consciousness that experiences the world in a similar manner as we do. At first, we perceive others as physical bodies that exist in our field of perception. But it is through acts of empathy that these *physical* bodies (perceived at first as *mere objects* existing in the world) are constituted as *living* bodies (perceived as *distinct subjects* living and interacting in the world). In constituting the other person as a conscious being, Stein argues that we discover that the other person is also an “I” who acts on objects in the world as we do (*OPE* §107).

Unlike physical objects, such as buildings or cars, living bodies have “fields of sensation” that allow us to be drawn into their experiences via empathy (*OPE* §63). As Stein explains, what we perceive when we encounter another *person* is not just a physical body but rather a “*sensitive, living body* belonging to...an “I” that *senses, thinks, feels, and wills*” (*OPE* §3, emphasis added). Because sensations essentially belong to the “I”, Stein maintains that there already exists a foreign “I” given together “with the constitution of the sensual level of the foreign physical body...” (*OPE* §67). Since we perceive this other body as being sufficiently like our own, there is a presupposition that this other physical body is also a “psychophysical individual” who perceives the world like we do and thus possesses a “zero point of orientation” (*OPE* §99, §69).

5.3 Grasping Another Person’s World Image and Zero Point of Orientation

According to Stein, when we empathically project ourselves into the phenomenological world of others and experience them as sensing, living bodies we obtain a “new image of the spatial world” derived from that other person’s situated perspective and discover a new “zero point of orientation” that uniquely belongs to the other person (*OPE* §69). A zero point of orientation is analogous to one’s perspective of the world that is mediated through their own bodily

experiences and conscious awareness of the world. These zero points of orientation produce a world image that individuals possess to make sense of their understanding of the world. The key is that, in order to empathize with others, it is important respect their perspectives and to not impose one's own world image onto them in an attempt to make sense of their experiences.

For example, suppose you have a doctor's appointment in downtown Toronto. As you leave the subway station and approach the doctor's office, you notice that there is heavy construction taking place that prevents direct access to the office building (e.g., you see potholes on the road, and you see cement trucks and construction workers fixing the cracked pavement). At the same time, suppose you see a blind woman who is headed in the same direction, and you have a sudden urge to rush over to her in order to *help her* because you believe it would be dangerous for her to cross the street with all the noise from the construction machinery.

In this example, you have a 'world image' consistent with your ability to use all your senses, whereas the blind woman's 'world image' is one where visual perception is not applicable. Although Stein maintains that a person "without eyes fails to have the entire optical givenness of the world" that fully-sighted individuals may possess, nevertheless a world image "*suiting [her] orientation*" as a blind woman exists (*OPE* §70, emphasis added). Thus, while the blind woman cannot *visually* perceive the construction on the street, she is still capable of navigating the area by making use of her other senses. For example, she can use her cane to *feel* the ground to ensure her pathway is clear, and she can attentively *listen* to the oncoming vehicles and use audible crosswalks to determine when it is safe to cross. In this instance you both are able to successfully navigate the busy downtown core, avoid the disruption caused by the construction workers, and reach your respective destinations, albeit in a slightly different way.

But if you were to project or impose *your* world image onto her and assume that she perceives the world in the same manner as *you* do—or if you assumed that the blind woman was helpless because you project an image of what *you* would feel like if you were blind (without all the skills for navigating the world without vision that she has learned)—Stein argues that this constitutes a *failure* of empathy since you would be under a “gross empathic deception” (*OPE* §70). Given the qualitatively distinct way of perceiving the world, imposing your own world view onto the blind woman, or presuming you could fully know how she feels, goes against the spirit of Stein’s empathic approach. Similarly, a person with schizophrenia who has delusions may perceive the world in a qualitatively different way than someone else. But the fact that these existential differences exist—and different zero points of orientation and world images exist—should not be used as a way to dismiss, or undermine, the other person’s experiences.⁶⁰

Stein acknowledges that the world image we project or ascribe onto others cannot be the same world image we possess and experience firsthand. However, she highlights the importance of acts of empathy for modifying our world image to better grasp the world image of another foreign consciousness. Even if we encounter someone whose experiences are completely unfamiliar to us, this presents an opportunity for “enriching our own world image” through engagement with the other person (*OPE* §70). Moreover, by empathizing with those who have “differently composed personal structures” than we do, Stein’s approach is beneficial as it can help us better understand ourselves *and* others by revealing the essential structures of the mind that makes experiencing possible (*OPE* §130, §100).

Recognizing that others experience the world in different ways can lead us towards developing receptive and caring attitudes towards others who, at first glance, may appear wholly

⁶⁰ To be clear, while a blind person can make sense of the world in ways that a person with schizophrenia might find more difficult, especially if they are experiencing frightening delusions, this example aims to demonstrate that Stein’s approach does not discriminate against these different modes of experience in a judgmental way.

distinct from us. By opening up new possibilities of experiencing the world from the different and unique perspectives of others, understanding Stein's description of sensual empathy helps to eliminate some of the barriers of understanding others, most notably, persons diagnosed with schizophrenia. More importantly, Stein's theory of empathy has several therapeutic advantages over simulation theory that makes it a viable alternative for its applications within the context of mental healthcare. These advantages will be discussed in greater detail below.

6. The Advantages of Stein's Theory of Empathy Over Simulation Theory

This final section will make the case for Stein's theory of empathy as an appropriate alternative to simulation theory within the particular context of mental healthcare. Specifically, it will highlight six advantages that her theory has over simulation theory, especially in overcoming some of the objections raised against simulation theory at the end of Chapter 2.

6.1 Sensual Empathy Involves an Inner Participation of the Other's Experiences

At first glance there are certain features of Stein's theory of empathy which shares some similarities with the explicit simulation theories of Goldman, Heal, and Gordon. In fact, Stein explicitly states that if there were no possibility of "transferring the self into the other's orientation," then the other person's statements about their phenomenal world would always "remain unintelligible" or, to borrow the term from Jaspers, always remain 'un-understandable' (*OPE* §73). But as I have argued throughout this chapter the main distinction—and one of the defining strengths of Stein's position—is that the primordially of the other person's experience remains intact and there are no attempts at replicating their experiences within ourselves.

While the common sense understanding of empathy is exemplified in the statement "*I know just how you feel*," as indicated throughout this analysis, Stein's approach to empathy

maintains a distinction between the self and the other, and there is no conflation, fusion, or merging of the two perspectives into one (*OPE* §66, §54). Throughout her work in *On the Problem of Empathy* Stein insists that, in the act of empathy, two people are not “joined together” in the sense of a total identification (*OPE* §10, §25). As Calcagno (2014) explains empathy allows me to “stand in the other’s place, *not as identical* with that subject, but *as myself*” (Calcagno 2014, 35, emphasis added).⁶¹ Stein recognizes that both subjects in this empathic exchange are experiencing their own primordial phenomena, and it is through empathy that engagement with the experiences of others is possible. As Stein explains:

If I experience a feeling as that of another, I have it given twice: once primordially as my own and once non-primordially in empathy as originally foreign. And precisely this non-primordially of empathized experiences causes me to reject the general term “inner perception” for the grasping of our own and foreign experience (*OPE* §39).

That said, Stein rejects the notion of “inner perception” as means to understand the experiences of others because the focus is on *my* primordial experiences, not the other person’s experiences. Simulation theory, in this regard, can be understood as a form of inner perception because I am using my own cognitive states to simulate what *I* would feel if I were in *your* situation.

By contrast Stein favours viewing empathy as an “inner participation” of the other person’s experience because it does not result in me imposing my experiences onto yours (*OPE* §16). Even though we are not qualitatively experiencing the same exact phenomena ourselves, through inner participation we do gain access to the other person’s perspective by feeling it *with them*. Consequently, this subtle nuance of Stein’s account allows for the possibility for us to engage with someone else’s experiences “*almost as if* we were having the experience ourselves” but we are consciously aware that we are not (Meneses and Larkin 2012, 171).

⁶¹ Although I am not feeling the other person’s primordial experiences directly, Stein notes that what I sense non-primordially can “coincide exactly with the other’s primordial sensation” (*OPE* §66). Thus, while not a recreation of the other’s experience, her account allows us to sense the other’s primordial sensation *at the same time*.

6.2 Preserving the Distinction Between Self and Other

Another advantage of Stein's theory of sensual empathy is that it preserves the distinction between the self and the other. For Bubandt and Willerslev (2015), empathy involves a "double movement" of the imagination and requires "a stepping into and a stepping back from" the perspective of the other person. This process involves both an appreciation of similarities that exist between individuals but also requires a "determined insistence on the other's alterity" which, as I have argued throughout, is a key component of Stein's theory of empathy (Bubandt and Willerslev 2015, 7-8). In empathic exchanges, they claim that the recognition of difference between persons is something which is "indispensable" and is "deliberately maintained" rather than "completely dissolved" (Bubandt and Willerslev 2015, 19; Molas 2018b, 65).

With respect to members of groups who have been historically marginalized, it is important for persons in positions of power and privilege to not only respect the other person, but they should avoid assimilating, or co-opting, their experiences (Molas 2018b, 65). On this point, Code argues that empathy *at its best* preserves yet seeks to know the other person and it respects the boundaries between self and other and does not "seek to assimilate...the other into itself" (Code 1995, 141; Molas 2018b, 65). As Duranti notes, empathy is the "primordial experience" of participating in the actions and feeling of another being "*without* becoming the other" (Duranti 2010, 22). As I have demonstrated throughout this chapter, Stein's theory of empathy is intended to provide an account of what it means to experience some other being *as another person*. For Stein, empathy is something that happens naturally as a characteristic of humanity. But I also maintain that empathy is an act as well that can be performed responsibly or irresponsibly. When practiced responsibly, empathy preserves the uniqueness of the other person's experiences and does not attempt to substitute the other's experience with one's own.

That said, although Stein preserves the distinction between the self and other, she does not disregard similarities altogether. As Gallese (2003) notes, the basic connotation of empathy is that the other person is grasped through an appreciation of *similarity* (Gallese 2003, 176). But it remains vital to reiterate that this appreciation of similarity *does not* require identifying with the other's first-person experiences or overstepping one's epistemic boundaries. Furthermore, while it is easier to understand what another person is going through if you have had a similar experience, this is not necessary for empathy to occur (Ratcliffe 2015, 235, 245-246).

For example, suppose your best friend is grieving the death of a family member. If you, too, have experienced the grief of losing a loved one, you might be better able to offer the appropriate kind of support to your friend during this difficult time. But acts of empathy do not require us to have similar experiences as others in order to understand them. All that is required is that the other person shares the same fundamental structures of consciousness that makes experiencing possible. And since a person diagnosed with schizophrenia is also an "I" that possesses a living body and perceives the world through their senses, being drawn into their experiences and feeling *with* them is achievable and a possibility under Stein's account.

6.3 Avoiding Projective Deception

A third advantage of Stein's theory of sensual empathy is that she avoids the issue of what Shum (2012) calls "projective deception" (Shum 2012, 179; *OPE* §9). Projective deception is the act of ascribing to someone else mental states that are familiar to us, but that may not reflect their actual experience. The issue with projective deception is that it privileges the empathizer's own feelings and imposes them onto the other.

As I argued in the previous chapter, without careful application of the process, simulation can resort to merely substituting our own experiences for the experiences of others. As Ratcliffe argues, simulation without openness to difference inevitably amounts to “a total failure of empathy; it could not be directed at another person without one’s ceasing to experience her as a person at all” (Ratcliffe 2015, 247). Stein explains that by using ourselves as the standard, we “lock ourselves” into the “prison of our individuality” and, as a result, rather than using empathy as a means to celebrate different ways of being in the world and using this knowledge to gain more insight into the world and others around us, other people “become riddles for us, or still worse, we *remodel them into our image...*” (OPE §130, emphasis added). The intended purpose or end goal of empathy is not to know all of the experiences of the other. It should instead be conceptualized as a way to engage with others that opens new possibilities of understanding and learning more *about* them *from* them. This is precisely what Stein’s account permits us to do.⁶²

6.4 Recognizing Empathy as a Joint Process

A fourth advantage that Stein’s theory of sensual empathy has over simulation theory is that she views empathic acts as a joint and collaborative process, not something that can be done unilaterally and unidirectionally. Recall that, under a simulationist framework, the purpose of empathy is to provide access to another person’s mental states from a first-person perspective (de Vignemont 2010, 290; Dullstein 2013, 337). Since all that is required is reconstructing the other person’s mental states within our own cognitive systems, simulation should be able to tell us *what it is like* for another person to experience certain phenomena. Furthermore, because it is a first-person imaginative act, simulation does not *necessarily* require any interaction with the

⁶² Dialogue can help in this process, as well as allowing others the opportunity to share their narratives in a safe and receptive environment. See Halpern (2001, 2012).

other person at all. As a result, it can be conceived as an individual process of attempting to understand others in an indirect and detached manner.

By contrast, Stein's theory of empathy is an *interpersonal* process of becoming aware of another's experience in a direct manner. In fact, under Stein's view, empathy is impossible without the presence of the other because they draw us into their lived, embodied experiences that we perceive through sensual empathy. Empathy is always other-focused and thus any attempt to empathize with the other person will be "misguided" to the extent that it takes "first-person replication" of the other person's experience as its goal (Ratcliffe 2015, 230-231). Unlike simulation, Stein aims to provide a "direct, non-mediated...*co-givenness*" of another person's "embodied, embedded, [and] minded experience" (Meneses and Larkin 2012, 175-176, emphasis added). As Meneses and Larkin argue, empathy is always a second-person experience *not* an "authentic personal experience" (Meneses and Larkin 2012, 175-176). Similarly, as I will argue in the later chapters, within the context of therapy the act of care is an activity which cannot be done from a detached, impersonal stance either.⁶³ Thus, as a process of understanding another person's perspective, Stein's account of empathy allows caregivers to share in the experiences of those who are diagnosed with schizophrenia to better understand them, which has positive implications for reconceiving these therapeutic relationships in beneficial ways.

6.5 Acknowledging that Empathy Varies in Degrees

Recall that, for Jaspers, empathy with persons with schizophrenia is impossible because their experiences of primary delusions are un-understandable from an external perspective. But even if

⁶³ As Svenaeus (2018) notes, under other theories of empathy, such as simulation, one could potentially empathize with others who are not physically present and, moreover, "empathizing" with subjects who are not real, such as fictional characters in movies or books, remains a possibility. But Stein's account is different because it is based on "the perceptual emergence of the other person in front of me" (Svenaeus 2018, 746).

an empathizer cannot fully understand what it is like to experience living with schizophrenia, or understand what it is like to experience unique phenomena such as primary delusions firsthand, this does *not* mean that persons with schizophrenia defy empathic understanding.

While both simulation theorists and Stein admit that attempts at empathizing with others may not always be successful, and there may be instances where empathic engagement seems to be impossible (e.g., persons diagnosed with schizophrenia who are catatonic and who do not respond to any sort of stimuli), a fifth reason why Stein's account is promising for its applications in mental healthcare is because she does not promote a one-size-fits-all theory of empathy. Rather she maintains that there are different levels of empathic accomplishment that can be achieved (*OPE* §19). Viewing empathy as something that can vary in degrees can be helpful for reaching a wider range of people in a more inclusive manner. But it also allows for new ways of understanding others. As Dullstein notes:

[p]erceiving the other person in her way of expressing a mental state—be it in gestures, words, or whatever—not only forms the first step of the process of empathy, but it also helps to confirm, to modify and possibly correct the way the process [of empathy] develops (Dullstein 2013, 346-347).

Despite the impairments in their rationality brought about by their condition, people with schizophrenia are embodied beings, who experience the world through their senses, and this fact opens the possibility of being drawn into their experiences through acts of empathy. Thus, while persons with schizophrenia may sometimes struggle to articulate their experiences to someone else, and while caregivers may sometimes struggle to fully understand what the other person is experiencing, Stein notes that there remains a “very definite degree of empathic fulfillment” possible and I maintain that it is misguided to presume that empathy with persons with schizophrenia is impossible (*OPE* §66; Ratcliffe 2012, 489).

As Stein maintains, empathy is the experience of another consciousness “*irrespective of the kind of the experiencing subject* or of the subject whose consciousness is experienced” (*OPE* §10, emphasis added). For Stein, a single action such as “a look or a laugh” provides a “glimpse” into the “kernel of the person” (*OPE* §121-122).⁶⁴ Even if we cannot fully know the content of their experiences, the recognition that the person with schizophrenia is another living body, whose underlying experiential structure is like our own, indicates that she can be reached via empathy even on a basic level. And this basic recognition of the other is one of the first barriers toward overcoming this specific problem of empathy that I am focusing on in this dissertation that has persisted throughout the history of psychiatry (Walker 1995a/1995b).

6.6 Establishing How Empathy Leads to Concern for Others

As indicated at the beginning of this chapter, Stein’s focus in *On the Problem of Empathy* is on describing the conditions necessary for empathy to occur. And since her focus is on exploring the genesis of empathy and how to make sense of empathy as a theoretical concept, she does not spend much time exploring the ethical or practical implications that emerge from her analysis.

But through this process of being drawn into the experiences of the other and, subsequently, learning more about the person having those experiences, a final advantage that Stein’s theory has over simulation is that her theory helps us to understand why empathy often results in the development of concern for other people (Svenaeus 2018, 759). Unlike simulation theory, which is primarily a descriptive theory and does not offer any normative guidance on *how* to engage with others, this emergence of care and concern for others from Stein’s theory (perhaps stemming from her experience as a nurse) has ethical implications for building

⁶⁴ Moreover, since we are guided by the other person in this joint-process, Stein’s theory of empathy provides more immediate feedback from the other person to ensure that our understanding of them is accurate (*OPE* §50).

connections between caregivers and care recipients within the context of mental healthcare. I return to the therapeutic benefits of empathy—and the applications of Stein’s theory—in later chapters.

7. Conclusion

I close this chapter by summarizing the main distinctions between the simulationist and Steinian accounts of empathy. Whereas simulation theory views empathy as a cognitive exercise of the imagination, Stein’s approach involves intuitive, affective, and cognitive components for understanding others. Whereas simulation can theoretically be done in isolation and without any direct engagement with others, Stein maintains that empathy is a collaborative and joint-process and is dependent upon the presence of the other for empathy to occur. Whereas the inferences made about the mental and emotional states of others, via simulation theory, are based on an inner perception of the other’s experience, Stein’s theory of empathy involves an inner participation into the other’s experience with them. Finally, whereas simulation theory suggests the possibility of replicating the other’s primordial experiences via simulation, Stein’s approach allows for direct grasping of the other’s primordial experiences but in a non-primordial way.

At its core, Stein’s phenomenological account of empathy (or “sensual empathy”) is preferable to simulation theory within the context of mental healthcare because it focuses on the lived experiences of the other person. Her emphasis on how the lived body of the other pulls us into feeling their experiences with them preserves this level of interpersonal engagement which is crucial for supporting persons with schizophrenia in their recovery. Moreover, I maintain that Stein’s approach is more receptive towards persons diagnosed with schizophrenia because, rather than viewing their condition as defective or deficient, it presents an opportunity to learn more

about their experiences of the world (Molas 2020, 40). Although it might be the case that caregivers cannot fully understand their primordial experiences of living with schizophrenia, this does not suggest that empathizing with persons diagnosed with schizophrenia is impossible. Rather it means that current understandings of “empathy” need to be re-worked and Stein’s phenomenological theory of sensual empathy offers one potential solution.

Despite the numerous benefits that Stein’s theory of empathy has for its practical applications in areas such as healthcare and mental healthcare, there still remain a few objections against the necessity and applications of the concept of empathy which I will address in the following chapter.

Chapter 4 – Defending Stein’s Theory of Empathy Against Objections

This chapter explores three objections against the necessity of empathy that can be targeted against Stein’s theory of sensual empathy. The first objection states that empathy is problematic because emotions are insufficient for guiding morality. The second objection is that empathy is not something that can be taught, therefore it cannot be something that needs to be advocated for in contexts such as in healthcare. The final objection is that empathy leads to emotional fatigue and burnout, which is inherently problematic in the context of healthcare. I demonstrate how Stein’s theory is uniquely positioned to respond to these objections (in ways that simulation theory may not be able to do) and demonstrate how her theory can overcome these objections.

1. Objections Against the Necessity of Empathy and Responses

Given her insistence on preserving the distinction between ourselves and others, I have argued thus far that Stein’s phenomenological account of empathy has advantages over simulation theory that are appropriate for its therapeutic potential within the context of mental healthcare. But even if empathy, conceptualized under the Steinian framework, remains a possibility with persons who have traditionally been seen as excluded from this category of empathic engagement, an important ethical concern that needs to be addressed is whether empathy is necessary in the first place. Despite the potential benefits of empathy as a tool for understanding others and gaining insight into their experiences, several objections against the use of empathy as a method for engagement have been raised in recent years. Although the theorists discussed in this chapter are critiquing empathy as a general concept and are not focusing on any specific theory, I will nonetheless demonstrate how Stein’s phenomenological theory of empathy overcomes these objections that other models of empathy may have difficulty addressing.

2. The Emotional Component of Empathy Cannot Guide Moral Decisions

One objection against empathy is that it is not motivating, and that the emotional component of empathy is problematic because it cannot guide moral decision-making.⁶⁵ Since the emotional aspect of empathy can lead to bias and preferential treatment, Bloom argues that our emotions should be temporarily set aside when making moral decisions to ensure that those choices are strictly impartial and as rationally informed as possible. To overcome the issue of partiality, Bloom advocates removing oneself from the face-to-face encounter with others (Bloom 2016, 111). The motivation is that by minimizing any external factors which may sway someone's moral decisions (positively or negatively), the result is that the moral decision will have been made with strict impartiality and chosen fairly. One way of achieving this impartial mode of moral decision-making is by adopting procedures, such as a cost-benefit analysis, as evidenced through normative ethical theories such as utilitarianism, or by appealing to objective and universal moral principles as evidenced through Kantian deontology (Bloom 2017, 25-27).

2.1 Emotions Lead to Genuine Concern for the Suffering of Others

On face value, Bloom's suggestion is enticing because appealing to normative ethical theories can help guide us in our everyday decisions as moral agents. For instance, if we are left with a difficult decision to make, we may decide to weigh the outcomes based on their intended consequences (utilitarianism) or we can appeal to certain duties to determine the right course of

⁶⁵ It could be argued that this objection to empathy does not apply to my analysis because outlining and defending Stein's theory of empathy does not involve moral-decision making at all. In response to this criticism, I maintain that there is an underlying ethical element that runs throughout my dissertation, and the main motivation for taking up this project. This issue of the role that emotions play in guiding moral-decision making is a legitimate concern in the empathy literature, but I argue it is an issue that Stein's account can address. And it can address these issues in ways that other theories of empathy, such as simulation, may struggle to overcome. Moreover, given the focus on improving the relationship between caregiver and care recipient as stated in the introductory chapter, there is something to be said about moral and ethical caregiving and what kinds of practices of care are morally appropriate for the treatment of persons diagnosed with schizophrenia. This is an ethical issue that should be addressed, and not simply reserving these discussions of morality and moral decision-making in the abstract.

action (deontology). By not relying on our emotions to influence our decisions, these approaches can offer impartial and reliable guides for morality and can be applied to a wide variety of cases.

However, rather than minimizing the influence of emotions from moral decision-making, I agree with Held (2006) who maintains that “moral emotions” must be cultivated to get a better sense of what morality demands from us (Held 2006, 10; Molas 2019, 297). As a care ethicist Held argues that, from the perspective of care, moral inquiries that rely entirely on “rationalistic deductions” are “deficient” precisely because they fail to acknowledge the importance of cultivating emotions (Held 2006, 10; Molas 2019, 293-294).⁶⁶ While the other normative ethical theories, such as utilitarianism or Kantian deontology, may be more likely to distance themselves from these features, an approach to care that acknowledges the role of emotions and the importance of interpersonal relationships for guiding moral behaviour is needed in healthcare.⁶⁷ But when it comes to acting in morally appropriate ways, Noddings (1984) argues that genuine acts of care involve an *emotional sensitivity* towards others (Molas 2018b, 56-57).⁶⁸ And, as I have argued throughout, this emotional sensitivity is found in Stein’s theory of empathy and it is precisely this emotional sensitivity to their experiences that makes acts of empathy possible.

⁶⁶ Within moral philosophy, there are three dominant theories that inform most philosophical discussion on ethics: consequentialism, which focuses on the outcomes of one’s actions and not the intention of the actor; deontology, which focuses on moral duties and is not necessarily concerned with the consequences of one’s actions, so long as one is acting in accordance to duty; and virtue ethics, which focuses on the cultivation of one’s moral character. A fourth approach, the ethics of care, emphasizes the importance of relationships and acts of care as the center of morality. I lean towards the ethics of care for its insights within the context of mental healthcare.

⁶⁷ Because its methodology and focus centers on the uniqueness of personal narratives as a source of knowledge, it remains clear that narrative medicine is not as systematic as alternative approaches to ethics. As Montello (2014) argues, a narrative approach focuses less on universal principles and rules because a framework for morality and moral decision making “cannot be neatly diagrammed into four boxes or four principles” as is the case with normative ethical theories or even the principles of bioethics (Montello 2014, 5). Within the field of bioethics, the four principles that serve as the foundation for medical ethics are: (1) the principle of autonomy, which involves respecting the person’s choices as it pertains to their medical options available to them; (2) the principle of beneficence, which involves upholding the duty to promote the person’s well-being and minimizing harm; (3) the principle of non-maleficence, which requires caregivers to not intentionally cause harm to the other person who is in need of medical care or treatment; and (4) the principle of justice, which requires caregivers to treat people equally and fairly. For more on the four principles of bioethics, see Beauchamp and Childress (2013).

⁶⁸ For more on the connection between the ethics of care and empathy, see Slote (2007).

With this in mind, in response to the claim that empathy is not very motivating, and that moral motivation should emerge from something like moral outrage towards injustice (Prinz 2011a, 225), the primary responsibility of caregivers is to offer support to those under their care and to improve the quality of their well-being. That said, under the recovery framework of mental healthcare that I will discuss in Chapter 6, both caregivers and care recipients are motivated towards the shared goal of helping the person recover a functional sense of self and to be able to cope with the symptoms of their condition. While I agree with Prinz that something like moral outrage towards suffering and injustice can cause people to *want to act* to alleviate that suffering and ameliorate those injustices, one reason why there may be hesitancy towards supporting persons with schizophrenia is because the stereotyped image of “the schizophrenic” or “the mentally ill patient,” has resulted in discomfort in the public which often creates a barrier that prevents them from viewing anyone who has been diagnosed with schizophrenia in a positive way. But shifting these misconceptions of mental illness to depict people with schizophrenia in a more positive light is made possible through empathy. Without the *feeling* of empathy, and without that initial inclination to *want* to engage with the experiences of others in order to help alleviate their suffering, motivating positive change is less likely to happen.

Moreover, contrary to Bloom, I argue that emotions are important, and that the affective component of Stein’s theory of empathy is necessary for someone to be moved by the suffering of others and to be drawn into their experiences. As Svenaeus argues, Stein’s theory of empathy provides an “emotional gateway” that leads to “a more developed form of knowledge” about the experiences of the other person. This can result in making someone care about the experiences and suffering of others in order to help them (Svenaeus 2017, 173). Empathy is the starting point

for practices of care to occur and, as Simmons (2013) notes, empathy in its fullest form is always essential for caring about another person's well-being (Simmons 2013, 98).⁶⁹

Throughout acts of empathy, it is important to remember that this process is not “devoid of feelings” but it is best seen as a “concerned endeavor” where the goal is connecting with another person both mentally and emotionally to understand her experiences (Svenaeus 2015, 242). In addition to the cognitive awareness of the other person's experience that is made possible through the first stage of Stein's theory of empathy, empathizing with the suffering of others involves sharing in the “affective dimensions” of the other person's suffering as well (Simmons 2013, 102). Emotion is so closely linked with the notion of empathy that it is important to recognize the benefits of both concepts in reconfiguring practices of care.

That said, while I maintain that emotions are important for motivating people to act, there are some instances where emotions *can* be manipulated in order to produce a specific outcome. To demonstrate how easily our emotional responses can change when presented with certain kinds of information, Chung and Slater (2013) describe an experiment where two groups of people are shown a film of people who are suffering after being diagnosed with HIV/AIDS. The narrative told to the first group of viewers is that the people in the film contracted HIV/AIDS through an infected blood transfusion, whereas the second group of viewers are told that the people in the film contracted HIV/AIDS through intravenous drug usage (Chung and Slater 2013, 907; Bloom 2017, 26). In response to the “transfusion victims,” the first group felt more *empathic* towards the people in the film, and they were more inclined to want to help them relieve their suffering. However, the second group did not share the same emotional response to the “drug users” and, instead, the people in the film are met with *apathy* instead of *empathy*.

⁶⁹ The reason why the needs and interests of persons with illness receive preferential treatment is because there is an immediacy to their suffering that necessitates the call to action from the caregiver (Frank 2014, 19).

Although this example shows the potential inconsistencies of relying too heavily on emotions to govern how to inform interactions of care towards others, it also demonstrates the effects stereotypes and stigma have on constituting the identities of others in generalizing ways. For instance, if people with HIV/AIDS are depicted, in the first scenario, as *victims* of an infected blood transfusion, but the same group of people are stigmatized as *drug users* in the second scenario, then this demonstrates that the stories told *about* certain groups of people influence how those groups of people will be treated. Analogously, if caregivers continue to approach persons diagnosed with schizophrenia with stigmatizing attitudes in mind that are based on preconceived ideas inherited by the tradition of Kraepelin, Bleuler, and Jaspers, then the result will be a continuation of oppressive practices that can negatively impact the person's well-being and significantly hinder their ability to recover. But if caregivers are open to exploring alternative modes of representation, such as personal narratives, that actively portray people with schizophrenia in a different light—as *people*, first and foremost—then shifting the negative stereotypes of mental illness remains a possibility. I return to this in the next chapter.

While Prinz and Bloom remain skeptical about the influence that empathy and emotions have towards motivating moral behaviour, I maintain that the motivational strength of narratives to influence moral action is supported by witnessing precisely how the experiences of others impact them. Without engaging with persons in marginalized groups directly, and without empathizing to better understand them, at best caregivers may have a surface-level understanding of what the other person is experiencing. But that surface-level awareness is insufficient for minimizing stigma and uprooting master narratives. Instead, it is precisely by exploring the depths of the person's narrative that helps to remove the layers of stigma that have been

established by the dominant master narratives. And it is by removing these misconceptions that allows caregivers to approach persons with schizophrenia in more open and caring ways.

3. Empathy Cannot Be Taught

A second objection against empathy is the inability to teach caregivers *how to be* empathic.

Edward (2006) argues that caring attitudes cannot be “specifically prescribed” and that, just as we cannot teach people to fall in love, Määttä (2006) notes that we “cannot train the capacity for experiencing the affinity that occurs in the empathetic process” (Edward 2006, 236-237; Määttä 2006, 7). While training caregivers to be empathic to improve therapeutic relationships is an important goal, the worry is that this professionalized training will be “ineffective” and result in a “superficial or technified” understanding of the empathic process (Määttä 2006, 7).

On that note, Priebe et al. (2011) maintain that while therapists should be “genuine, warm and open” in order to invite the other person to engage with them, demonstrating genuineness and openness towards others cannot be achieved by “applying technical communication skills alone” (Priebe et al. 2011, 405). Similarly, although active listening is an important skill to develop to help facilitate Stein’s account of empathy in action, if the practice of empathy becomes too procedural and formulaic for caregivers, then it loses its meaning as a therapeutic strategy. As Frank argues, once the act of active listening and having concern for others becomes a “task” much of its “therapeutic efficacy” is “lost” which is problematic (Frank 1998, 199).

Finally, since the version of empathy I have endorsed throughout is a built-in human capacity, it can be argued that this objection does not amount to much because Stein’s theory of empathy does not *need* to be taught. Stein’s theory of empathy is a basic form of intentionality (like things such as perception and memory) and serves as the basis for all human interaction. As

a result, it is not a talent or a skill that can be developed and refined with practice or effort.

3.1 Caring Attitudes Conducive for Empathy Can be Cultivated

In response to the last point first, one of the distinctions between Stein's analysis of the *concept* of empathy, and how I am *implementing* her theory in this dissertation, is that Stein's focus was never about exploring the *applications* of the concept of empathy as I do. I think that empathy can be both something we naturally do and something we can learn as a skill. But even if it does not *need* to be taught, because it is a built-in human capacity, there are still ways to hone and cultivate it to become *better*. And more importantly, there are still ways to hone and cultivate these natural human capacities for the specific purpose of improving practices of care.

On that note, while it may not be possible to teach people how to be empathic directly, the caring attitudes and dispositions which are conducive for empathy to emerge *can* be taught and it is possible for caregivers to improve their existing interpersonal skills which can lead to improved practices of care. For instance, Määttä notes how activities that increase a person's self-awareness, increase their active listening and communication skills, and promote attitudes of respect and tolerance towards others can facilitate the application of Stein's theory of empathy into practice (Määttä 2006, 7). These core elements have positive implications for improving therapeutic relationships between caregivers and care recipients and will be addressed in subsequent chapters.

Recall that one defining feature of Stein's theory of sensual empathy is to be drawn into the experiences of others, to sense what they are experiencing with them. To that end, it *is* possible to teach caregivers to focus on actively listening to their care recipients' *verbal* narrative accounts or become active readers of their *written* narrative accounts. It *is* possible to teach

caregivers to withhold their prior judgements about the nature of schizophrenia and examine the person as she currently perceives herself. And it is possible to teach caregivers not to project their own beliefs and attitudes onto others and allow the other person to derive their own meaning from their experiences. Thus, while it is not a step-by-step guide for helping caregivers to suddenly become “empathic,” as I argue in Chapter 6 the benefit of adopting the tools of narrative-based medicine is that it can train caregivers to be more sensitive to those under their care. In doing so it achieves similar ends that Stein’s theory of empathy seeks to demonstrate.

Furthermore, while I maintain that being able to empathize with others is a skill that can be cultivated and improved over time (in fact, even Jaspers agrees that empathy is not something that occurs instantly but it is a gradual process that takes time to develop), Bloom maintains that attempting to train people to become empathic can result in “empathic distress” which can lead to emotional burnout or compassion fatigue that can discourage people from helping others (I return to this objection in the next section). By contrast he advocates for “compassion training” which he argues leads to the augmentation of “positive affect and resilience” which helps the person to be better able to cope with stressful situations (Bloom 2017, 28; Bloom 2016, 95).

Although Bloom’s suggestion is reasonable, particularly for its intended effect of minimizing the real phenomena of emotional burnout and compassion fatigue that plagues many healthcare professionals (particularly in high stress environments such as emergency rooms), it is unclear how Bloom’s proposal of ‘compassion training’ avoids empathic distress or motivates people to care for others, either. A feeling of compassion—which I view as synonymous for sympathy or having a concern for others—does not automatically mean that someone would be *motivated to act* to relieve the suffering of others. For instance, I can have *concern for* or have *compassion* for a homeless person I see in my neighbourhood, and I can have *sympathy* for the

people in countries that are ravaged by spreading wildfires and other climate-related catastrophes across the world. But I may not actually donate money to this person or change my behaviour in any meaningful way to help combat global climate change.

With that in mind, I do agree that compassion and sympathy are important moral emotions to cultivate that, much like empathy, can raise awareness about the unjust suffering of others. But compassion, on its own, does not do anything to help support people in their recovery or help to dispel harmful stereotypes generated by social stigma. This is because sympathy or compassion, I argue, is a more *passive* approach which does not necessarily motivate someone to aid others. Empathy, as a process of *feeling with* others, is more *active* and makes engagement more immediate since you are trying to understand the experiences of others. For example, during the holiday season in late November and early December, some charities will run television commercials asking people to donate money to help feed starving children living in impoverished countries. One way to encourage people to donate money is by showing photographs of children that will benefit from these donations. By showing photos of vulnerable children in need, donors may end up *feeling sorry for* these children and have concern for their welfare, and then be motivated to donate to help relieve their suffering.

But *feeling for* someone, which is characteristic of sympathy, is different from how Stein conceives of *empathy* (Darwall 1998; Simmons 2013). As Dullstein notes, a sympathizer has an emotional reaction towards another person but “*her emotions are different* from the ones the target has” (Dullstein 2013, 336, emphasis added; *OPE* §18). Sympathy is an important emotion for moral agents to cultivate. But sympathy does not draw someone into the experiences of others to understand them in the way empathy does. And this inability to be drawn into someone’s experiences—which then leads to motivation to want to help that person—is what

makes empathy distinct and, contrary to what critics suggest, makes empathy morally significant and necessary. Furthermore, while the original objection suggests that empathy is something that cannot be taught, Bloom remains unclear on what precisely is required for “compassion training” and it remains uncertain whether compassion has any therapeutic benefits not already found in Stein’s theory of sensual empathy. Therefore, it does not serve as a viable alternative to empathy.

4. Empathy Leads to Compassion Fatigue and Emotional Burnout

The final objection against empathy, particularly in healthcare, is the phenomenon of “compassion fatigue” or burnout. If empathy involves emotionally identifying with the other person’s experiences directly, the drawback is that the caregiver will be exposed to such emotionally draining experiences from their patients that they, too, will be affected by the suffering of others. Moreover, the repetitive exposure to emotionally draining experiences can cause personal distress and lead to a diminished capacity for feeling compassion over time.⁷⁰

To illustrate the phenomena of burnout with an example I discussed elsewhere (Molas 2018b), imagine a therapist who is engaging with a person diagnosed with severe clinical depression on a daily basis. At the beginning of this therapeutic relationship the caregiver is attentively listening to the other person’s struggles with daily life. She is genuinely concerned for the well-being of the other person, and she goes above and beyond her duties to help provide the other person with coping strategies for dealing with depression to help them feel better. During the first few meetings with the person diagnosed with chronic depression, the caregiver approaches this person's life and situation with a set of fresh eyes; there is a high level of hope

⁷⁰ This specific objection is taken directly from a previously published article. See Molas (2018b). For a detailed description of the emotional toll that burnout has from a critical disability perspective, coupled with a first-person narrative lens from someone living with a disability, see Piepzna-Samarasinha (2018).

and optimism, and the caregiver ensures that she will do whatever it takes to help support the person under her supervision of care because this is the career path she has chosen.

But suppose that after several weeks of therapy, and despite all the time and effort placed into finding ways to help this person to be able to manage their chronic depression, the caregiver is not noticing any positive progress at all. In fact, suppose that their depression has worsened, and they have been unable to follow the caregiver's advice and strategies for coping with depression. Given the heavy subject matter of listening to this person's experiences of battling severe depression on a daily basis, the caregiver starts showing signs of emotional fatigue. The effects of emotional fatigue and burnout are that the caregiver can become more callous and distanced towards the other person and less engaged in their subsequent therapeutic exchanges. This is problematic because, as Hoffman explains, if a person's empathic experience of another's situation becomes intolerable it can result in an "intense feeling of personal distress" which may move that person out of their "empathetic mode" and drive them to alleviate their own suffering rather than attending to the needs of others (Hoffman 2000, 198). As a result, the feeling of emotional fatigue and burnout can jeopardize the effectiveness of the therapeutic relationship because the caregiver may neglect the other's needs and may not be as emotionally invested as she should be to offer the best quality of care possible (Molas 2018b, 54-55). Because the emotional component of empathy is of vital importance for Stein's theory of sensual empathy, her account is susceptible to dealing with this issue of emotional fatigue and burnout as well.

4.1 Sensual Empathy Establishes Boundaries Between Self and Other

Whenever the notion of "care" is evoked in everyday conversation, the image of a "caring person" might be one which is typically conceptualized as being one-sided and, perhaps, self-

sacrificial. But, according to Pettersen (2011), understanding care based on an “individualistic ontology” like this is problematic because it depicts the act of care as a “mono-directional activity” and something which is “transferred” from the caregiver to the care recipient (Pettersen 2011, 56). As I argue elsewhere (Molas 2018b), viewing care in this way is problematic because the caregiver’s interests can be severely neglected since they are investing their own cognitive and emotional resources into these therapeutic relationships and it is easy to understand how draining this can be (Molas 2018b, 67). However, building collaborative and positive relationships with individuals and their families, treating persons diagnosed with mental illness with respect, recognizing their fundamental dignity and humanity, avoiding paternalistic and dismissive attitudes, and taking the necessary steps to empower these individuals are all ways in which professional caregivers can not only help improve the health outcomes of others but also can help prevent emotionally exhausting themselves in the process.

Given the repeated exposure to the suffering of others, it is important for caregivers to limit the degree of their empathic engagement with others. As Mullin (2006) points out, there must be limits placed on the degree of care because we do not want to risk overextending the caring relationship so that it becomes problematic for the caregiver or paternalistic for the care recipient. While it is important for caregivers to develop meaningful connections with their care recipients, both Hem and Pettersen (2011) and Molas (2018b) highlight the importance of maintaining respectful distance to preserve the well-being of both the care recipient and the caregiver (Hem and Pettersen 2011, 73; Molas 2018b, 66).⁷¹ To address this issue of compassion

⁷¹ If efforts to empathize are unsuccessful, caregivers may experience similar distress because they are unable to reach out to their patients in order to care for them. That said, to mitigate this issue it is important to provide adequate training and knowledge about the empathy process to caregivers; to give caregivers time to meet and engage with their patients in meaningful dialogue; and to give caregivers an opportunity to reflect upon their feelings with other caregivers and health professionals (Agosta 2014; see Svenaeus 2017, 172). Even though the feeling of compassion fatigue often comes as a result of a caregiver feeling powerless to help others in need, one way to limit this problem is for caregivers to focus less on how one is powerless and more time on the ways in

fatigue, Simmons explains that caregivers must be willing to “intellectually and emotionally identify, connect, and relate” with those under their care but, at the same time, they must also caution themselves against becoming *excessively* empathic by maintaining awareness of themselves as *distinct* from others as well (Simmons 2014, 109-110; Molas 2018b, 67).

Similarly, as Code argues, empathy at its best calls for a “finely tuned sensitivity” in order to figure out how much one *can know* about the experiences of others, as well as how much one *should know* about the other person and her unique situation (Code 1995, 126). In other words, if cultivated properly, responsible caregivers would *know* the limits of their empathic practices since they should know how much understanding of the other person is possible and whether they are trying to understand too much (Molas 2018b, 67). If empathy proceeds without establishing boundaries between persons, the likelihood for compassion fatigue certainly increases. But while setting boundaries is important to curb burnout, keeping respectful distance does not require remaining wholly detached from the person in front of them.

Although this objection is problematic for simulation theory (as I noted in Chapter 2), Stein’s account of empathy mitigates this issue of burnout because of her insistence on preserving the distinction between ourselves and others. While her approach cannot guarantee that emotional fatigue or burnout never occurs, by promoting the non-primordial experience of others via empathic engagement, Stein’s position allows caregivers to be drawn into the experiences of care recipients but without recreating those experiences within themselves.

Moreover, while the motivation behind distancing oneself from the suffering of others is commendable, as it may allow the caregiver to better assess the situation from an impartial position, Stein’s account overcomes this concern, as well, because her account does not involve a

which they can help make a positive impact on the lives of those under their care (Hoffman 2000, cited in Simmons 2014, 109-110; Molas 2018b, 68).

total identification with the other person. Burnout occurs when the caregiver is too closely associated with the feelings of the care recipient to the point where they may internalize those experiences within themselves. As Prinz notes, empathy is often presumed to “induce a sense of oneness and identification with others as extensions of ourselves” (Prinz 2011b, 226). But, to reiterate, Stein’s theory of empathy is *not* a sense of oneness or fusion with the other. Although Stein’s account facilitates a feeling of closeness with the other person, there is never an attempt to conflate our own emotional and mental states with the emotional and mental states of others. And because of this distinction which separates her theory of empathy from simulation theory, or any of the alternative views of empathy highlighted before, this objection does not stand.

5. Conclusion

Until now the focus and analysis of the topic of empathy has remained rather theoretical. But given that the philosophical investigation of this dissertation is focused on the area of mental healthcare, exploring precisely how Stein’s theory of empathy can be put into practice, or how Stein’s theory can be implemented to facilitate engagement and understanding with persons diagnosed with schizophrenia, is a necessary next step. I maintain that one way of better understanding the experiences of persons with schizophrenia, and facilitating Stein’s theory of empathy, is by engaging with written narratives authored by persons with schizophrenia directly.

As noted in the Introduction chapter, this focus on written narratives may seem counterintuitive because Stein’s theory of empathy requires direct engagement with the other person. Thus, it may seem that her account of empathy cannot work through the medium of written narratives because they are qualitatively distinct from face-to-face encounters with other people. But as Svenaeus (2018) maintains, Stein’s account of empathy can be opened up to apply

to a wider range of possibilities than originally thought. Although Stein's account of empathy is based on the perceptual emergence of the other person in front of me that allows empathy to occur, Svenaeus argues that her theory of empathy:

does not disqualify the role of literature or human imagination in gaining a deeper understanding of other persons, it only denies that what I am doing when I am imagining what my friend would think about this book that I am reading, or, what a character in the book would think about me, are cases of empathy (Svenaeus 2018, 746).

Narratives *do* have the capacity of drawing someone in and that emotional pull that narratives possess (especially non-fiction narratives) can have similar effects as Stein's theory describes. Of course, a "narrative" can happen in real time and can be transmitted verbally between individuals (e.g., a conversation or through a diagnostic interview). But given the scope and focus of this dissertation, I maintain that written narratives can also work as a viable option for facilitating empathy. As I will argue in the next chapter, allowing persons with schizophrenia to share their narratives of lived experience and engaging with their narratives helps in them feeling recognized by medical professionals and, in doing so, it helps to combat the dehumanizing effects of stigma which depicts persons with mental illness in negative ways. And by implementing Stein's phenomenological theory of sensual empathy, therapists and caregivers can see and value persons who are diagnosed with schizophrenia as *subjects* who are capable of empathic engagement, rather than just viewing them as "patients" or "schizophrenics" with "mental disorders" whose experiences, as Jaspers suggested, are "un-understandable" and remain beyond the reach of empathy.

Chapter 5 – The Role of Narratives for Facilitating Stein’s Theory of Empathy

Having established the possibility and viability of Stein’s theory of empathy as an alternative to simulation theory, this chapter explores the role of narratives for facilitating Stein’s theory of empathy in the context of mental healthcare. It begins with a discussion on the importance of narrative for the constitution of one’s identity and explores how the identities of persons with schizophrenia are damaged due to stigma. It then illustrates the therapeutic potential of narrative by exploring first-person accounts of schizophrenia authored by persons who have lived with this diagnosis. The chapter closes by responding to key objections against the epistemic significance of narratives as a way to understand the experiences of others and argues in favour of narrative-based medicine for reconfiguring therapeutic relationship in more positive ways.

1. The Impact of Stigma on Persons with Schizophrenia

As I have argued elsewhere (Molas 2018a, 725-728), stigma is the process of ascribing undesirable qualities to individuals in a group which results in “devaluing, discrimination, and out-group distancing” of the members belonging to that group (Rice et al. 2014, 3).⁷² Stigma adds an additional layer of suffering to the illness experience because, in addition to coping with the symptoms of their diagnosis, people with schizophrenia struggle with a “second illness” since they must deal with the public’s misunderstanding of what schizophrenia is. This lack of understanding is detrimental to their well-being as it leads to increased social isolation and limited social opportunities (Schulze and Angermeyer 2003, 299).

In terms of how stigma works, Link et al. (2004) argue that, first, people distinguish and label differences (in this case, the label ‘mentally ill’ or ‘schizophrenic’ is a mark of difference). The dominant members of society attach that label to individuals who have “undesirable

⁷² This brief section on the nature of stigma is taken and slightly modified from Molas (2018a).

characteristics,” which then creates a separation between “us” and “them” (Link et al. 2004, 512-513; Helmus et al. 2019, 2). The result of this labelling process is that the members of the stigmatized group experience discrimination that leads to unequal outcomes in society.

Discrimination against stigmatized groups occurs on three levels: the individual level, the structural level, and the interpersonal level. On the individual level, lack of employment opportunities and limitations on securing affordable housing increases the rate of homelessness which makes it more difficult for persons diagnosed with mental illness to live independent lives (Rice et al. 2014; Link et al. 2004, 513; Overton and Medina 2008, 146). On the structural level, people living with schizophrenia are often denied social opportunities that makes it more difficult for them to flourish. For instance, Corrigan (1998) argues that many people with schizophrenia suffer from “interpersonal, self-care, and cognitive deficits” that prevent them from achieving their life goals. As a result, they typically rate their quality of life as “poor” because of the discrimination they experience daily (Corrigan 1998, 201-202). And on the interpersonal level, stigma influences how other people react to persons with schizophrenia and this perception is almost always negative and heavily based on stereotypes.

1.1 The Perpetuation of Stigma Through Stereotypes

One way that stigma is perpetuated is through stereotypes. According to Corrigan et al. (2005) and Rüsch et al. (2005), stigma is the phenomenon of social groups endorsing stereotypes about a certain group and using those stereotypes to influence how people belonging to that stigmatized group are treated (Corrigan et al. 2005, 179; Rüsch et al. 2005, 530). Because they contain “collective opinions” about different groups of people, stereotypes are a tool of discrimination because, not only are they an efficient way to categorize different social groups, but they also

allow people to “quickly generate impressions and expectations” of persons belonging to a stereotyped group (Rüsch et al. 2005, 531). And if people belonging to these groups are unable to live up to societal norms because of their illness, it may cause those individuals to develop feelings of “inferiority, self-hate, and shame” which leads to further dehumanization and alienation (Overton and Medina 2008, 144; Gallo 1994, 407; Angermeyer et al. 2010).

In addition to classifying, labelling, and separating people with mental illness from the rest of the population, stereotypes also inform the public’s emotional reaction towards people with mental illness, which contributes to the harmful effects of stigma. For instance, Angermeyer et al. (2010) note that while the general public displays “positive feelings” when confronted with someone suffering from depression or anxiety, such as compassion and empathy, the emotional response quickly turns to fear, uneasiness, or disgust when confronted with a person who is perceived to have schizophrenia.⁷³ And while most people generally have a desire to help someone who is suffering from depression or anxiety, research indicates that a substantial proportion of the public has negative attitudes towards people who have either been labelled ‘schizophrenic’ or who exhibit symptoms typically associated with schizophrenia. Alarming, Angermeyer et al. note that 28% - 50% of the public are afraid of those diagnosed with schizophrenia. Moreover, the percentage of people who feel “uneasy” around someone with schizophrenia is between 37% - 67% (Angermeyer et al. 2010, 27-28). Due to this uneasiness, there is a desire to have greater social distance from them and a refusal to enter social relationships with them (Rice et al. 2014, 6; Schulze and Angermeyer 2003, 300).

⁷³ Even the assumption that another person has schizophrenia—without knowing anything else about the person or their history—can be seen as stigmatizing because the basis for these assumptions about the other person may be derived solely from stereotypes and false ideas that reinforce a negative and harmful narrative about people diagnosed with this condition.

For Goffman, stigma is harmful because it “affects the very identity of those the negative attribute is ascribed to” and complicates their interaction with others (Goffman 1986; Schulze and Angermeyer 2003, 299; Abderholden et al. 2016, 357). Goffman argues that the mark of stigma is damaging because it signifies that the person carrying this mark or label is “different from others” and of a “less desirable kind” and this can lead to the belief that people with mental illnesses are “‘not quite human’” (Goffman cited in Schulze and Angermeyer 2003, 299). Since people diagnosed with schizophrenia are typically stereotyped as violent and dangerous, they are often missing supportive social networks and lack meaningful relationships.⁷⁴ This leads to further social isolation from their communities (Corrigan 1998, 206). Priebe et al. (2016) note that social isolation poses a significant challenge for community mental healthcare. Due to this social isolation, people with mental illness experience poorer mental and physical health, their quality of life is often impacted, and their engagement with mental health services is hindered.

Without question, the prevalence of social stigma and the perpetuation of stereotypes negatively impact the well-being of persons with schizophrenia in a variety of ways. But given the knowledge that healthcare professionals have about schizophrenia, why does stigma still exist and why do misconceptions of people with schizophrenia continue to permeate throughout society? One reason why the stigma surrounding mental illness remains so entrenched is because of the influence of dominant master narratives which portrays schizophrenia in a negative way.

1.2 The Similarities Between Stigma and Master Narratives

As a theoretical concept, master narratives are the stories that have emerged from “socially shared understandings” of our world that permeate and influence all aspects of our society

⁷⁴ Despite the common belief that people with schizophrenia are ‘aggressive’, ‘violent’, ‘unpredictable’, ‘scary’, and ‘crazy’, the DSM notes that most people living with schizophrenia are *not* aggressive and are more likely to be victimized than individuals in the general population.

(Lindemann Nelson 2001, 6).⁷⁵ Similar to the effects of stigma and stereotypes, Lindemann Nelson (2001) explains that master narratives “exercise a certain authority over our moral imaginations” and the stories contained within these narratives inform our “moral intuitions” about certain groups of people (Lindemann Nelson 2001, 6). Master narratives are an inherent aspect of society as they can influence and govern interactions between groups of people depending on which group someone belongs to (e.g., dominant or subgroup). And while one may argue that master narratives are ideas societies should strive to get rid of, master narratives are not *inherently* problematic or discriminatory and they do provide a function to society.

While some master narratives can be viewed as positive and as having a beneficial function for bringing people together (e.g., master narratives of religion can create a sense of community and togetherness for people who live in a religious society), master narratives can also be used as tools of discrimination and oppression when they portray the identities of certain groups in negative ways. Master narratives damage the identities of those belonging to marginalized groups by upholding certain archetypes and roles that persons who are designated to those subgroups must continuously perform. One such master narrative that I argue is problematic is the master narrative of medicine as it relates to mental health and wellness. Highlighting the research of Frank (1991), Sakalys (2003) notes that “medical metanarratives” (which can be understood as synonymous with “master narratives”) are characterized as the:

normative scientific, social, and cultural narratives that shape the meaning of our experiences. By defining health, illness, care, and patienthood in terms of disease conditions, *they tend to suppress subjectivity and the uniqueness of experience, dominating and objectifying the person* who is the patient. The *danger* is that these *metanarratives can be internalized* as valid descriptions of self and experience; and a prevailing message in autobiographical illness narratives is that the illness experience involves a struggle to preserve selfhood (Sakalys 2003, 230, emphasis added).

⁷⁵ While Lindemann does not seem to refer to Jean-François Lyotard in her work, there are similarities between her concept of “master narratives” and Lyotard’s concept of “metanarratives.” Specifically, the notion of master narratives relying upon archetypes to help inform how we understand certain groups of people.

As a result, the master narratives (or metanarratives) of medicine establish the norms through which our experience of what it means to be “sick” or “ill” are understood. And the consequence of shaping our understanding of what it means to experience things, such as illness, is that master narratives can damage the sense of identity of individuals in marginalized groups. Master narratives damage identities through *deprivation of opportunity* and *infiltrated consciousness*.

1.3 How Do Master Narratives Damage One’s Identity?

The first way master narratives cause damage to someone’s sense of identity is through the *deprivation of opportunity* (Lindemann Nelson 2001, 21). Deprivation of opportunity occurs when members belonging to dominant social groups enforce and reinforce practices, policies, ideas, and beliefs that unfairly and unjustly impact people belonging to marginalized subgroups (Lindemann Nelson 2001, 20; Stramondo 2020, 34). For example, if a lesbian woman and her partner are denied custody of their child on the grounds that she is a lesbian and do not fit the heteronormative model of parenthood, or if a person with a mobility disability is unable to accept a job offer because the office space is wheelchair inaccessible, these external discriminatory factors impact the woman’s identity as a mother and the employee’s identity as an ambitious worker (Lindemann Nelson 2011, 20). Because our social identities function as guides for how we treat others, a person whose identity has been damaged by a master narrative can be prevented from exercising her moral agency or enjoying access to the goods that are offered to other people in her society (Lindemann 2014, 109). Deprivation of opportunity can thus be seen as an *external* source of harm that impacts someone’s well-being and sense of identity.

In addition to one’s identity being damaged as a result of being excluded from opportunities available to members belonging to more dominant social groups, a person’s

identity is also damaged when she internalizes those harmful ideas that other people have of her or members of her group. This second phenomenon is described as *infiltrated consciousness* (Lindemann Nelson 2001, 21). Infiltrated consciousness occurs when a person who is subject to oppression and discrimination “internalizes as a self-understanding the hateful or dismissive views that other people have of her” (Lindemann Nelson 2001, 21).

Going back to the previous examples, if the lesbian woman and the employee with a mobility disability repeatedly experience these instances of systemic discrimination, they may start believing that they are unworthy of being fit to be a mother, or as feeling like an outsider within the corporate workplace, respectively (Stramondo 2020, 34). In turn, the internalization of these negative beliefs has a secondary effect of preserving the master narratives which initially reinforced these harmful beliefs in the first place. Unlike the harm created by deprivation of opportunity, infiltrated consciousness can thus be seen as an *internal* source of harm that impacts someone’s well-being and their sense of identity.

Similar to the nature of stigma, one of the reasons why master narratives hold weight is because the beliefs embedded within them influence us subconsciously. And since we are often not consciously aware of the implicit beliefs embedded within the master narratives that influence our perceptions of others, attempts to actively resist master narratives by appealing to evidence to the contrary often receive little uptake (Lindemann 2014, 51). Even if persons in marginalized groups attempt to challenge these misconceptions about their identities, Lindemann notes that members of the dominant group often *refuse* to acknowledge those marginalized perspectives and, instead, draw upon “defective identity-constituting stories” to justify their unjust treatment of people belonging to these subgroups (Lindemann 2014, 115).

Given how deeply the effects of master narratives and stigma influence our perception of others, it may seem that it is impossible to challenge these deeply rooted systems of belief within society. And, given this uphill battle, it seems very unlikely that the stereotypes and harmful master narratives surrounding schizophrenia can ever be rewritten. But since personal identities are “narratively constituted” and can be “narratively damaged” by the influence of master narratives, Lindemann Nelson explains that they can be “narratively repaired” through the creation of *counterstories* (Lindemann Nelson 2001, xii).

1.4 Counterstories, Narrative Repair, and Restoring One’s Sense of Self

Counterstories are stories or narratives that “resists an oppressive identity” and attempt to replace it with one commanding respect from those belonging to socially dominant or advantaged groups (Lindemann Nelson 2001, 6). The purpose of counterstories is to challenge master narratives and shift our understanding about members of marginalized groups. According to Lindemann Nelson, counterstories are conceptualized as “narrative acts of insubordination” and they consist of “*stories of self-definition*” that involve *actively recreating* a sense of one’s identity and repairing one’s identity damaged by dominant master narratives (Lindemann Nelson 2001, 8, 9). Counterstories seek to repair someone’s damaged identity in two ways.

The first way counterstories can repair damaged identities is by altering the *oppressors’* perception of the marginalized group. For instance, if the dominant group is neurotypical and the subgroup consists of persons with mental illness, the aim is to shift the dominant group’s perception of members of the subgroup and to dispel misconceptions about them. By doing so, the dominant group would be less likely to deny opportunities to the members of the subgroup and, thus, members of the subgroup would be allowed to exercise their moral agency more

freely. The second way counterstories seek to repair a damaged identity is by altering a person's perception of *herself* in virtue of being a member of a marginalized group (Lindemann Nelson 2001, 7). By challenging master narratives with alternative narratives that showcases the person's strengths, capabilities, and other positive attributes, counterstories shift the individual's perception of herself into an agent deserving of moral respect. By creating counterstories and going through the process of narrative repair "the damaged identity is made whole" as the person is reclaiming their sense of self by exercising their agency (Lindemann Nelson 2001, 150).

As a concept, counterstories have the potential for empowering persons diagnosed with schizophrenia and other conditions in order to help shift the public's misconceptions and stereotypes concerning what it means to be "schizophrenic."⁷⁶ But what do counterstories look like within the context of minimizing stigma and improving therapeutic relationships? And how can caregivers empathically engage with these counterstories? One way is by exploring the first-person narrative accounts of people who are living with schizophrenia.

2. Why Are Narratives Important for Understanding Persons with Schizophrenia?

Whereas master narratives, or the medical metanarratives, focus on the objective features of a person's condition, "illness narratives" are stories told by care recipients "about their experiences of illness rather than about the disease process and its treatment" and in doing so they "express

⁷⁶ But this raises an important question: why would we counter misconceptions about schizophrenia with *stories* instead of *facts about* schizophrenia? In response to this question, it is important to realize that within the anti-stigma literature, there are three main ways to combat stigma: education, protest, and interpersonal contact. While education involves combating false beliefs with true ones in hopes of educating someone that their beliefs are wrong or misguided, and protest involves a more direct form of challenging another person's false beliefs directly, studies have indicated that interpersonal contact and connection with someone else is the most effective way of correcting misinformation about them and can change someone's perception of a member belonging to a stigmatized group. The analogue to the topic of this dissertation is clear: while educating or attempting to dissuade someone from harbouring false beliefs about persons with schizophrenia may have *some* degree of success, the most impactful way of doing so is by engaging with persons with schizophrenia directly and realizing that the stigma surrounding "schizophrenia" is simply unwarranted. And engaging with someone's lived experience or story is one way to help reach this goal. For more on anti-stigma methods, see Rice et al. (2014) and Overton and Medina (2008).

the truth of personal experience” in the person’s own voice that stands in contrast to “the medical account” of their condition (Sakalys 2003, 231). But before examining why personal narratives are important for understanding the lived experience of schizophrenia—and more specifically why narratives are important for facilitating empathy within a therapeutic setting—it is helpful to briefly discuss how personal narratives relate to the constitution of one’s sense of self.

2.1 Narrative Identity and the Constitution of the Self

According to Rimmon-Kenan (2002), a narrative is a mode of “experiencing, perceiving, and interpreting” the world and it also involves “negotiating identities” embedded within the world (Rimmon-Kenan 2002, 22). For Hamm et al. (2013), a narrative is a meaningful account of one-self which involves articulating an “evolving and storied sense of one’s life” which goes beyond simply a “collection of facts” about that person’s life (Hamm et al. 2013, 50).⁷⁷ Narratives also play an important role in the constitution of one’s identity. According to Lindemann Nelson:

Identities are constituted from the first-person perspective through the loosely connected stories we weave around the things about us that matter most to us: the acts, experiences, and characteristics we care most about, and the roles, relationships, and values to which we are most deeply committed...Equally necessary to our identities is the narrative activity that takes place from the third person perspective: other people weave the things about us that matter most to *them* into stories that also constitute our identities. Important too is our membership in various social groups, whose identities are themselves narratively constructed (Lindemann Nelson 2001, 71).

Lindemann Nelson argues that personal identities are “complex narrative constructions” consisting of a “fluid interaction” of many stories and “fragments of stories” that concern things that are most important about a person’s life over time (Lindemann Nelson 2001, 20). Narratives can be told in a variety of forms, but the focus here is on exploring autobiographical accounts of

⁷⁷ As Estroff (1989) argues, while clinical accounts document the course of an illness these reports rarely provide “a narrative of the person through time” and that the person’s psychiatric history is only one aspect of that person’s entire life narrative (Estroff 1989, 190).

persons diagnosed with schizophrenia. The justification for this choice is because first-person accounts of the lived experience of schizophrenia offer:

an accessible, educational source for those trying to *gain insight* into the *first-hand experience* of severe mental illness...First person accounts place the illness in the *context of real lives* and vividly illustrate how someone's life has changed...Uniquely *individual*, they do not necessarily generalize to others, but their *experiential diversity* reflects the *heterogeneity* of mental illness...An appreciation of the impact made by severe mental illness helps *humanize the condition*, *foster empathy* and compassion, *reduce stigma*, and *generate hope* (Rowland, *Schizophrenia Bulletin*, emphasis added).

When it comes to engaging with people living with mental illness in a respectful and supportive manner, Patricia Deegan (1996), a psychiatric survivor and mental health advocate, correctly points out the importance of recognizing the “simple yet profound realization” that people who have been diagnosed with mental illnesses are “*human beings*” (Deegan 1996, 92, emphasis added; Molas 2020, 35). As indicated in the previous sections, the problem with depictions of schizophrenia sustained by stigma and master narratives is that they transform the idea of the ‘mentally ill person’ or ‘the schizophrenic patient’ into someone who is unworthy of moral respect and who is beyond the reach of empathy. But if the goal of examining applications of Stein’s theory of empathy is to be drawn into the experiences of the other person in order to gain a better understanding of what it is like to live with schizophrenia, an insightful source of knowledge are the narratives of people living with, or who have recovered from, schizophrenia.

2.2 What Do Narratives Reveal About the Lived Experience of Schizophrenia?

With this in mind, the following autobiographical accounts reveal a common set of themes which help illuminate the effects of stigma and how it impacts the lives of people who have been diagnosed with schizophrenia. Although many of the narratives cited below echo similar sentiments and imagery throughout, for thematic purposes, the narratives are grouped into

distinct sections to demonstrate just how damaging the effects of stigma and master narratives are on the lives of persons diagnosed with this condition. Furthermore, as I have explained elsewhere (Molas 2020), these narrative excerpts are quoted in considerable length to represent the person's lived experience as fully as possible and to assist the reader in recognizing how empathy can be cultivated through the medium of narrative engagement.⁷⁸

2.2.1 Experiences of Loneliness and Isolation

Janice Jordan (1995) offers her account of what it is like to live with schizophrenia. She highlights the loneliness and isolation that comes from living with this diagnosis:

The schizophrenic experience can be a terrifying journey through a world of madness no one can understand, particularly the person traveling through it. It is a journey through a world that is *deranged, empty*, and devoid of anchors to reality. You feel very much *alone*. You find it *easier to withdraw* than cope with a reality that is incongruent with your fantasy world. You feel *tormented* by distorted perceptions. You cannot distinguish what is real from what is unreal. Schizophrenia affects all aspects of your life...you feel fragmented and so very *alone* with your "craziness" (Jordan 1995, 501, emphasis added).

Dominic Hanley (2016), someone who is living with childhood trauma and addiction in addition to schizophrenia, describes how learning of his diagnosis resulted in feelings of despair, primarily due to how strong these stigmatizing beliefs are held:

I lost all contact with reality. This altered reality was the most difficult world to live in. *In my eyes, my life was over*. Everything I had dreamt of doing, and all my aspirations in life, were now *nonexistent*. I felt completely *nullified* (Hanley 2016, 1313, emphasis added).

The people around me saw that I had changed, and so, *they began to separate themselves from me. I lost all hope for myself and I lost my ability to enjoy the company of others*. I became a worry for some, and *got left in the dust* by others...I discontinued seeing friends, I stopped attending university, and I even stopped talking to my own family. *My life had come to a halt and I started going backward...* (Hanley 2016, 1314, emphasis added).

⁷⁸ Some of these autobiographical excerpts are also discussed in Molas (2020).

The feeling of being misunderstood is common among people with schizophrenia. Whether it is family members being uncertain of how to accept that their loved one is living with a mental health diagnosis, a friend who is quick to lose touch, or healthcare providers failing to acknowledge their experiences in appropriate ways, many narratives reflect living in a world of isolation, lost connections, and of being alienated from one's community (Molas 2020, 37-38).

2.2.2 Feelings of Depersonalization and Dehumanization

The perception of being viewed in a depersonalized and dehumanizing way is another common theme reflected in many first-person narratives. People who have been diagnosed with any type of severe mental disorder often feel dehumanized because they are not recognized as complete human beings. In a profound way, being labelled "schizophrenic" casts someone in a new light.⁷⁹ The consequence of being labelled by stigmatizing master narratives is that the humanity and sense of self of these individuals is stripped away and they are viewed as nothing but an illness.

On that note, Betty Blaska (1991), a mental health advocate and researcher, recounts her experiences of being treated at a psychiatric hospital. Through a series of vignettes taken from her life experiences, she outlines what it means to be labelled by mental health professionals as a "CMI" or "chronically mentally ill." Reflecting on her encounter with therapists, Blaska writes:

You ask questions, and they *look at each other* and respond to themselves, *not to you*. You spend the entire hour having the two shrinks talk *to each other*, not to you, but *about* you, *in front* of you...And then they can justify calling you by the *malignant label they've designated you by*—resisting treatment or "noncompliant," passive dependent, passive aggressive, paranoid, or borderline personality disorder. They're all different labels. But they all mean the same thing: *you're not really you. You're just a CMI. And that justifies their dehumanization of you...* (Blaska 1991, 174-176, emphasis added).

⁷⁹ To add to this point, although the criteria outlined in the DSM are meant to be regarded as neutral and purely descriptive, the devastating effects of being labelled "schizophrenic" can have potentially long-term negative consequences for that individual. As a result, Caplan notes that people who utilize and draw upon these manuals and promote using these labels (which have negative consequences) should take some responsibility for helping to minimize the harm caused by their actions (Caplan 1995, 11).

What have you learned as a CMI? *Abuse...humiliation; belittlement; vulnerability; lack of credibility...stripped of dignity...stigmatized; expected to conform...given a lack of choice; lack of control...left with nothing; and finding it's better not to feel, not to try, and even not to live* (Blaska 1991, 174-176, emphasis added).

The reduction of Blaska's identity to a three-letter initialism, "CMI," demonstrates the dehumanizing ways in which some therapists and mental health professionals view and approach their care recipients. Instead of recognizing the *person* behind the illness, Blaska's account illustrates how some caregivers demonstrate a lack of compassion and empathy towards persons with mental illnesses and how these individuals are reduced to a list of their symptoms.

2.2.3 Internalizing Stigma and a Negative Sense of Self

While not to deny the significance of caregivers, nurses, therapists, and psychiatrists to identify the nature of a person's condition to ensure that effective treatment options can be administered, Caplan argues that the act of labelling individuals as "mentally ill," and subsequently creating a division between "normal" and "abnormal", often results in more feelings of anguish for the person rather than alleviating their suffering (Caplan 1995, 11-12). Explaining the harmful effects of stigma that emerge after being labelled abnormal by psychiatrists, Caplan writes how many people diagnosed with severe mental illnesses often experience:

needless *shame, fear, panic*, conflict, and anger when messages that *they are not normal* are conveyed either formally or informally by an official diagnosis, a comment from a family member, or the rolling eyes of others... (Caplan 1995, 9, emphasis added).

In addition to living with the symptoms of their diagnosis, self-stigma is just as destructive as being stigmatized by other people.⁸⁰ As Liberman and Kopelowicz note, many people with schizophrenia internalize these negative attitudes which often results in poorer outcomes in their health and functioning (Liberman and Kopelowicz 2005, 736). For instance, an anonymous

⁸⁰ For more on self-stigma and the internalization of these external beliefs, which impact one's sense of worth and can inhibit one's recovery, see Gallo (1994). For more on the struggle of personal identity, see Lord et al. (1987).

author (Anonymous 1989) describes how he internalized a negative sense of self after receiving his diagnosis of schizophrenia. Reminiscent of the concept of infiltrated consciousness discussed above, note how he internalizes a self-conception that results in him being reluctant to disclose personal information to others:

I am a normal-looking and normal-acting person...But on a few occasions I have been stigmatized and know the *shame, humiliation, rejection, and confusion* that occur when people find out that you have a mental illness. One girlfriend *refused to see me* after I got out of the hospital. She said *she saw no potential in me* and that *I had no future*. I was deeply *ashamed*, but also *half believed her* (Anonymous 1989, 638, emphasis added).

Similarly, Molly Watson (2015) describes how her mother reacts when she tries to discuss her symptoms. Notice how her account highlights the silencing effect of both social and self-stigma:

My mother is *uncomfortable* talking about the changes she sees in me. As a result, *I don't talk about it...*I traverse between 2 worlds—the world I experience is held in silence and shame while at the same time, I try to act as though I am nothing other than what is normal (Watson 2015, 7, emphasis added).

This illness has affected all aspects of *how I perceive myself and how others perceive me*. There's been a radical shift in my social interactions...Bearing the *brunt of stigma* and confronting the mind-set that I am somehow in control of the situation leaves me *feeling hollow and cut off* (Watson 2015, 7- 8, emphasis added).

2.2.4 Experiencing Hopelessness for the Future

The stigma of mental illness, and the accompanying master narrative within the medical model of psychiatry, informs people with schizophrenia that they will only reach a certain threshold in their lives, and it would be impossible for them to fully recover and reach certain milestones that “healthy” people take for granted, such as having a fulfilling career, having a family, or being an active member of their community (Molas 2020, 39). But even if a person who is diagnosed with schizophrenia is shown to have recovered to a significant degree, some proponents of the strict medical model of illness could respond by saying that this must mean the person diagnosed must

have been *wrongly diagnosed*, which therefore preserves the original ‘doom and gloom’ diagnostic perspective as intact and not subject to further reconsideration.

As indicative of this belief that persons with schizophrenia are limited and are destined to have no future, Dr. Elyn Saks (2007), a prominent researcher and mental health advocate, describes how her experience with schizophrenia is initially viewed as restrictive and leaving her with a bleak future life trajectory. Because schizophrenia is perceived as an incurable brain disorder under the medical model of illness, informed by the tradition of Kraepelin and Bleuler, Saks explains how her diagnosis promotes the idea that people with schizophrenia will *never* recover. In her memoir, *The Center Cannot Hold: My Journey Through Madness*, Saks writes:

I was told I would...lose the capacity to take care of myself. I wasn’t expected to have a career...I wouldn’t be able to form attachments, or keep friendships, or find someone to love me, or have a family of my own—in short *I’d never have a life*...I was being told that whatever had gone wrong inside my head was *permanent*, and...*unfixable*...It felt more like a *death sentence* than a medical diagnosis (Saks 2007, 168, emphasis added).

Reflecting on her past self, Patricia Deegan’s (1993) narrative describes the limiting effects of being diagnosed “schizophrenic” under the dominant master narratives. Because receiving a diagnosis of schizophrenia impacts one’s sense of self on both personal and social levels, Deegan notes how her past self exhibits a sense of loss and falling into hopelessness and despair:

I am witnessing the flame of a human spirit faltering. She is losing the will to live. She...wants to die because *nothing seems worth living for*. Her hopes, her dreams, and her *aspirations have been shattered*...Her future has been reduced to the *prognosis of doom* she had been given (Deegan 1993, 8, emphasis added).

Deegan, like Saks, reinforces the notion that some therapists approach schizophrenia in narrow and strictly medicalized terms. But this approach does not offer the person any comfort or hope for the future. Rather it forces the person to adopt a “sick role” identity which is another common experience shared across numerous narrative accounts.

2.2.5 Adopting a “Sick Role” Identity

Reminiscent of Goffman’s discussion of the mark of stigma discussed earlier in this chapter, Corin (1998) notes that personal narratives often reflect the feeling that the person who is diagnosed with any kind of illness is “trapped” in a “sick role” identity that sets up expectations for how they will behave in the eyes of medical professionals. Moreover, the consequence of being labelled *schizophrenic* makes these individuals feel as if they are “intimately marked” by the gaze of others (Corin 1998, 144). Reflecting on her experience with psychosis, acclaimed author Irit Shimrat (1997) describes the limiting role that persons with mental illness are confined to once receiving their diagnostic label. As Shimrat writes:

Many people who go (or are put) into a mental hospital or psychiatric ward get diagnosed and drugged and *become mental patients for life...once you’re diagnosed, you’re generally told you have to stay on drugs forever. You are expected to...fall apart whenever anything in your life goes wrong, require continuous professional help, and go back into the hospital...when things get really bad* (Shimrat 1997, 21, emphasis added).

What you are told about yourself has a huge impact on what you do, and how and who you are. Year upon year of hearing yourself *described by a medical label* can cause you to *see yourself as a walking disease* (Shimrat 1997, 165, emphasis added).

Marcia Lovejoy (1982) echoes the problems associated with the traditional medical model of illness and illustrates how master narratives of medicine impose the adoption of the sick role identity. Moreover, sociologist Arthur Frank (1991) highlights the transformation that takes place in terms of how one is perceived through a medicalized lens once they become diagnosed with any kind of illness or condition. And, as I have argued throughout this chapter thus far, this feeling is exacerbated when an individual becomes diagnosed with schizophrenia:

I saw myself as incurably ill, as someone who would always need to be taken care of by others...I left the hospital and tried to fit into my new role as sick and retired from active living, but I was overwhelmed by the emptiness of my future (Lovejoy 1982, 606, emphasis added).

In *becoming a patient—being colonized as medical territory* and becoming a spectator to your own drama—you *lose yourself*. First you may find that the lab results rather than your body's responses are determining how you feel. Then, in the *rush to treatment*, you may *lose your capacity to make choices*, to decide how you want your body to be used (Frank 1991 56-57, cited in Sakalys 2003, emphasis added).

Similar to Saks, Lovejoy, Deegan, and Shimrat, Dale Walsh (1996) explains how he initially views his diagnosis as a limiting and debilitating condition with no hope for the future:

Many people who have been diagnosed as mentally ill hate labels...After people are diagnosed, everything that happens to them is seen through the *filter of their labels*...Often people with psychiatric labels have *lost hope*. They see their disability as a *death sentence* (Walsh 1996, 88-89, emphasis added).

Just like Blaska, he also describes the lack of interpersonal communication between himself and his caregivers. Throughout his narrative Walsh hints at the impersonal, procedural, and distanced approach between himself and those responsible for helping him improve his life circumstances:

For many years I believed in a traditional medical model [of illness]. I had a *disease*. I was *sick*. I was told I was *mentally ill*, that I should...*change my expectations*...and realize *I would always have to live a very restricted life*. After I was diagnosed, I was put in a box up on a shelf. Occasionally I was taken down and my medication was changed. But *no one really talked to me*... (Walsh 1996, 86, emphasis added).

Reflecting on her experiences of living with psychosis and receiving psychiatric treatment, Emma Goude (2020), an international award-winning documentary film maker and author, highlights the importance of reconceptualizing how mental illness is approached from the perspective of treatment. Describing the limitations of the mental health system using an analogy of a broken clock, Goude writes how:

We can see [that the presence of mental illness is] like a broken clock that doesn't work because there is too much dirt in the mechanism. The mental health service puts the clock on the shelf labeled 'damaged' and gives it a little oil so it feels less bothered about the fact that it doesn't work properly. *But there is nothing wrong with the mechanism: it just needs a good clean*. Psychiatry could and should be doing just that (Goude 2020, emphasis added).

As these passages illustrate, the experience of dealing with caregivers under the standard medical model of care often contributes to a sense of loneliness, disconnect, and feelings of dread for the care recipient. The medical model reinforces the belief that, once diagnosed, people are set on a trajectory that leaves little room for growth or the possibility of getting better:

I felt despair and deep loneliness. This old *patriarchal system of treatment and culture of disease* is characterized by a *hierarchical arrangement of power*, a *mechanistic view of the mind*...an emphasis on a *person's deficits*, and treatment administered by an expert—*always at a professional distance* (Walsh 1996, 86, emphasis added).

I wish some of my doctors would have shown more faith in me...Some were quite formal and *distant*. *I felt like a "patient," not a person*. Therapists need to understand that "patients" *need the human touch*...just as much as they need the technical expertise of the professional (Anonymous 1989, 637, emphasis added).

As indicated earlier in this chapter, part of the reason why interpersonal connection is difficult to achieve is because diagnostic labels, when imbued with stigma, alters how someone approaches those who are diagnosed with, or are perceived to have, schizophrenia. Although the purpose of diagnostic labels, such as "schizophrenic" or "bi-polar" or "borderline personality disorder" are to remain neutral as they are intended to be purely descriptive, as evidenced throughout these passages the impact felt by the person labelled "schizophrenic" is far from neutral.

2.2.6 Lacking Recognition from Caregivers

One final common theme is that many people perceive that their descriptions of their experiences are not being acknowledged, or taken seriously, by healthcare professionals. At the time of her writing, Esso Leete (1989) recalls her daily experience of living with schizophrenia for over 25 years. Leete describes the silencing effects of the therapist's professional stance towards her, and she highlights how even the attempts to describe her lived experiences often goes unnoticed or

outright dismissed.⁸¹ Moreover, she vividly describes how being labelled “schizophrenic”

contributes to a social identity that is often disregarded and influences how others perceive her:

Life is hard with a diagnosis of schizophrenia. I can talk, but *I may not be heard*. I...*may not be taken seriously*. I can report my thoughts, but they *may be seen as delusions*...To be a patient...is to be *discounted*. Your *label* is a reality that *never leaves you*; it *gradually shapes an identity* that is hard to shed... (Leete 1989, 199, emphasis added).

Speaking on the issue of how persons diagnosed with mental illness are taken less seriously by mental health professionals, Shimrat explains how:

As a mental patient, you don't just lose your credibility with other people, *you're taught not to believe in or trust yourself*. You're taught to *doubt your own perceptions*—they may be signs of your illness. It's especially bad if you don't think you're sick. *That means you have no “insight”*—the *psychiatric term* for agreeing with your doctor about what's wrong with you and what should be done about it. If you fail to appreciate the nature of your illness, *you will be deemed incompetent* to make treatment decisions (Shimrat 1997, 9, emphasis added).

Finally, Rae Unzicker's (1989) personal narrative encapsulates the lived realities of what it means to live with a diagnosis of “schizophrenia,” especially when the prevailing master narrative depicts persons with mental disorders in negative and stigmatizing ways. As a civil rights and mental health advocate, Unzicker stresses the dehumanizing aspect of being judged for having a mental illness. She describes in significant detail the existential experience of what it means *to be* a “mental patient” in the eyes of many medical professionals and experts:

To be a mental patient is to be *stigmatized, ostracized...psychiatrized*. To be a mental patient is to have *everyone controlling your life but you*...To be a mental patient is to live with the *constant threat* and possibility of being locked up at any time, for almost any reason...To be a mental patient is to take drugs that *dull your mind, deaden your senses*,

⁸¹ To further illustrate this point, in a CBC article entitled “At 23, I had my cancerous thyroid removed. My family doctor thought I was depressed,” Alexa Everett (2019) went to her family doctor complaining about throat pain, fatigue, and unexpected weight-gain, and her family doctor brushed off her concerns and prescribed her anti-depressants. After going to a walk-in clinic, however, the physician ordered tests on her thyroid which ultimately turned out to be thyroid cancer. In describing her relationship with her family doctor, Everett said “I felt intimidated, like I was bothering her with my questions.” Even if the doctor's intention is to relieve Everett's suffering, her focus on the *symptoms* and surface-level engagement without going deeper into what Everett was *experiencing* is problematic. Although Everett does not have a diagnosis of schizophrenia, or any other mental illness according to this article, this example is nonetheless useful as it may be reflective of a larger issue with how health services are delivered and how someone's testimony within the healthcare setting can still be dismissed.

make you jitter and drool, and then you take more drugs to lessen the ‘side effects.’ To be a mental patient is to apply for jobs and lie about how you’ve spent the last few months or years, because you’ve been in the hospital...*To be a mental patient is to not matter.* To be a mental patient is *never to be taken seriously*...To be a mental patient is to be *a statistic*. To be a mental patient is to *wear a label*...that never goes away, a label that says little about *what* you are and even less about *who* you are...To be a mental patient is to...*become a no-thing*... (Unzicker 1989, 76-77, emphasis added).⁸²

Part of the reason why the master narratives within psychiatry have persisted is because students training to become psychiatrists are often not taught to examine anything else *beyond* the symptoms of illness. Particularly under the default view of the medical model of illness, their role as psychiatrists is primarily to treat the person’s symptoms in order to alleviate their suffering, which then impacts their life and well-being in negative ways. And while it is important for psychiatrists to accurately diagnose people so that safe treatment methods can be administered, focusing purely on symptoms of illness, without taking the whole person into account, can lead some in continuing to view those with schizophrenia in a depersonalized way.

On that note, Unzicker argues that one reason why some people with mental illness feel dehumanized is because their caregivers have forgotten that they are “dealing with *individuals*, *not psychiatric labels*” (Unzicker 1989, 75-76, emphasis added). In a similar vein, reflecting on her encounter with her own psychiatrist, Deegan writes:

Today I know that this psychiatrist...merely...recognized me as the schizophrenic who had been handed down through the generations by Kraepelin and Bleuler. He did not see *me*. He saw *an illness*...Students emerge from school with *knowledge about* neurotransmitters and schizophrenics...They become *experts in recognizing illness* and disease. But...we have not taught them to...move beyond mere recognition in order to seek the essence of what is. *We have failed to teach them to reverence the human being who exists prior to and in spite of the diagnosis we have placed upon them*...What exists...is not an illness or disease. What exists is *a human being* and wisdom demands that we see...*this human being before all else* (Deegan 1996, 92, emphasis added).

⁸² As Helmus et al. (2019) note, people with mental illness experience stigmatization inside mental healthcare facilities to roughly the same extent as with the general public (Helmus et al. 2019, 2). And since stigmatizing attitudes are also held by mental health care professionals, this can negatively impact the person’s recovery because she may feel that she is lacking the support necessary to heal (Helmus et al. 2019, 2). For more on how individuals perceive the therapeutic encounter, see Schulze and Angermeyer (2003).

In her book, *A Fragile Revolution: Consumers and Psychiatric Survivors Confront the Power of the Mental Health System*, Barbera Everett (2000) interviews several psychiatric survivors and documents their first-hand experiences of living with mental illness and receiving psychiatric care. One interviewee, Mary, highlights the need for caregivers and therapists to do better to shift past the limiting and narrow scope of diagnostic labels and to develop more humanistic and person-centered approaches to care. To reiterate my position once more, while medical expertise and skill is important for developing appropriate care options, when it comes to *improving* practices of care for persons diagnosed with mental disorders, Mary's testimony is insightful:

It's not about theories and textbooks. It's about simple things. *Just by giving a person the time of day, we're telling them they are of value and that's not taught in school.* You have to allow people to sense *that you really believe in them* and you believe in their abilities....I would say that the people in the *most* need are those who are so isolated...you have to be patient and you have to just be there with a message of "Yes, I care." And it takes an extended period of time and it isn't about taking control of someone's life or using power. *It's about very basic people skills* and I don't think we concentrate at all on these things (cited in Everett 2000, 194, emphasis added).

Patrick Brown, another person interviewed by Everett, highlights the need for caregivers to view their care recipients as human beings and to afford them the same level of kindness and support as anyone else who is receiving treatment from the healthcare sector. In particular, Brown highlights the importance of offering support and encouragement to those in need. He writes:

We need empathy. We want to hear, "Hey, you can make it!" If you *place your confidence* in people...you'd get the kind of results that would blow you away. Most [psychiatric] survivors don't have confidence and *that's what they need* (cited in Everett 2000, 194, emphasis added).

Shimrat echoes Brown's narrative and highlights the stark difference in emphasis between the traditional medical model of care with the recovery model of care. Rather than perceiving persons with mental illness in limited and restricted ways, Shimrat maintains that:

We need *support, love, human contact*—the same things everyone else needs. *Opportunities. Experiences.* Once you become institutionalized, *you go into a shell.* Once you have opportunities again, *you blossom* (Shimrat 1997, 158, emphasis added).

Unlike master narratives which characterize people “categorically rather than singly” (Lindemann Nelson 2001, 86), counterstories reveal the *person* who becomes obscured when she is depicted in a generalizing manner or is painted with a broad brush. And, as illustrated through these narrative excerpts, there is much more substance and depth to these individuals’ lives than can be captured under the banner ‘schizophrenic patient.’ Because counterstories are specific and depict individuals who resist identities imposed onto them, there is no requirement for them to stand as being representative of the experiences of the entire group. But it is possible to draw on these narratives to highlight that living with schizophrenia need not remain a limiting diagnosis.

Since counterstories seek to challenge the dominant master narratives that impose harmful identities onto people in marginalized groups, counterstories open a new space for understanding the lived experience of persons with schizophrenia in a new and direct way. But, as Lindemann explains, a counterstory does not need to “uproot” the entire master narrative for it to be considered a good counterstory. If a counterstory manages to “dilute the moral poison” of the master narrative and help someone regain their moral agency, then the counterstory is “good enough” (Lindemann Nelson 2001, 186). By raising awareness to the realities of schizophrenia, and by revealing the experiences of dehumanization caused by stigma, these narratives can function as counterstories and challenge the master narratives of mental illness. But while narratives can help humanize an individual who has been stigmatized and stereotyped by dominant master narratives, and while engaging with another person’s narrative is one way of emotionally connecting with them and empathizing with their unique situation, the use of narratives—and their legitimacy as an epistemological tool—is often called into question.

3. Limitations of Narrative-Based Approaches and Responses

This section will examine several objections against the epistemic value of narratives for understanding the experiences of persons diagnosed with schizophrenia. While written autobiographical narratives are the selected medium and focus for this dissertation, it is important to remind the reader that a “narrative” can be conveyed both verbally and non-verbally and that my defense of the importance of narrative applies to both varieties.

3.1 Narratives Are Unreliable as a Source of Knowledge

Despite the therapeutic potential of narratives for understanding the experiences of persons with schizophrenia, one objection against the use of narratives as a way to better understand and support persons with schizophrenia is that narratives are too unreliable and are not sufficiently empirical enough to be constituted as a source of knowledge (cf. Tekin 2011; Davidson 1994; Given 2008, 47; Mitchell 2014, 13). As Gupta (2014) explains, in clinical research there exists an “evidence hierarchy” which ranks various research methodologies on a scale from the most valid to the least valid (Gupta 2014, 22). For example, methods such as double-blind and randomized controlled trials are ranked among the most objective and reliable in terms of their evidence that can be used to improve treatment options, whereas personal narratives and testimony are often perceived to be less reliable due to the element of subjectivity embedded within them (Rosti 2017, 4). And since contemporary medicine is dominated by a “natural-scientific paradigm,” the legitimacy of personal narratives and their epistemic value is often discredited and undermined because they are deemed “non-scientific” and “merely subjective” in character (Svenaeus 2017, 172-173).

Moreover, as resources like the DSM gained more prominence for diagnosing mental disorders, Andreasen notes that psychiatrists were taught that their care recipient's self reports of their experiences with illness should be "discounted" and that the role of the therapist is to "dig beneath" the other person's narrative to reach the "real truth" of their condition as defined through the DSM's diagnostic descriptions (Andreasen 2007, 110; Barker et al. 2001, 200; Molas 2020, 27-28). Finally, given the severity of some people's experiences of living with schizophrenia, such as delusions, critics maintain that personal narratives are simply unreliable because the person is not in the right frame of mind to accurately judge their sense of self.

3.1.1 Narratives Offer Invaluable Insight into the Experience of Illness

As discussed in the beginning of this chapter, the effects of stigma and master narratives on persons with schizophrenia is problematic precisely because people living with this diagnosis are stereotyped in ways which do not accurately reflect the strengths and capabilities of these individuals directly. Moreover, master narratives depict members of marginalized groups as static and unable to deviate outside of the parameters set up by the master narrative in the first place. But in response to the claim that narratives are unreliable sources of knowledge, and thus contrary to the master narrative that dictates otherwise, Davidson and Solomon (2010) note that not only do most people diagnosed with schizophrenia reach some degree of significant or full recovery over time but that, despite their perceived inability to create coherent narratives of their experiences, persons diagnosed with schizophrenia are often "the most knowledgeable reporters of their own experiences, needs, and interests" (Davidson and Solomon 2010, 93; Molas 2020, 28). Recognizing this fact is one step that must be acknowledged if developing improved and ethical therapeutic options is going to gain any traction within practices of psychiatry.

As Reaume (2017) notes, people who are experiencing any kind of phenomena first-hand are best able to describe what is happening “to their [own] interior feelings” than someone who is merely “observing, but not undergoing this process” directly as would be the case for caregivers trying to make sense of the other person’s mental states from a distance (Reaume 2017, 292). Similarly, Kalitzkus and Matthiessen (2009) maintain that first-person narratives provide the “most authentic reality” of a person’s life and their experience of illness (Kalitzkus and Matthiessen 2009, 80-81). Because narratives provide insight into illness in ways that are otherwise inaccessible, these first-person insights are valuable sources of information that should be welcomed into traditional approaches to medicine, not be immediately discounted.

People are experts on their own lived experience, and it is advisable that therapists and caregivers should not impose meaning on these experiences which do not coincide with how the person derives meaning from them for herself (Molas 2020, 31). To be clear, this does not mean that a therapist or caregiver should never *disagree* with what their care recipient says, nor does it mean that a therapist or caregiver cannot offer alternative *suggestions* to help the other person clarify the meaning of her experience. The main point is that it is important not to immediately dismiss the credibility of the narrative—or the narrator—as a source of knowledge as this practice can lead to further instances of marginalizing and silencing persons diagnosed with mental illness.⁸³ Drawing from her own experience of living with psychosis, Goude writes:

To say a person is out of touch with reality is to ignore the validity of the reality that they are in touch with. This is not only disempowering, it fails to celebrate the journey that the person is on, albeit in their alternate reality (Goude 2020).

⁸³ There are similarities between the kind of epistemic harm and silencing against persons with schizophrenia that are caused by master narratives and stigma and the kind of epistemic harm and silencing explored by feminist philosophers who focus on issues of race. For more on the epistemic harm done to persons belonging to historically marginalized and racialized groups, particularly through instances of epistemic silencing and undermining one’s agency as an epistemic knower, see Fricker (2007), Dotson (2011), Berenstain (2016), and Toole (2019).

Of course, this does not suggest that the perspectives of therapists observing someone's situation externally should be totally excluded. And, within the therapeutic context, this does not suggest that the person's individual testimony automatically trumps whatever the perspective of the healthcare professional is either. But there must be a balance between respecting the person's lived experiences with the knowledge, skills, training, and experience possessed by the caregiver. Given the history of how people diagnosed with mental illness have been treated within psychiatry, coupled with how persons with mental illness often feel due to the effects of social stigma, there is much to be learned *from* them to improve practices of care intended *for* them.

Secondly, even though some people diagnosed with schizophrenia might have symptoms that make interpersonal engagement more difficult and presents a challenge towards the implementation of appropriate forms of care, in response to the objection about the inability for someone to provide their own narrative due to the nature of their condition, Lindemann Nelson maintains that counterstories can be created "*by or for the person*" whose identity needs repair (Lindemann Nelson 2001, 19). Thus, she leaves open the possibility for identities to be *co-authored* by appealing to the notion of a shared collective identity.

On that note, Bekhta (2017) suggests exploring the possibility of a collective subjectivity referred to as a "we-narrative." While I maintain that the strength of counterstories is that they showcase the resilience of persons with schizophrenia as they reclaim their sense of self, appealing to a shared collective identity can serve as a strong counterstory to undermine master narratives and to begin the process of minimizing stigma. This is because, as Lindemann Nelson suggests, good counterstories aim to free not only individuals "*but the entire group*" whose identity is damaged by an oppressive master narrative (Lindemann Nelson 2001, 183, emphasis added). Moreover, she maintains that repairing a damaged identity does not require having any

particular “narrative or normative expertise” but only requires “ordinary amounts” of “narrative and normative competence” (Lindemann Nelson 2001, 66). Under Lindemann’s approach, the baseline for narrative competency is not as restrictive as other accounts and, as a result, persons with schizophrenia satisfy the criteria for being recognized as narrative agents who, despite their illness, are capable of providing a narrative account of their lives that depicts an authentic self.⁸⁴

The experience of illness or disability, of any kind, is a deeply personal experience that cannot be replicated by anyone else. As such, the experiences of one person cannot be generalized to all individuals who share that same condition. While it is true that the focus of recovery narratives is often on the specific details of an *individual’s* life experiences of living with illness and chronicling their personal journey (including overcoming the difficulties they encountered along the way), Connelly maintains that sometimes a personal narrative “holds universal truths” which can help to make sense of the experiences of others as well (Connelly 2002, 147; Rashed 2020, 17).⁸⁵ Despite the different ways that schizophrenia can affect someone’s sense of self and identity there are several recurring themes that spread across all the narratives I selected and many more not shown here. Whether it is feeling stigmatized by society, being dehumanized by caregivers, or feeling disconnected from family, friends, and even from oneself, these narrative accounts share many similarities and illustrate the issues with how master narratives and stigma can cause tangible harm that negatively impact the quality of someone’s well-being. But more importantly, they collectively raise awareness about the importance of shifting current therapeutic practices to become more supportive of individuals who need it.

⁸⁴ For competing narrative accounts that Lindemann refutes in her analysis, see Nussbaum (1990), Rorty (1989), MacIntyre (1984), and Taylor (1989).

⁸⁵ Moreover, Barbara Everett maintains that stories are important because stories “foster feelings of mutuality and community” and they are “nested within a burgeoning sense of political purpose” that, I argue, can be used to create positive systemic changes in society (Everett 2000, 101). Thus, similar to the effects of counterstories, personal narratives of persons diagnosed with schizophrenia can also be representative of the experiences of the entire group that has been marginalized by dominant master narratives.

According to Kirmayer et al. (2015), empathy can be cultivated through the process of “affective attunement” and “close listening” to the person’s narrative and learning more about the “local social worlds” that are conveyed through their stories (Kirmayer et al. 2015, 16-17). As Keen (2006) notes, human beings are “story-sharing creatures” that have a “built-in capacity” to *feel with others* through narrative engagement (Keen 2006, 209). This narrative engagement is beneficial because narratives depicting a person’s emotional states can help contribute to practices of empathy by “opening readers' minds to others, changing attitudes, and even predisposing readers to altruism” and this shares similarities to Stein’s theory of empathy and the emergence of concern for others (Keen 2006, 213-214). Rather than minimizing the importance of emotions for moral-decision making, emotions should be featured more prominently as they can play a significant role in motivating moral action and promoting positive social change.

That said, as noted in Chapter 3, there may be certain people with whom this type of engagement seems impossible because their symptoms inhibit their ability to communicate. Although dialogue may be unattainable in some instances, it is important for caregivers to remember that revealing one’s narrative—even brief glimpses of it—is not restricted to *verbal* communication, or even *written prose* which has been the focus of this analysis. For, according to Charon, sometimes there are “performative tellings” that emerge from a person’s body language and other non-verbal cues that “go beyond prose and linear written narratives” (Charon 2005, 262-263). As Derntl and Regenbogen explain, “empathic contents” can be transmitted through various ways including “facial expression, emotional speech, or body language” (Derntl and Regenbogen 2014, 76). Similarly, Rosti notes that narration can also be channeled through non-verbal outlets such as drawings, pictures, or videos to help describe an experience to another

person (Rosti 2017, 4). Thus, there are multiple ways that therapists can engage with care recipients for the purposes of better understanding their unique experiences of schizophrenia.

3.2 Recovery Narratives Reinforce the Medical Model of Illness

A second set of interrelated objections against narratives is that the structure of “recovery narratives” (narratives created by persons after “recovering” from illness) is problematic as it simply reinforces the medical model of illness. In particular, the structure and focus of recovery narratives often highlight the individual’s triumph of overcoming the symptoms of their disorder and typically highlight the person’s return to a ‘normal’ state of functioning. Although overcoming the challenges in living that typically accompany a diagnosis of schizophrenia is something worthwhile to promote, the criticism is that these narratives reinforce the medical model’s claim that the end goal of treatment is to eliminate a person’s symptoms and restore them back to a previous state of health. And for individuals who view the presence of “mental illness” as a constitutive feature of one’s identity (e.g., Mad Pride), reinforcing the medical model of illness is harmful because it is an attack on one’s sense of self and identity.

As Woods et al. (2019) argue, while not to deny the importance of recovery narratives as demonstrating the resiliency of persons diagnosed with mental illness who are able to share their experiences and raise awareness about the injustice of some psychiatric practices, the editing and revising of these narratives is often “carefully constructed” to generate a specific effect on an audience (Woods et al. 2019, 9). Furthermore, while the structure of narratives is embedded with meaning for the person authoring it, the privileging of certain types of narrative forms and structures to be constituted as the definitive “recovery narratives” has the potential of excluding other forms of narrative and, thus, producing a silencing effect as well (Woods et al. 2019, 13).

Because autobiographical narratives are written at a particular point in time of someone's life, an additional worry is that they can be received as a finished product and therefore be interpreted as a definitive characterization of the person and her experiences. This is problematic because the person's finished narrative becomes static and not something that is open to further exploration. Moreover, although recovery narratives have been promoted for their therapeutic benefits for the author and for raising awareness about the suffering of marginalized individuals which can lead to positive social change, Costa et al. (2012) raise some legitimate concerns about the potential harms that emerge from the decision to share one's narrative publicly. These concerns include the question of who benefits from telling one's story, how do organizations use these stories to promote their causes and enact social change, and whether the act of storytelling should be conceptualized as an act of labour worthy of compensation (Costa et al. 2012, 85).

Most notably among these considerations is that the permanence of digital records means that the person's narrative will likely be accessible for a long time, and this may influence how that person is treated. For instance, if someone decides to publish their recovery narrative in hopes of raising awareness about the stigma of mental illness, a future employer or landlord may come across these digitally-preserved records during background checks, which can negatively impact their ability to find work or secure housing. This, in turn, repeats the destructive cycle of stigma that the recovery narrative was originally intended to disrupt (Woods et al. 2019, 14).

3.2.1 Recovery Narratives Showcase the Resiliency of Individuals

In response to these numerous and key objections, I agree that a person's narrative should not be seen as a static object that prohibits further interpersonal dialogue and engagement between people. I also agree that one important step in reconfiguring therapeutic relationships between

caregivers and care recipients is to create and sustain meaningful dialogue between both sides. But that important step is facilitated by, first, engaging with the person's narrative, in whatever form that takes. It is a mistake to view someone's narrative as being a static object that represents the person's life indefinitely. Rather, the appropriate mode of engagement should be one of an ongoing dialogue which, I have argued, is facilitated through Stein's theory of sensual empathy.

Moreover, it is important for that person's narrative to exist in the first place in order to lead to further engagement later on. For example, if engaging with a person's narrative leads someone (caregiver or otherwise) to reflect on their own potential biases and prejudice towards people diagnosed with schizophrenia, and if this reflection raises awareness about the humanity of the other person, it is plausible to suggest that the recipient of the narrative will be more likely to continue engaging with the other person because their narrative struck at something deeper within them. Similar to Stein's theory of empathy, which allows us to be drawn into the suffering of the other person, narratives have this capacity of drawing someone into the world of another and to gain a fuller picture of their subjective experiences. And if a recovery narrative—one which highlights the person's resiliency and overcoming unjust treatment and adversity—can help shift a person's perception of this illness, then this exposure to the humanity of the person behind the narrative can influence positive systemic change for many more people.

Secondly, while it is important to be critical about the kinds of narratives that are promoted in anti-stigma and public awareness campaigns (such as Bell Canada's annual *Let's Talk* initiative), one aim of showcasing these narratives is to help put an end to the systemic discrimination and unjust treatment of persons with mental illness. It is true that many recovery narratives are structured in ways that make them both accessible and understandable to a wider audience. But if the result is that caregivers, and the broader public, have access to these stories

and reflect on their implicit assumptions about persons with schizophrenia, and if they reflect on practices that are discriminatory to those who have been marginalized, then reaching a wider audience and slowly uprooting the ideas embedded within master narratives is a worthy goal.

On that note, it could be the case that some psychiatric survivors may feel pressured to publicly share their personal narrative in order to contribute to ‘the greater good’ in the fight against minimizing stigma within society. The decision to publicly share one’s narrative is a personal choice, and no one should be coerced into revealing their lived experience with mental illness if they do not feel comfortable doing so. But that decision to share should be ever present within the scope of therapy and mental healthcare. Allowing individuals diagnosed with any type of mental illness the opportunity and ability to form their own narratives and providing a receptive and caring audience to receive those narratives, can prove to be therapeutically beneficial because it is an act of recognition of the other person’s experiences and an invitation for collaboration. By engaging with the other person’s narrative and responding (when appropriate) in a caring and empathic manner, not only would their experience of stigmatization be respected and not seen through the traditional lens of pathology. But we would also gain a sense of their resiliency in coping with the suffering brought about by their illnesses.

4. Conclusion

In light of the systemic barriers created by the pervasiveness of social stigma and the master narratives of mental illness that are reflected in the narratives showcased throughout this chapter, it is likely that many people with schizophrenia have, at some point in their lives, been discriminated against and have felt dehumanized because of their condition (Molas 2018b, 64). But one of the positive implications of engaging with narratives is that they can be used to

connect with others across “boundaries of difference” and can promote positive changes in our interactions with others (Keen 2006, 223). Understanding the narratives of others encourages connections between people and, without narratives, Connelly argues that “deep human contact” is difficult to achieve (Connelly 2002, 148). Similarly, the kind of empathic knowledge that emerges from Stein’s approach can help facilitate these deeper connections with others.

Addressing the specific task of improving patient-caregiver relationships to better support people with schizophrenia in their recovery, and also addressing the broader goal of minimizing stigma and challenging harmful master narratives, requires paying extra attention to individuals who need help. Thus, it is precisely this interpersonal and emotional component of Stein’s theory of empathy that is central because practices of care center on recognizing and responding to the suffering of others immediately present. It is this direct approach that makes it possible to engage with the person’s suffering and raise awareness of broader systems of injustice which can lead to more positive systemic change. And it is this direct engagement that allows for reconceiving what “schizophrenia” looks like.

But how can engaging with personal narratives be used to facilitate Stein’s theory of sensual empathy, reconfigure the relationship between caregivers and care recipients, and improve practices of care in more ethical ways? One way is through exploring the potential benefits of narrative-based medicine as a model of therapy.

Chapter 6 – Implications of Narrative-Based Medicine and Empathy for Mental Healthcare

This chapter examines the implications of both Stein’s theory of sensual empathy and narrative-based medicine in the context of mental health care. It begins with a discussion of the distinction between evidence-based medicine and narrative-based medicine. It then examines the broader implications of narrative-based medicine within a recovery model of care. The chapter closes with a discussion of the numerous benefits for caregivers in adopting narrative-based approaches for improving therapeutic relationships with persons diagnosed with schizophrenia.

1. Distinction Between Evidence-Based Medicine and Narrative-Based Medicine

Before exploring how narrative-based medicine can help improve therapeutic relationships to better help support people with schizophrenia, it is helpful to remind the reader of some of the main contrasts between narrative-based medicine with its counterpart, evidence-based medicine.

1.1 The Benefits of Evidence-Based Medicine

Evidence-based medicine (EBM) is defined as the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Evidence-Based Medicine Working Group 1992, cited in Gupta 2014, 118). One goal of EBM is to optimize the health outcomes for as many patients as possible. Since the aim of EBM is to provide an objective and value-free approach to medicine, and since it is grounded in the “principles of objectivity and rationality,” EBM claims to provide one of the most accurate and effective treatment methods available for addressing health concerns (Gupta 2014, 46, 160). Within modern medicine, EBM has become the standard and the most widely adopted model of medicine that has been embraced within the medical community, including psychiatry.

As I noted in Chapter 1, the early stages of diagnosing mental disorders—in the tradition of Kraepelin and Bleuler—focused on identifying clusters of symptoms and then attributing certain diagnoses to patients based on their symptoms. But while the creation of these diagnostic labels, as per the DSM, did offer some objective standards to psychiatry, it is important to keep in mind that the decision to label someone with a mental disorder is often a judgment call and done at the discretion of the therapist. As Boyle (2002) notes, the process of *diagnosing* schizophrenia in someone is based “entirely on clinicians’ judgements of behaviour and reports of private experiences” (Boyle 2002, 208). Moreover, unlike somatic disorders, the identification and treatment of mental disorders was not clearly defined and there were few objective standards that could reliably be drawn upon. As a result, part of the reason why psychiatry adopted EBM is because it provided an objective and fair standard to help therapists avoid incorporating their own biases in determining the classification of mental disorders and the treatment options for patients (Gupta 2014, 167-168). While not perfect, the development of the DSM and other ways of classifying mental disorders provided some consistency in order to group people exhibiting certain symptoms together so that they can be treated appropriately.⁸⁶

1.2 Criticisms of Evidence-Based Medicine

However, because the focus of EBM is on symptom reduction and restoring a person’s state of health, one reason why EBM is limited in certain areas is because it often neglects the additional

⁸⁶ Diagnostic tools can provide a standardization of psychiatric care that helps therapists treat those under their care. For example, the goal of the DSM was to help therapists to diagnose mental disorders more objectively by making the diagnostic criteria less open to interpretation. The purpose of this approach is to minimize the therapist’s own values and biases while making diagnoses (Gupta 2014, 22; Andreasen 2007). But while the intention behind this is to make diagnosing mental disorders more reliable, one issue with this approach is that therapists may rely too heavily on it instead of engaging more attentively with their care recipients. This is problematic because, to quote Andreasen at length, relying too much on diagnostic manuals and criteria can provide an: “oversimplified and incomplete view of the clinical picture, discourage clinical sensitivity to individual patients and comprehensive history-taking, lead students and even clinicians to believe that ‘knowing the criteria is enough’...and discourage...innovative thinking about the psychological...mechanisms of schizophrenia” (Andreasen 2011, 7).

social and existential features of a person's life that must be factored into successful treatment options. Furthermore, while this focus on symptom reduction is certainly important and should not be neglected, the downside of EBM is that it does not provide much in terms of actively promoting the person's future beyond their illness (Kelly and Gamble 2005, 246). As Gupta explains, while symptom reduction can be a significant outcome for the individual person receiving care, outcomes such as "social integration, workforce participation, or standard of living" may be more relevant to persons living with mental illness and these external factors need to be addressed as well (Gupta 2014, 143; Jacob 2013). Since EBM is not designed to address these issues, it offers an incomplete model of care in some areas. One way to address these factors, and to fill in the missing gaps of EBM, is to turn to narrative-based medicine.

1.3 What is Narrative-Based Medicine?

Narrative-based medicine (NBM) provides insight into the person's lived experience that offers a more holistic picture of the person that can inform how the therapist approaches treatment options. In terms of its distinguishing features, Charon et al. (2017) explain that narrative medicine began as:

a rigorous intellectual and clinical discipline to fortify health care with the capacity to skillfully receive the accounts persons give of themselves – *to recognize, absorb, interpret, and be moved to action by the stories of others. It emerged to challenge a reductionist, fragmented medicine* that holds little regard for the singular aspects of a patient's life...*to widen the clinical gaze to include personal and social elements* of patients' lives vital to the tasks of healing (Charon et al. 2017, 1, emphasis added).

As Rosti (2017) notes, narrative medicine involves a form of interaction with others that "invites one to be moved by the story of illness" and through this process the aim of narrative medicine is to promote a "healing relationship" with patients, colleagues, and the self (Rosti 2017, 3-4).

Practices of narrative medicine requires therapists to have sensitivity for the other's illness

experience; it requires the development of communication skills, such as active listening and the ability to explore with the other person and connect with them; finally, narrative medicine also involves a degree of self-reflection both for care recipients and for caregivers as well (Kalitzkus and Matthiessen 2009, 84; Zaharias 2018a, 178; Zaharias 2018c; Ragan and Kanter 2017, 473).

Narrative medicine is a tool to foster better communication which can have a beneficial effect on improving the care recipient's overall quality of life. Training in narrative medicine helps the caregiver to enhance their capacity to collaborate with others, it helps the caregiver to empathize with the other person's situation, and it allows the caregiver to adopt a patient-centered approach (Rosti 2017, 3).⁸⁷ By shifting the focus to the care recipients' narrative and prioritizing its function at the center of the clinical encounter, Zaharias explains that NBM "fundamentally changes the doctor's stance toward the patient so that the doctor's focus becomes 'attentive listening' and 'the need to understand,' rather than 'the need to problem solve'" (Zaharias 2018a, 179). To be clear, the knowledge gained about the nature of mental disorders derived from the objective methods of EBM does play an important role in helping to support people diagnosed with schizophrenia. But as indicated in the introductory chapter, the goal of NBM is not to upend EBM and serve as a total substitute across all medical disciplines. Rather, NBM best *complements* EBM by raising awareness about how the illness experience matters for the person experiencing it. Through this engagement therapists can broaden their understanding

⁸⁷ Rosti gives example of someone describing their experience of pain to their doctor. When the doctor asks this person to rate his pain on a scale of 1 to 10, the person replies that his level of pain is "3." On the surface, a subjective pain feeling of 3 suggests that the person is experiencing minor pain and does not suggest that anything else is wrong with him. However, Rosti explains how this particular patient indicated that, because of his condition, he is no longer able to spend time with his family and friends, the activities he previously enjoyed have been deprived of him, and his prior sense of identity as being an active member in his community has been diminished. While the person's self-report of feeling "3" on a pain scale does not give the doctor much information to work with, factoring these additional components of his life that *are* meaningful to him suddenly makes that "pain" feel significantly worse. By going further into the person's broader narrative history and identity, and by not focusing solely on the features of medicine that are objectively measurable and quantifiable, a narrative-based approach opens up more avenues of exploration that allow the caregiver to get a better sense of the other person as a whole.

of mental illness and can use this insight to improve the therapeutic options available to support individuals in their recovery. But what does “recovery” mean within this therapeutic context?

1.4 Narrative-Based Medicine and the Recovery Model of Care

Unlike standard approaches to psychiatry as per the medical model, which are characterized as unidirectional interactions between caregivers and care recipients, the recovery model of care focuses on peer support between individuals; it emphasizes an individual’s empowerment in medical decision-making; it encourages individuals to take responsibility for reclaiming their agency; and it provides hope so that people can overcome social barriers and reintegrate into society (Davidson 2003; Davidson et al. 2004b). A person’s recovery from mental illness is a gradual process that requires cultivating systems of support between individuals, their caregivers, and their communities at large (Dixon 2000; Farkas 2007). According to Anthony (1993):

Recovery is described as a *deeply personal*, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the *development of new meaning and purpose in one’s life* as one grows beyond the catastrophic effects of mental illness (Anthony 1993, 527, emphasis added).

Recovery-oriented care centers on the idea that both parties to the caregiver-care recipient relationship should be treated as equals. This means that persons diagnosed with mental illnesses should not be coerced into treatment options that they are uncomfortable receiving, and that greater attention should be placed on shared-decision making opportunities as individuals reclaim their agency and reintegrate into their communities (Burns and Drake 2011, 636). But even within the discussion of recovery-oriented care, Davidson and Roe (2007) highlight the distinction between ‘recovery from’ versus ‘recovery in’ mental illness.

‘Recovery from’ mental illness involves the reduction of the person’s symptoms to facilitate the person’s return to a healthy state following onset of the illness (Davidson and Roe 2007, 463). This approach, I argue, is promoted under EBM as it involves eliminating the symptoms of one’s diagnosis so that the person can return to how they were before they were diagnosed. By contrast, ‘recovery in’ mental illness refers to a process of “minimizing the destructive impact” of the illness while simultaneously building on an individual’s strengths so that this person can restore a sense of identity beyond that of a “sick patient” or “schizophrenic” (Davidson and Roe 2007, 464). ‘Recovery in’ mental illness involves moving past identities that have been imposed upon certain individuals due to them being diagnosed with schizophrenia. And much like the effects of counterstories, this approach allows the person to shift the narrative of what it means to live with illness and to transform it into a positive light.

According to Young and Ensing (1999), since one’s sense of self becomes “altered, damaged, or even destroyed” due to the presence or emergence of illness, a key feature of recovery-oriented care is a person’s “quest” for a “newly defined, coherent, and stable sense of self” (Young and Ensing 1999, 220). Similar to counterstories, the process of recovery is viewed primarily as a “process of reconstruction” that is designed to restore and heal an individual’s identity that has been harmed by negative social influences (Davidson et al. 2004b, 229). And this ability for an individual to reclaim their sense of self and derive meaning from their experiences is one of the core features of narrative-based medicine.

2. Criticisms of the Recovery Model of Care and Responses

One of the implications of adopting narrative-based medicine is that it coincides with the core principles of the recovery model of care. Unlike therapeutic approaches endorsed under the

medical model of illness, the recovery model of care focuses on empowering individuals and helping them reclaim a sense of self that has been undermined due to dominant master narratives. Although the recovery model of care can help reshape the current understanding of mental illness, and while the recovery approach possesses the same kind of transformative potential that counterstories have at challenging preconceptions of mental illness, the concept of “recovery” within the area of psychiatry is not without criticism.

2.1 “Recovery” is Vague and Difficult to Define

The first objection against the recovery model of care focuses on what precisely the concept of “recovery” means for persons diagnosed with schizophrenia. If the definition of recovery remains unclear or sets up unrealistic expectations, critics argue the bar will be set too high and some people with schizophrenia may become demoralized if they do not reach specific recovery checkpoints or milestones (Lieberman and Kopelowicz 2005, 740). A related objection is that there is a limited understanding of what a recovery-oriented mental healthcare system would look like and how currently existing mental healthcare systems must be modified to incorporate the principles of recovery (Lal 2010, 87; Burns and Drake 2011, 636). Given the limited resources that mental healthcare typically receives, and due to the more hands-on approach that would be required to support people in their recovery, a full transition to a recovery-based model of care is challenging and thus clearer criteria for training caregivers are required (Lal 2010, 87).

2.1.1 Recovery is Open-Ended and Inclusive

In response to the first objection, I concede that providing a precise and concrete definition of “recovery” is a very difficult task to achieve. But this lack of providing a concrete definition of

“recovery” is not due to a lack of imagination or insufficient empirical research. Rather, it is difficult—and counterintuitive—to provide a concrete definition of “recovery” because it is a concept that holds multiple meanings for multiple people. The purpose of recovery is a personal journey that an individual must travel as they adjust to a life of living with a diagnosis, such as schizophrenia. Recovery *can* involve a person’s quest to rid themselves of the symptoms of their condition. But recovery can also involve a person *embracing* their identity and *transforming* it into something positive and affirming of their sense of self (e.g., the celebration of “madness” and the promotion of neurodiversity through events such as Mad Pride). Thus, attempting to provide a definitive definition of ‘recovery’ goes against the spirit of the recovery model of care as it sets up parameters that persons with mental illness must either realize or fail to realize.

Because there is no strict definition, the advantage of the concept of recovery is that it is open-ended and that the more input the individual has towards defining their own concept of “recovery” then the better the result will be. But this does not absolve caregivers of their duty to help support their care recipients throughout this process. Caregivers still have a responsibility to help their care recipients define their own goals and set up their own expectations because those additional systems of support have a significant impact on the success rates of recovery. Given the open-ended and inclusive nature of recovery, in terms of what a recovery-oriented model of care would entail, Mead and Copeland (2000) provide numerous suggestions that caregivers can implement to establish recovery-oriented services within a healthcare framework. To help support people in their recovery, Mead and Copeland stress the importance for caregivers to:

Treat the *person* as a *fully competent equal* with equal capacity to...take action to create life change...Focus on *how the person feels*, what the person is experiencing, and *what the person wants* rather than on diagnosis, labeling, and predictions about the course of the person’s life...Pay close attention to *individual needs and preferences*...*Recognize strengths*...*listen* to the person, *let them talk*, hear what they say and what they want,

making sure *their goals are truly theirs* and not yours... (Mead and Copeland 2000, 327-328, emphasis added).

These suggestions put forward highlight many of the foundational concepts that serve as the basis for narrative-based medicine as well. Because the focus of recovery-oriented care is on the person who needs assistance—and therefore there is less emphasis on the medical model’s approach which prioritizes the presence of the medical professional—a recovery approach invites more collaboration between both caregivers *and* care recipients. The way that a recovery approach achieves this collaboration is by inviting dialogue, by focusing on peer-support, and by prioritizing the wholeness of the person rather than viewing them as a cluster of symptoms.

As Davidson and Strauss (1992) explain, the aim of recovery involves the utilization of a “functional sense of self” that is brought about by focusing on the strengths that people have in relation to their disorder and using these capacities to help the person effect positive change in their lives (Davidson and Strauss 1992, 134). Rather than only focusing on mitigating their symptoms through medication, caregivers should also focus on developing long-term goals with their care recipients and should aim to help them develop the skills that are necessary for coping with any challenges that stem from the symptoms of their diagnosis. This holistic approach helps restore a person’s self-esteem and self-worth, it focuses on improving their sense of well-being, and provides opportunities to take more responsibility for reclaiming their agency which may have been denied from previous encounters with therapists.

2.2 The Recovery Model Sets Unrealistic Goals

Another objection against the recovery model of care is that the promise, or hope, of recovery sets up unrealistic expectations for persons suffering from severe mental disorders. Although many mental health practitioners advocate for the effectiveness of the recovery model of care,

Lal cautions that overhyping the benefits of a recovery approach can lead to the risk of inflating recovery's importance within the healthcare sector to the point where it "shortchang[es] the capacity of the mental health system for delivering prevention and promotion efforts at the public health level" (Lal 2010, 87). Similarly, Masland (2006) is skeptical of the implicit assumption that "recovery" is something that is universally applicable to all persons diagnosed with any type of mental disorder, regardless of the nature of the disorder or the severity of one's symptoms. Although there has been an increased promotion of the recovery model as a therapeutic alternative to traditional treatments that solely prioritize psychopharmaceutical intervention,⁸⁸ Masland maintains that treating individuals with "severe neuropsychiatric damage" through recovery-oriented care is "simply not possible" because they are too far gone to respond to these treatments (Masland 2006, 1510).

2.2.1 The Goals of Recovery Are Realistic and Achievable

In response to the first objection, that recovery sets up unrealistic expectations and false hope for persons with schizophrenia, it is important to clarify that the purpose of recovery is often on restoring a person's life and capacities to the state they were *before* they were disrupted by their illness. As Davidson et al. note, many people express a desire to return to a previous functional way of life and to do things which have become more difficult as their disorder progresses (Davidson et al. 2004, 228; Davidson 1994). In fact, research done by Eriksen et al. (2012) indicates that many people with severe mental illnesses express the desire to be respected as a "normal person" and to not be viewed solely as an illness or reduced to a set of symptoms.

⁸⁸ To reiterate, I do not believe that all medications should be abandoned or that they have no benefits at all. Medications that help manage a person's symptoms of schizophrenia play an important role in the success of a person's journey to recovery. But medication is only one component of supporting people in their recovery and should not be the only solution. Medication, in combination with accessible systems of social support, the presence of caring therapists, and the promotion of peer support are all necessary components of what "recovery" entails.

But when they are asked to define what it means to be a “normal” person, Eriksen et al. note that being “normal” means being “‘perceived as a *human being*’, ‘to *experience reciprocity* in contact with others’... ‘to be *listened to*’ and ‘to be *seen as an individual*’” (Eriksen et al. 2012, 358, emphasis added). Given the history of unjust and inhumane treatment methods administered to people with mental illnesses, including forced institutionalization, solitary confinement, lobotomies, and other experimental procedures, and being heavily medicated with anti-psychotic medications (Eghigian 2017), these types of treatments deny persons with schizophrenia of their social nature by erecting barriers between themselves and others.

However, as evidenced throughout the first-person narratives showcased earlier, a recurring theme expressed by many people with schizophrenia is the desire to (re)connect with others and to be viewed as more than a diagnosis. Building reciprocal relationships with others, socializing with friends, and becoming an active member of one’s community are many of the desires expressed by people throughout their journey towards recovery. Given the open-ended concept of ‘recovery,’ these goals are quite modest and even incremental improvements in a person’s life would be considered a success under a recovery model. Instead of reinforcing the master narratives which dictate that persons with schizophrenia will *never* recover, and instead of relying on treatment methods that potentially hinder, rather than help, someone’s ability to heal, a recovery-oriented approach to care seeks to actively promote the person’s strengths, capabilities, and aims to restore a sense of self which better represents that person and her goals.

In fairness to Masland’s criticisms, even though it is true that *some* people diagnosed with schizophrenia suffer from severe cognitive impairments that make certain treatment options more difficult, there is no reason to suggest that *all* people with schizophrenia are alike and there is no reason to suggest that these impairments are *permanent*. Between 45% - 65% of people

diagnosed with schizophrenia will experience significant to full recovery over time (Roe and Davidson 2005, 92-93; Burns and Drake 2011, 636; Marcisin et al. 2017, 122). Given that the recovery rates for persons diagnosed with schizophrenia are quite high—with or without recovery-oriented practices of care in place—it seems plausible to suggest that caregivers should strive to provide the most supportive form of care possible to assist people in recovery.

Moreover, regardless of the severity of one's impairment, Lamb (1988) argues that there is always an "intact portion of the personality" to which rehabilitation efforts can be directed towards in helping improve the person's situation (Lamb 1988, 330). In other words, there always remains the essence of humanity of the other person, even if it becomes obscured due to the presence of illness. Thus, the moral aim of therapy should be on empowering the person and helping them in the process of rebuilding their sense of self. The goal of treatment is not only to return the individual to the way they were *before* the onset of the illness as per the medical model. Rather the goal is to give them the tools necessary to live as complete people (regardless of whether or not they continue experiencing symptoms of their condition) and to help reshape the environment in which they live by challenging misconceptions and stigma of schizophrenia. These goals, I argue, are achievable through the implementations of the recovery model of care.

2.3 Recovery is Too Individualistic and Reaffirms the Medical Model of Illness

A final objection against the recovery model of care focuses on the individualistic nature of many recovery approaches. Under the predominant recovery models discussed in this literature, recovery is characterized as a process of the *individual* reclaiming a sense of self and taking the necessary steps to achieve this goal *for herself*. Part of the criticism against the personal recovery model is that its intended aims are derived from the medical model of illness, which views one's

experience with schizophrenia as something needing to be “fixed” in order to restore someone back to a previously functioning state of health.

Given the heterogeneous nature of illness, these accounts implicitly presume an ideal agent who is capable of going through the recovery process, whose strengths are emphasized and whose weaknesses are minimized, and who is able to overcome the limitations imposed by her condition (Gosselin 2019, 22). Moreover, because the focus is on restoring an individual’s ability to cope with their illness, the personal recovery model is viewed as problematic since it emphasizes idealized individual traits, such as personal agency and willpower, and neglects the *relational* aspects of the self that are important for the constitution of one’s identity.

2.3.1 Recovery is Best Seen as a Relational and Collaborative Act

Rather than focusing solely on the individual’s journey to recovery, I agree with Gosselin’s (2019) claim that a just approach to recovery must consider the real limitations of a person and their illness experience and to also recognize that one model of recovery cannot apply universally to everyone. But I also agree with her that a just approach to recovery must frame mental health care as a *social* good, rather than strictly an individual good, and that the focus on a recovery model requires social change and not simply be limited to instances of individualized treatment (Gosselin 2019, 7). Focusing solely on the individual and *her* ability to overcome adversity diverts attention away from exploring and critiquing sources of systemic inequalities and injustices, including various forms of discrimination, which may impede one’s ability to access the necessary supports needed for recovery to be an option (Woods et al. 2019, 6).

To that end, the concept of recovery is best conceptualized as a relational and collaborative endeavour that involves the contributions of both the person diagnosed with mental

illness as well as their caregivers and other systems of support. While it is important to acknowledge the role that the individual plays in authoring her own counterstory and repairing her damaged identity, it is also important to view the social and relational aspect of human life.⁸⁹ The individual must make the effort to rehabilitate herself and reclaim the sense of agency that was lost due to her illness. But the community to which that individual belongs also plays a significant role in supporting that person's recovery. Despite the emphasis on the individual's journey, there are many aspects of interpersonal interaction necessary for recovery to succeed.

3. The Benefits of Narrative-Based Medicine for Improving Therapy

The remainder of this chapter focuses on five benefits that NBM has over EBM for improving therapeutic relationships between persons with schizophrenia and their caregivers. Moreover, the aim is to demonstrate how narratives and NBM can work in conjunction with Stein's theory of sensual empathy in practice to help better understand persons with schizophrenia and to help support them in their recovery.

3.1 Uncovering Meaning Embedded in Illness

One benefit of NBM is that exploring narratives can help the individual uncover the meaning behind their experiences of illness. As Frank (1998) argues, telling one's own story can help someone work through a difficult situation in their lives by creating critical distance between the narrator and her story. For Roe and Davidson (2005), the importance of narratives stems not necessarily from the content generated by these narratives, but it is the *act of narration* that helps to make sense of one's experiences and contributes to the development of what Bargenquast and

⁸⁹ I have argued elsewhere in favour of viewing agency and autonomy as *relational*, particularly with supporting persons with mental illnesses, rather than in the strict individualistic terms established by the tradition of Frankfurt (1971) and Dworkin (1989). See Molas (2016).

Schweitzer (2014) describe as a “coherent sense-of-self” (Bargenquast and Schweitzer 2014, 233). By giving one’s own life a narrative form, a narrative crystallizes a specific perspective through which the narrator or author of that story can “perceive and display all dimensions...of the situation” of their own life which is helpful for making sense of one’s experiences and finding the meaning embedded *within* those experiences (Charon 2005, 266; Frank 1998, 207; Roe and Davidson 2005; Roe and Kravetz 2003; Kleinman 1989).

According to Mitchell (2014), stories (verbal and non-verbal) often hold “deeper truths” and they reveal features and insights about a person’s life that may otherwise remain unnoticed in routine clinical encounters (Mitchell 2014, 12). Because the focus of standard approaches to medicine is on removing the person’s symptoms, Frank notes that healthcare professionals “do not routinely find meaning in illness” and they are not often disposed to listen to how the other person attempts to reconstruct her sense of self or to find meaning behind her illness experiences (Frank 1998, 205). But the methodological approach offered by NBM and a recovery model of care allows caregivers to attend to the meaning embedded within their care recipients’ experience of illness. This approach shifts the focus from viewing the patient as a cluster of symptoms towards a therapeutic dialogue between the caregiver and care recipient.

The potential of narrative approaches in medicine is to “reorient” our understanding of therapeutic relationships (Frank 1998, 199). To that end, Martinez (2002) maintains that creating an environment of compassion and empathy that allows the person to explore the meaning behind their experiences can help resist the “psychiatric colonization” of the patient’s experiences that can occur under the traditional medical model (Martinez 2002, 133-134). Through this exploration of what the illness experience means for the person, it is possible to

“break the vicious cycles” of the traditional hierarchical patient-caregiver relationship that “amplify distress” for those who are on the receiving end of care (Frank 1998, 198).

Narratives provide insight into what a person is experiencing in ways that would be otherwise inaccessible (Barker et al. 2001, 201).⁹⁰ Rather than approaching the therapeutic encounter with preconceived notions in mind, Charon maintains that it is helpful for therapists to approach others with an open mind, paying close attention to not only *what* the person says but *how* they say it. By approaching the other person with an open and receptive attitude, caregivers can help their care recipients interpret the meanings behind their illnesses and use that information to help develop effective care options. Rather than imposing meaning onto the person’s experiences, Edward explains that caregivers should serve as a guide to help others learn more about themselves “within the context of their own understandings and truth” and through this exploration of the other person’s experiences, caregivers can “forge a therapeutic alliance” with them which is essential to providing appropriate care (Edward 2006, 236).

3.2 Promoting Active Listening in Therapeutic Exchanges

Another benefit of narrative-based approaches in medicine is the promotion of active listening. Active listening allows caregivers to pay closer attention to the storytelling of the other person’s experiences that are often neglected in many clinical encounters. And, unlike the perceived accuracy of simulation theory, narrative-based approaches that promote active listening provide caregivers with the conceptual and practical tools to “listen and see” with “intensified accuracy”

⁹⁰ One suggestion is to compare a person’s self-narrative with a case history. The justification for this is that case histories are a form of narrative and they sometimes contain a lot of non-clinical detail that pertains to the specific meanings that a person attaches to their life. While this is certainly an interesting idea to explore further in later work, the fact that a case history is written *about* the care recipient and not *by* the care recipient is crucial. While it could be argued that NBM would require the caregiver to be more attentive and careful in drafting the case history based on their interaction with the other person, and being careful not to miss any important details, I am a bit hesitant because it is not coming from the care recipient’s perspective. As such, while case studies may offer *some* helpful insights, it may not fully capture the experience as it would be articulated by the person directly.

and can help caregivers to focus on the “ethical and existential elements” involved in the care of persons living with a diagnosis of any kind of mental illness (Martinez 2002, 133-134).

While a focus of narrative-based approaches is on the speaker’s ability to actively narrate their own experiences, the role of the *listener* should not be neglected or minimized. Even if someone is retelling their narrative while the other person listens attentively, having one’s speech be received demonstrates an act of reciprocity.⁹¹ When someone actively listens to us retelling a narrative of ourselves, Halpern (2014) notes how this act not only affirms our story but it “builds a scaffold for our thinking and telling” and makes it possible “to imagine a wider or more constricted range of options” (Halpern 2014, 27). As argued in the previous section, the act of narration helps the individual make sense of their experiences and explore hidden meanings which may go unnoticed. But it is the therapist’s responsibility to listen to (or, in some cases, read) the other person’s narrative in a “close, careful, and nuanced way” so that they can help the other person reflect on its meaning (Childress 2002, 122). Moreover, caregivers can further explore the meaning that their care recipients articulate by asking open questions to encourage deeper reflection and to guide the other person into revealing more about their narrative by reframing the focus away from strictly questions about medical conditions and focusing instead on how the illness experience has impacted that person’s life directly (Sakalys 2003, 235).

As a therapeutic tool, then, active listening not only helps caregivers learn more about the other person’s experiences but it “sets the stage” for effective care to emerge (Edward 2006, 236-237; Yip 2004). On that note, the appeal of Stein’s theory of sensual empathy, in relation to practices of NBM, is that it emphasizes the importance for caregivers to suspend their own preconceptions of mental illness to allow their care recipients to explore meaning for themselves.

⁹¹ Rather than viewing narratives as individual stories that exist in isolation, Everett argues that storytellers use stories and narratives to “seek a representation of reality which is intimately connected to the listener and bounded by the interpretive dialectic *they create together*” (Everett 2000, 81, emphasis added).

Acknowledging that their experiences are meaningful *for them* and, subsequently, being drawn into their experiences via Stein's theory of sensual empathy can help the process of shifting the negative perceptions of mental illness in more positive ways.

3.3 Fostering Dialogue Between Caregivers and Care Recipients

In addition to promoting active listening and uncovering the meaning embedded within a person's experiences, a third benefit of narratives and NBM is that it promotes dialogue between caregivers and care recipients. As Frank observes, the standard relationship between caregivers and care recipients is often configured as an interaction between "subjects-who-know" and "objects-who-are-to-be-known" (Frank 1998, 199).⁹² Under practices of NBM within a recovery model of care, however, the traditional 'patient-caregiver relationship' is reconfigured as an "ongoing, constructive *conversation*" where the therapist plays the role of a "critical reader" who is skilled in listening to and interpreting the other person's "story" by not only paying attention to *what* they say but *how* they say it (Childress 2002, 122, emphasis added).

To that end, Hem and Pettersen (2011) explain that practices of care should be viewed as a *relational* activity, not an isolated task, and the therapeutic relationship which serves as the foundation for practices of care should be viewed as a *dialogue* between two people rather than a *monologue* where the therapist controls the narrative and dominates the discussion (Hem and Pettersen 2011, 66; McCamant 2006, 335). The important feature of this narrative-based

⁹² Charon discusses the importance for narrative to shift how doctors view their patients. For example, Charon reflects on her encounter with a 52-year old diabetic man who recently suffered a stroke. When attending to this individual his referral note read: "Severely ill 52 yo man s/p aortic dissection, s/p CVA, insulin-requiring diabetes" (Charon 2005, 264). Although accurate descriptions of a person's symptoms are vital for helping healthcare professionals to attend to treating them, the depersonalized characterization of the person suffering from this condition reflects a broader trend within the tradition of evidence-based medicine regarding how people with illness are perceived in the first place. Reminiscent of Blaska's experience of being reduced to a "CMI," if illness is reduced to a cluster of symptoms, then beyond the descriptive features of their current symptoms there is nothing to be found in this description that reveals anything about this person *as a person*. A narrative approach, by contrast, conceptualizes the other person as more than just a collection of symptoms that need to be remedied.

approach is that the therapist is affirming the person's narrative *with* her and engages with her in a collaborative manner. Given the fact that some people with schizophrenia may be hesitant to disclose their experiences to others due to fear of negative judgment or of not being taken seriously, facilitating this sense of collaboration and engagement between both parties is vital.

Dialogue is integral for defining problems and setting goals to help the person throughout their journey to recovery. Engaging in dialogue with others allows them to have some input on their care options and, as a result, they are more likely to continue being invested in the types of mental health support options available to them (see Lysaker et al. 2014, 197; Helmus et al. 2019, 2). Good communication forms a part of the therapeutic treatment itself and can result in improved outcomes and greater satisfaction with healthcare services. Good caregivers listen and make the effort to reach out and provide opportunities for participation and collaboration (Molas 2018b, 64).⁹³ But if caregivers are dismissive of the other person's contributions in these dialogical exchanges, Sandhu et al. (2015) note that these individuals will feel neglected and more likely to disengage from mental health services. This consequence is something that ought to be avoided as much as possible and NBM offers a framework to begin to rectify this issue.

3.4 Facilitating Interpersonal Connections

A fourth advantage of NBM is that it helps the empathic process by facilitating connections between individuals that are conducive for empathy to occur. Within the context of the standard patient-caregiver relationship, the ability to meaningfully engage with another person requires a

⁹³ In the documentary, "Take These Broken Wings - Healing From Schizophrenia, Cure Without Medication", Catherine Penney, a psychiatric survivor who is now a registered nurse, tells her story about her encounter with her therapist, Dr. Daniel Dorman. At the beginning of her treatment Catherine was so deep in her experience of illness that she appeared to be unresponsive to Dr. Dorman's attempts to treat her and she even refused to open her eyes during their one-on-one consultations. Although she was consistently attending her sessions without fail, it took several years of developing a rapport with her therapist before she opened her eyes. She met with Dr. Dorman six days a week for 7 years. He refused to give up on her.

degree of empathy in order to better understand what the other person is experiencing. But in addition to the power dynamics which typically pervade these kinds of relationships, Toombs (1987) suggests that part of the reason why caregivers and care recipients have difficulty connecting with each other is due to a “fundamental disagreement” about the nature of illness (Toombs 1987, 219). This disagreement can also be explained through the contrast Rimmon-Kenan makes between the “voice of medicine” which embraces the medical model and views illness through objective descriptions of symptoms, and the “voice of life” which articulates what the person is experiencing first-hand as a result of the illness (Rimmon-Kenan 2002, 11).

Whereas individuals living with illness focus on the effects of the illness and how it impacts their sense of self, therapists are trained to view illness as collections of symptoms which are characteristic of specific diagnoses. And because the caregiver and care recipient attend to different aspects of the experience of illness, Toombs maintains that they focus on a different “reality” of illness (Toombs 1987, 222; Molas 2020, 33-34).⁹⁴ As I argued earlier, since therapists are often trained in understanding medical facts only, they sometimes fail to appreciate the uniqueness which manifests in the subjective or lived experience of the illness for that individual. But in order to make it possible for establishing a shared world of meaning between both parties, it is crucial that therapists temporarily set aside their interpretation of illness in terms of “theoretical disease constructs” so that they can focus on what the other person considers valuable and fundamentally meaningful *to them* (Toombs 1987, 229; Molas 2020, 34).

Focusing on what the other person considers to be valuable for them requires shifting the preconceived notions of illness into an attitude that is more open-minded and receptive to different ways of being in the world. This shift towards exploring mental illness in a different manner is evidenced in some of the works of the pioneering figures in the anti-psychiatry

⁹⁴ For further discussion of Toombs, see Molas (2020).

movement, such as R.D. Laing. For Laing (1969), engaging with people with schizophrenia should be based on the three core values of (1) *compassion*, in terms of recognizing that the person is suffering; (2) *respect*, in terms of acknowledging the person and not discrediting her experiences; and (3) *empathy*, in terms of trying to understand their experiences.⁹⁵

With these core values in mind, Laing maintains that to better understand the experiences of people with schizophrenia, the role of the therapist is to “enter into” the “strange world” of the other person and “share it with him” and, by doing so, the therapist becomes engrossed in how the other situates himself in the world (Laing cited in Matthews 2007, 317-318). For humanistic psychologist Carl Rogers (1975), entering another person’s world of experience involves:

being sensitive...to the changing felt meanings, which flow in this person...It means temporarily living in his/her life...*without making judgments*, sensing meanings of which he/she is scarcely aware...To be with another in this way means that...*you lay aside the views and values you hold for yourself* in order to enter another world *without prejudice* (Rogers 1975, 4, emphasis added).

Echoing the three stages of Stein’s theory of sensual empathy, the purpose of understanding another person in this manner is to acknowledge that, as a “visitor” to this person’s “world,” their world ought to be treated with a basic level of respect.⁹⁶ Most importantly, accessing the phenomenological worlds of others requires suspending assumptions about their experiences. It is important for therapists and caregivers to be receptive to the lived experience of illness and to try to enter these “worlds” with the other person to bridge the epistemic gap between them. And through engaging with first-person narratives, especially, therapists and caregivers can gain deeper insight into what the other person is experiencing by embracing this more holistic approach by witnessing how that person describes that experience directly.

⁹⁵ Note that the values underlying Laing’s approach bears many similarities with Stein’s phenomenological approach for empathizing with others.

⁹⁶ This approach shares similarities to Lugones’ concept of ‘world-travelling.’ I have discussed the possibility of world-travelling as a conceptual framework to help minimize stigma surrounding mental illness. See Molas (2018a).

Although this attempt at “world-traveling” (to borrow a concept used by Lugones), seems like a good way to begin the process empathizing with the experiences of others, as Spitz (2003) notes, bridging the gap between worlds can be “hazardous” because it is easy to jump to conclusions that we truly *understand* what another person is experiencing (Spitz 2003, 234; Molas 2018a, 733).⁹⁷ To that end, Parnas et al. (2013) maintain that for a caregiver to gain access to the world of her care recipient, it is important to suspend the “standard presuppositions” of the “shared, common-sense world” and critically reflect on these assumptions to open up space for others to describe their own lived worlds of experience (Parnas et al. 2013, 276).

Furthermore, I agree with Potter (2003) who maintains that meaningful engagement with persons with schizophrenia requires letting go of many preconceived ideas we have *about* mental illness (Potter 2003, 216). As indicated throughout this dissertation, these preconceived ideas include the belief that persons with a diagnosis of schizophrenia are dangerous and violent; that persons with a diagnosis of schizophrenia do not respond well to treatment; that persons with a diagnosis of schizophrenia are unable to recover once they have been diagnosed with this condition; and that persons with schizophrenia, once diagnosed, are limited in their cognitive functions and capacities for the rest of their lives. The ability to suspend judgement and quarantine these kinds of negative ideas about schizophrenia is important not only for Stein’s theory of empathy to emerge and be successful. But it also plays a role in overcoming stigma and challenging master narratives which depict persons with mental illness in negative and limiting ways. And of the two models of medicine discussed in this analysis, NBM can aid in shifting these harmful preconceived notions whereas EBM may not necessarily be able to do so.

⁹⁷ As I argued in previous chapters, Stein’s theory of empathy prevents jumping to this conclusion whereas simulation theory can potentially perpetuate it.

3.5 Advocating Reciprocity in Therapy

The fifth and final benefit that NBM has over EBM is that it advocates for the importance of reciprocity in therapeutic relationships (Zaharias 2018b, 290). Given the asymmetrical nature of the patient-caregiver relationship exemplified through the standard EBM framework, therapists are perceived to be in a position of epistemic authority because they know the medical facts of the illness in question. By contrast, the insight that emerges from a person's narrative can bridge the gap between them because the story serves as a ground on which individuals meet in "*mutual knowing*" (Frank 1998, 199). This sense of mutual knowing is a central feature of reciprocity.

Reciprocity plays an important role in guiding caring relationships between individuals. Pelto-Piri et al. (2013) maintain that one of the core values of reciprocity in the therapeutic context is its commitment to mutual respect and co-operation between caregivers and care recipients. According to Sandhu et al. (2015), reciprocity involves the presence of shared exchanges where caregivers and care recipients remain "engaged in the interaction" with an "awareness of the other" while meeting their own personal needs (Sandhu et al. 2015, 463; Molas 2018b, 57). In therapeutic relationships, reciprocity allows care recipients to feel acknowledged by caregivers and allows them to rebuild their self-esteem that has been denied to them (Brier and Strauss 1984, 954).⁹⁸ As Charon notes, reciprocity allows both parties to share in being "fundamentally transformed in the process of care" (Charon 2014, 21). Staeheli et al. (2004) discuss the importance of reciprocity in relationships and their impact on the person's journey to recovery. Unlike the typical relationship between caregiver and care recipient, the

⁹⁸ Moreover, Buunk and Schaufeli (1999) note how a lack of reciprocity can lead to increased emotional burnout, a sense of depersonalization in the caregiver, and a decrease in the caregiver's sense of personal accomplishment in the workplace (Buunk and Schaufeli 1999, 277). I return to this objection in the next chapter.

exploration of the relationships between persons with mental illness and how they can support and care for *each other* is also important (Staeheli et al. 2004, 237).⁹⁹

Recall that, due largely to the effects of stigma, many people diagnosed with mental illness lack meaningful relationships with others and it often leads to social isolation. But while reciprocity can be achieved between caregivers and care recipients, one of the advantages of the recovery model of care is that it also emphasizes peer-support and other options to help facilitate interpersonal engagement with others. The ability to openly connect with another person and disclose what they are experiencing, without judgement, plays a significant role in their recovery as it allows people to be recognized and this contributes to their sense of belonging in the world. For this reason, and the numerous reasons discussed above, NBM—as a potential alternative to EBM in this specific area of mental healthcare—has the potential for reconfiguring and improving therapeutic relationships for the benefit of persons living with schizophrenia.

4. Conclusion

Although it is difficult to alter stigmatizing attitudes, especially if they have been informed by stereotypes and reinforced by master narratives, one aim of this chapter and the previous chapter has been to demonstrate that it is not impossible to change them. As indicated above, master narratives are morally problematic because they are socially constructed narratives that influence our beliefs *about* persons with schizophrenia and constitute their identities in a passive way. But the strength and transformative impact of counterstories and personal narratives (which can also be referred to as ‘recovery narratives’) is that these identities are actively created *by* persons with

⁹⁹ To that end, rather than attempting to add further distance between “patient” and therapist” as per the standard approach to psychiatric treatment, Caplan maintains that some of the most effective work being done within the mental healthcare system is based “on the strengths of the therapist-patient relationship” and on the “judgments, feelings, and intuitions of each party” in this therapeutic relationship (Caplan 1995, 17).

schizophrenia and can directly challenge these oppressive viewpoints by transforming the preconceptions of what it means to live with this diagnosis.

Whereas I maintain that stigma and certain master narratives are *harmful* and can *dehumanize* people living with schizophrenia, counterstories and personal narratives are *beneficial* and can *humanize* the person and can be used by caregivers to connect with them and to learn about their experiences (Molas 2020, 40). Precisely because they emphasize the person's strengths, capabilities, positive attributes, and reveal the *person* behind the diagnostic label, counterstories and personal recovery narratives have the potential to change the conversation of what it means to live with mental illness and can serve as a powerful tool for dismantling harmful master narratives by giving voice to those in historically marginalized groups in society.

Stories are a vehicle for empathy that allows people to connect for the purposes of learning more about each other's experiences. Although they are not the only way to establish connections between individuals, the importance of actively engaging with someone and their narrative is to examine how that person navigates their world and to explore what *they* can teach us about their life experiences. Moreover, the principles put forward by narrative-based medicine and the recovery model of care helps people discover the meaning embedded in their experiences. As I argued in Chapter 3, Stein's theory of empathy allows caregivers to gain access to and understand another person's experiences in ways which do not co-opt their experiences. Through applications of both the principles of narrative-based medicine and Stein's theory of sensual empathy, caregivers can gain insight into the lived realities of schizophrenia and can use that knowledge for improving practices of care and supporting people in their recovery.

General Conclusion

This final chapter serves as a critical reflection on the aims of this project and highlights its contributions to this scholarly discourse. It offers a brief summary of the main arguments articulated in the preceding chapters and highlights the research contributions that have emerged from this analysis. This chapter also highlights some clarifications and limitations of the analysis and concludes by offering some future research objectives to pursue.

1. Summary of Research Objectives and Arguments

This dissertation set out to achieve three main objectives. First, I demonstrated how Stein's phenomenological account of empathy can offer a response to Jaspers' claim that it is impossible to empathize with persons with schizophrenia and I defended Stein's theory as an alternative to simulation theory. Secondly, I argued for the importance of narrative as a legitimate source of knowledge and argued for the advantages of narrative-based medicine. Finally, I explored how Stein's theory of empathy and narrative-based medicine can be applied to a mental healthcare context to help improve therapeutic relationships and help reduce the stigma of schizophrenia.

To achieve these objectives, in Chapter 1, I traced the history of the concept of schizophrenia and explored the influence of Kraepelin, Bleuler, and Jaspers in highlighting the problem of empathy that served as the motivation for this project. I then articulated Jaspers' endorsement of empathy and phenomenology as epistemic tools for understanding the mental phenomena of persons with mental disorders but highlighted the limitations of Jaspers' theory in regard to empathizing with persons who have been diagnosed with schizophrenia.

To address the limitations of Jaspers' position, in Chapter 2, I examined simulation theory as a viable theory of empathy. Despite the numerous benefits found within the simulation

theories of Goldman, Heal, and Gordon for understanding the experiences of others, several objections against simulation theory were raised that proved particularly problematic within a therapeutic context. Specifically, I highlighted the worry about the conflation of subjective experiences between ourselves and others and pushed back against the implicit assumption that it is possible to fully recreate another person's emotional and mental experiences within ourselves.

In response to the limitations of simulation theory, Chapter 3 and Chapter 4 defended Stein's phenomenological theory of sensual empathy and demonstrated its advantages over simulation. The key distinction and advantage, I argued, is that Stein's theory preserves the distinction between the self and the other. As a result, Stein's theory overcomes the objection of co-opting the experiences of others and substituting one's own (which is best exemplified through the "*I know just how you feel*" theories of empathy). Moreover, contrary to Jaspers, I demonstrated how Stein's conception of empathy leaves open the possibility of empathizing with persons with schizophrenia on a basic level. And, more pressingly for this topic, I demonstrated the numerous benefits Stein's theory has for its applications in therapeutic contexts.

In Chapter 5, I explored the significance of personal narratives and highlighted the ways that narratives can help facilitate Stein's theory of empathy. I examined first-hand narrative accounts of persons living with schizophrenia and defended the importance of narrative as a meaningful source of epistemic knowledge that offers valuable insights in reconfiguring therapeutic relationships for the purposes of minimizing stigma and challenging master narratives that contribute to the marginalization of persons diagnosed with schizophrenia.

Finally, Chapter 6 defended the importance of narratives and narrative-based medicine as an alternative to traditional approaches to therapy. Narrative-based medicine offers a novel response to traditional approaches to psychiatric care. In addition, I argued how Stein's theory of

empathy can help facilitate practices of narrative-based medicine to achieve the goal of improving therapeutic relationships between caregivers and care recipients.

2. Research Contributions and Practical Implications

To summarize the research contributions and practical implications of this dissertation, I first offered a critique of simulation theory as a theory of empathy and argued for the importance of phenomenology, empathy, and narrative as a way to make sense of the experiences of others.

Secondly, I explored Stein's theory of empathy and examined its applications and therapeutic potential in the area of mental healthcare. Precisely because the early historical explorations of empathy—particularly from a phenomenological perspective within the tradition of Husserl and other phenomenologists—focused on describing the theoretical and epistemological aspects of what it means to empathize in the abstract, Stein did not focus extensively on how empathy can be used in practice. To address this gap in the literature, I offered some preliminary applications of her theory of empathy in the context of mental healthcare. Applications of Stein's theory into practice is relatively new, so further exploration into precisely how her account can be implemented contributes to this expanding discourse.

Finally, I demonstrated the usefulness of Stein's theory of empathy within the broader framework of narrative-based medicine. Since Stein's theory involves an engagement with the experiences of others in a non-primordial manner, and since the personal narratives of persons diagnosed with schizophrenia offer insight into their lived experience with this condition, her theory of empathy can help bridge the gap between caregivers and care recipients to help improve these relationships. Moreover, as a consequence of empathizing with a person's narrative, I argued that this approach can help contribute to the goal of minimizing stigma.

3. Limitations and Reflections on the Analysis

Despite the contributions to this scholarly discourse, this section outlines some limitations and offers a critical reflection on my analysis throughout this dissertation.

3.1 The Nature of Autobiographical Reflection

The first limitation relates to the nature of autobiographical reflection. It is important for the reader to recognize that, for the most part, the narratives showcased throughout this dissertation are narratives written *after* these individuals have “recovered” from their diagnosis of schizophrenia. Due to the nature of reflection—and the temporal distance between these authors and their first-hand experiences of their symptoms of schizophrenia and their experiences of receiving psychiatric care—the narrative framework through which these accounts are presented is qualitatively distinct from the stories that persons experiencing symptoms of schizophrenia *in the moment* might articulate.

Whereas written narratives can be edited and restructured to perfectly capture the meaning of the author’s first-hand experiences, the verbal narratives of some individuals diagnosed with schizophrenia, retrieved from diagnostic interviews with psychiatrists, may be incoherent, fragmented, and difficult to follow. Nonetheless, as I have argued, this does not (and should not) discredit the value or usefulness of these narratives as an educational resource for caregivers and anyone else interested in understanding how schizophrenia can impact someone’s life (Molas 2020, 35-36). The narratives presented here are more like literary texts and are designed to be accessible to readers who want to learn about “what it is like” to live with schizophrenia and to get a sense of what it is like to be on the receiving end of stigma. And, on

that point, the narratives portrayed do a good job demonstrating the effects and reveal insights into how persons with mental illness are treated and viewed by some healthcare professionals.

3.2 Recognizing the Limits of Empathy to Avoid Romanticizing Care

Secondly, while there is an underlying element of care which has motivated my interest in this area and how it can be explored from a philosophical perspective, it is important to acknowledge that sometimes care, on its own, is insufficient to address broader systemic issues related to the treatment of persons with mental illness. Although the goal of defending the applications of Stein's phenomenological account of empathy is to find ways for caregivers to better support people in their recovery, it is crucial to avoid romanticizing how beneficial care and empathy are in this process without undermining the severity of their condition.

Despite efforts to defend a phenomenological account of empathy as being beneficial in a therapeutic setting, I noted in previous chapters that there may be instances where it is impossible to *fully* empathize with persons diagnosed with schizophrenia. Depending on the severity of one's symptoms (e.g., those with catatonia who are unresponsive and non-communicative), there are instances where efforts to empathize fall short. This reality is not due to a lack of effort on the part of the caregiver or as a result of some failing on the part of the care recipient. Sometimes there are barriers to knowledge that prevent one from fully understanding another person. But this challenge is faced by all competing theories of empathy and is not specifically reserved for Stein's phenomenological account. The advantage of Stein's approach, however, is that it recognizes that the capacity for empathy, on a basic level, *is still there* in virtue of the shared structure of consciousness that makes experience possible. By rejecting universal, one-size-fits-all models of empathy, and by acknowledging that empathic engagement

varies in degrees, caregivers can work with those diagnosed with schizophrenia to support them in ways which are relevant to each person. As psychiatrist Matthew Dumont notes:

To be mentally ill is to feel one's membership in society up for question. It is to be *marginal, deviant*. A mental health clinic cannot be expected to function as a model of utopia, but it can at *least try to minimize* the forces of alienation...of a society that is endlessly exclusive. These are not the technical issues of psychotherapy or medical management; they are *human* ones (quoted in Caplan 1995, 52, emphasis added).

Caregivers should *try* to empathize with their care recipients, as best they can, even if it does not produce immediate results. Empathic engagement is a lengthy process that requires a gradual development in the rapport between caregiver and care recipient. Despite the difficulties that may arise which impede a caregiver's ability to fully empathize with her care recipients, many first-hand narrative accounts reveal that caregivers who failed to give up on these individuals during difficult periods have a significant impact on those individuals' path to recovery.

Empathy is not a catch-all term and I do not intend for my application of Stein's theory of sensual empathy to be capable of doing everything in this area of investigation. But what it *is* capable of doing it does very well. As a means of preserving the distinction between self and other, as a way to support narrative-based medicine and help caregivers to be more receptive to those under their care, and as a way of facilitating meaningful engagement to support people in their recovery, Stein's theory of empathy is promising in the area of mental health care.

4. Future Considerations

This penultimate section highlights future considerations to explore that emerge from this doctoral research and addresses several real-world applications that emerge from this theoretical discussion.

4.1 Assessing Applications of Steinian Empathy and NBM in Real Time

First, although the focus of this dissertation was on exploring written narratives authored by persons with schizophrenia, examining how applications of Stein's theory of empathy can be used *in the moment* to help support persons with schizophrenia in a clinical setting is one area I wish to explore in greater detail. While the narrative accounts highlighted in this research have been written by people retrospectively, and while these retrospective narratives paint a vivid picture of what living with schizophrenia is like, exploring a verbal or dialogical narrative in the moment can help gauge the effectiveness of Stein's theory of empathy and NBM in practice.

4.2 Outlining Ethical Guidelines for Training Caregivers

Similarly, a second consideration worth exploring are the specific guidelines for adopting and implementing both Stein's theory of empathy and NBM into practices of psychiatry and other related areas of mental healthcare. In particular, I would like to explore precisely how training caregivers to practice empathy in a morally appropriate manner can help improve patient-caregiver relationships in ways that other theories of empathy may fall short. As I noted in Chapter 4, the majority of the objections raised against empathy are geared towards "*I know just how you feel*" theories which have the tendency of conflating the experiences of others into oneself. But given her reconceptualization of what empathy entails, I want to determine if Stein's theory is more amenable to be a teachable skill that can be added to a caregiver's repertoire.

4.3 Analyzing the Role of Care Recipients in Therapeutic Exchanges

While this dissertation focused primarily on how *caregivers* can develop empathy in order to better connect with individuals under their care, given that Stein's theory of empathy is a joint

process, exploring the responsibilities that *care recipients* have in actively reconfiguring therapeutic relationships is a third consideration that warrants attention. Especially since one of the objections against empathy is that it can lead to emotional distress or burnout on the part of the caregiver, exploring further the element of reciprocity between caregivers and care recipients can reveal strategies to help alleviate the emotional toll placed on healthcare workers in an already stressful work environment. As noted previously, a large portion of the recovery literature focuses on autonomy, agency, and personal responsibility as being vital for restoring a sense of self that has been impacted due to the presence of illness and traditional psychiatric treatments. Given that recovery is a collaborative goal that requires the full effort of both caregiver and care recipient, exploring the normative ethical components of what a “caring patient” looks like is a natural extension of this dissertation.

4.4 Examining the Long-Term Effects of Narrative-Based Medicine

Fourth, although NBM has been used in the treatment of other medical conditions such as cancer (Rosti 2017), there may be unique challenges and opportunities that are afforded by psychiatric care, specifically, that warrant further exploration. To measure the effectiveness of NBM in psychiatric care, it would be helpful to conduct qualitative interviews with both current and former psychiatric consumers—who have received treatment under both EBM and NBM models—to rate their first-hand experiences with these treatment models and see if NBM led to improved outcomes for those mental health consumers directly. Engaging with this direct feedback can help further refine practices of NBM and can be used as a pedagogical tool to prepare caregivers in the implementation of the principles of NBM in practice.

4.5 Applying Stein's Theory of Empathy to Other Mental Health Challenges

The focus of this dissertation was on the topic of schizophrenia primarily because it remains one of the most stigmatized mental disorders. Furthermore, given the lineage of theorists such as Kraepelin, Bleuler, and Jaspers, the topic of schizophrenia raises some important points about the scope of empathy as well as the potential limitations of empathic engagement.

However, a fifth future consideration I wish to examine is the applications of empathy and NBM to address other mental illnesses including: depression, anxiety, borderline personality disorder (BPD), dissociative identity disorder (DID), body dysmorphia, obsessive-compulsive disorder (OCD), and dementia. Similar to the insights revealed from the personal narratives of schizophrenia, examining the personal narratives of individuals living with any of these conditions would, I argue, offer valuable insights into how therapists and caregivers can better engage individuals living with these conditions. And while it could be argued that these other types of conditions may not be *as* stigmatized as “schizophrenia,” nevertheless it is still worthwhile to critically examine the impact of empathy and NBM on treating these groups of people to determine how broadly Stein's theory can be applied in this area.

4.6 Exploring Policy Implications of Stein's Approach

Finally, I am interested in exploring the policy implications of adopting conceptual frameworks such as NBM and Stein's approach to empathy. Given the collaborative aspect of NBM, and the underlying principles of the recovery model of care that places great importance of including persons with mental illness in the structuring of therapy, exploring the application of these models to reconfigure current practices of mental health care can inform policy procedures on how practices of care in the mental health sector can be modified accordingly.

5. Closing Remarks

Returning to the initial problem of empathy emerging from Jaspers, one implication of holding the belief that it is impossible to empathize with people diagnosed with schizophrenia is that the tendency for this group to be marginalized, stigmatized, and *othered* by dominant social groups increases. Given that the effect of stigma blurs the public's perception of people living with mental illnesses, it is important to pay greater attention to the particularity of persons living with a diagnosis of schizophrenia and their experiences. Overcoming the epistemological problem of our knowledge of others' experiences requires recognizing the importance of engaging with others through a process which allows others the opportunity to share their stories. This process requires a degree of sensitivity and a willingness to engage with the other in a respectful, caring manner. I maintain that this can be achieved, in part, by adopting Stein's phenomenological account of empathy and recognizing the limits of our understanding of the experiences of others.

As I have argued throughout this dissertation, engaging with personal narratives is one way of dispelling the stereotypes about schizophrenia that create separation and reinforce stigma. By revising master narratives which portray people with schizophrenia as occupying phenomenologically inaccessible worlds that defy empathy, my sincerest hope is that this analysis can extend beyond the clinical setting to transform the image of schizophrenia and address public misconceptions about mental illness. Prolonged and sustained interaction will allow caregivers to better understand people with schizophrenia. And if learning more about the person's narrative history can help shift the negative perceptions of people diagnosed with mental illness, then the goal should be actively trying to engage with people with schizophrenia on their own terms and do our best to understand them. Adopting Stein's theory of empathy and the framework of narrative-based medicine can be one step in helping to achieve this aim.

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