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Reflections on Mental Health Stigma, Narrative, and the Lived Experience of Schizophrenia

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Abstract: I offer a preliminary examination on the importance of narrative for helping to overcome the issue of stigma surrounding mental illness, specifically schizophrenia. I maintain that engaging with first-person accounts of schizophrenia allows caregivers, and the broader general public, to better understand the phenomenological lived experiences of persons living with this mental health challenge and to better understand the experience of dealing with stigma. In doing so, I maintain that both caregivers and the public can begin developing more accepting views of schizophrenia and begin to support those who need it the most.

Key words: stigma, schizophrenia, narrative, phenomenology, lived experience

1. Introduction

The aim of this paper is to offer a preliminary examination on the importance of narrative for helping to overcome the issue of stigma surrounding mental illness. I begin by discussing what narrative is and why narratives are important for authoring our own stories. I then discuss some potential reasons why the narratives of people with schizophrenia are often dismissed and I maintain that this is due in large part to the damaging effects of stigma. Shifting the negative and harmful impact of stigma surrounding mental illness and changing the public's perception of mental health challenges in a more positive manner, requires efforts to raise awareness about the realities of living with these diagnoses. To achieve this aim, not only do I draw on patient narrative accounts to underscore the effects of stigma, but I also draw on Husserl's phenomenological approach and Toombs' notion of "attentional focus" as means to view mental illness in a different way. By engaging directly with the lived experience of mental illness, and by engaging with the narratives which underscore the damaging impact that stigma has, I maintain that the public can begin developing more accepting views of schizophrenia and begin to support those who need it the most.

2. Why are the narratives of people with schizophrenia dismissed?

Narratives are stories and autobiographies, or first-person reflections authored by the individual, are one of the most common types of story. According to the *Schizophrenia Bulletin*, first-person narrative accounts are construed as follows:

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*).

Narratives tell, and retell, the histories and the stories of individuals. Narratives highlight the ways in which subjective experiences influence, transform, and shape the person in profound ways. The ability to narrate is something that we are all capable of doing. We all have experiences that have shaped the persons we currently are and, undoubtedly, we all have a story to tell. Why is it that the narratives of persons living with certain mental health conditions, such as schizophrenia, are treated differently, however? Why are *their* narratives undermined, discredited, viewed with suspicion, and fail to be given the proper uptake? Part of the reason stems from how schizophrenia has historically been characterized, typified, and how it is currently understood.

One of the reasons why the narratives of people with schizophrenia are dismissed stems from the historical understanding of this condition. According to Northoff (2015), early psychiatrists assumed that the “abnormality of the self” is a key feature of schizophrenia. Tracing the early historical descriptions of this mental illness, he explains that prominent psychiatrists, such as Emil Kraepelin in 1913, characterized schizophrenia as “the peculiar destruction of the inner coherence of the personality...[with a] disunity of consciousness” (an “orchestra without

conductor”); Eugen Bleuler, who in 1911 described schizophrenia as a “disorder of the personality by splitting, dissociation...[where the] I is never completely intact,” and Karl Jaspers, who claimed that the central factors underlying schizophrenia are “incoherence, dissociation, [and a] fragmenting of consciousness...” (Northoff 2015, 85).

Currently, schizophrenia is characterised as a disease that results in a “fragmentation” and “disruption” of experience (Ratcliffe 2012, 486-487). Northoff discusses the sense of self that is disrupted in patients with schizophrenia and maintains that there is the presence of a “disturbed ipseity” in which there is a kind of a dissociation in a person with schizophrenia, the feeling that their experiences are not their own but are being had by someone else (Northoff 2015, 85-86). The denial of having schizophrenia, or a lack of awareness of its symptoms, is also considered to be a key aspect of this condition (Roe and Davidson 2005; Roe and Kravetz 2003; Davidson and Solomon 2010, 93). This denial can present itself in two ways. First, persons with schizophrenia may steadfastly maintain that there is nothing wrong with them and may explain certain behaviours or beliefs as simply part of who they are as individuals. Second, this denial can also be viewed as a rejection of the diagnostic label “schizophrenia” or “schizophrenic” precisely because of the stigma associated with this label, which I discuss below.

The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) notes that the possession of a sense of individuality and self-direction that is typically present in a “normal person” is something that is “frequently disturbed” in patients with schizophrenia (APA 2013; Roe and Davidson 2005, 89). The prevailing clinical view of schizophrenia suggests that patients living with this condition have “lost their sense of self” because it has become fragmented due to this disorder and, consequently, that they have a “diminished capacity” to create “coherent narratives” about their own lives (Roe and Davidson

2005, 89). The side effect of characterizing schizophrenia as a disease which impacts one's sense of self and identity is the idea that people with schizophrenia are incapable of providing accurate and complete narrative accounts about their own lives. They are unable to do so, according to some theorists, precisely because their sense of self and personal identity is disrupted and distorted (Roe and Davidson 2005, 89). As diagnostic tools, such as the DSM, gained more prominence as way of diagnosing mental disorders, psychiatrists were taught that patients' self-reports of their symptoms and other experiences should be "discounted" and that the role of the therapist is to "dig beneath" these self-reports in order to reach "the real truth" (Andreasen 2007, 110; Barker *et al.* 2001, 200). These attitudes about schizophrenia reinforced the notion that it is an illness that cannot be understood, that people with schizophrenia are completely unknowable and unable to be engaged with, and that the person with schizophrenia is incapable of accurately authoring her own story.

Another reason why the narratives of people living with schizophrenia are likely to be silenced and dismissed is due to the negative and harmful effects of stigma.² Stigma is a label placed on persons, ideas, or activities which society collectively deems to be undesirable. Stigma indicates a mark of difference which causes separations among individuals and groups of people, and one predominant way stigma is manifested is through stereotypes. Stereotypes are social phenomena which colour, taint, and distort the ways in which people who fall under the diagnostic label of "schizophrenic" are perceived.³ Stereotypes are a way to quickly generate ideas and expectations for individuals who are grouped together under this term "schizophrenic." Without recognizing it, stereotypes form the ways in which we view individuals who fall under the stereotyped label. Even though we may discover that the generalizations attached to a specific stereotype are false, it could be argued that those false beliefs represented what mental health

experts, and others involved in the treatment of patients with this condition, thought they knew at the time and, perhaps, with imperfect or incomplete knowledge of this particular condition. I think both experts and non-experts have contributed to the creation and perpetuation of the stereotype of “schizophrenia.” For example, the depictions of persons with mental illness, particularly in media and film and entertainment, have helped generate this idea of someone who is completely unstable, violent, and aggressive. Yet the likelihood of persons with schizophrenia to be victimized is significantly greater than being the aggressors themselves. If early psychiatrists depicted them as lost causes, and the non-experts continued to perpetuate that stereotype in public discourse, then the false beliefs were buttressed by both professionals and non-professionals alike.

The problem with stereotypes is that they generalize and do not pay attention to individuals. Stereotypes are difficult to overcome because they are often so engrained within a society’s system of belief that they prevent us from engaging with others because barriers have been set up which separate “us” from “them.” By denying people the ability to provide a narrative account of their life, or by immediately casting doubt on the validity of their narrative precisely because they are “schizophrenic,” we are effectively stating that their experiences do not matter. The problem with stigma and the preconceived notions we have about persons living with mental illness is that it prevents people from recognizing and acknowledging the *persons* behind the illness. How, then, can we shift these harmful attitudes surrounding mental illness and how can we engage more caringly with these narratives? One potential answer lies in Husserlian phenomenology and the *epoché*.

3. How phenomenology can help shift these stigmatizing attitudes

Before discussing how applications of phenomenology can begin to shift the ways in which caregivers can support persons with schizophrenia, it is helpful to highlight some of the features

of Husserl's phenomenological approach. For Husserl (1977) phenomenology is a method which allows us to identify phenomena and to identify the essential qualities of those phenomena which exist in the world. This world, for Husserl, is a shared world of experiences and possibility. We, as human beings, are embodied, minded, and embedded within the world and we perceive the external world through acts of consciousness. Husserl's phenomenological method focuses on how individuals experience the world and a core feature of his phenomenological approach is to see things in neutral terms, to view them without prejudice, and to describe the essential features of the perceived phenomena (Langenbach 1995, 213).

One key feature of Husserl's analysis that is helpful for understanding this topic of stigma is his discussion of the natural attitude. According to Husserl, the natural attitude is the background set of assumptions and ideas that are taken for granted, including the idea that the world exists independently of our experiences of it. The natural attitude sets up expectations of how to make sense of the world and our perception of the objective world is mediated through this lens. For Husserl, we do not reflect on the fact that the objective world and reality we perceive are often taken for granted and we accept things without critically reflecting on them. Addressing the topic of stigma requires us to shift away from the stereotypes and preconceptions of schizophrenia that have been transmitted to us, via the natural attitude, and to approach and view persons with schizophrenia in a new and different light. One way to get at the essence of experience is by performing the *epoché* (Husserl 1977, §7, §8).

Through the *epoché*, Husserl advocates a total suspension or bracketing of the natural attitude. What emerges from this phenomenological reduction is a "sustained *attitudinal shift*" that allows us to "scrutinize more usually presupposed aspects of experience without distorting them in the process..." (Ratcliffe 2015, 20 emphasis mine). Englander (2016) maintains that through this

process, we abandon our “common sense understanding of reality as consisting of objects and their causal underpinnings” and instead adopt an appreciation of reality “as consisting of the acts of experiencing itself” (Englander 2016, 5). Consequently, we shift our focus away from concern with whether the objects experienced by the other person exist (i.e., delusions, hallucinations) to “the experiencing of these objects in consciousness” (Davidson and Cosgrove 1991, 93; Englander 2016, 5).

This approach is helpful in guiding interactions between psychiatrists and patients by allowing the psychiatrist to treat the patient’s anomalous experiences like any other type of perceived phenomena. As a starting point, it is important to respect the experiences of others as they experience them. Initially, we should not be concerned with the truth or reality of their reports of their experiences. Even if there is an awareness on the part of the caregiver that the patient is deluded, and even if the patient herself acknowledges that she is currently experiencing delusional phenomena within the scope of her perceptual awareness, engaging with people living with schizophrenia should begin by understanding that they are experiencing the world and that their experiences, even as delusions or hallucinations, are still *experiences*. People are experts on their own lived experiences and therapists should not impose their own meaning on these experiences. By using the *epoché* to suspend judgement and view their experiences *as experiences*, we can begin to transform the way mental illness is viewed and understood.

Why is Husserl’s phenomenological account appropriate for achieving this task? For Mohanty (1985), Husserl’s phenomenological approach can be understood as a phenomenology of *respect* which stands in contrast to what Mohanty calls a phenomenology of *suspicion*. A phenomenology of suspicion involves a questioning of the legitimacy of the other person’s subjective experiences. For example, when it comes to engaging with persons living with

schizophrenia, an attitude of suspicion could consist of undermining patients' narrative accounts, dismissing their testimony, speaking on behalf of patients and interpreting their experiences for them, or doing anything which attempts to silence and discredit patients' voices. In a pre-judgmental way, we would dismiss their narratives as 'crazy', 'incoherent', 'ludicrous,' 'ridiculous', 'unreal', and, quite simply, 'schizophrenic.' The impact of responding in these ways reinforces the belief that their beliefs and experiences do not matter, that their narratives do not matter and, indeed, that they do not matter.

By contrast, a phenomenology of respect involves trying to engage with the other persons' experiences on their own terms. Rather than simply writing them off as incoherent or nonsensical, adopting this respectful approach can allow a therapist or caregiver the opportunity to try to understand patients' subjective experiences (Davidson 2004, 154). This may very well involve a novel kind of dialogical exchange between patient and therapist. Although I do not go into detail here, the kind of dialogue that would be invoked is similar to the dialogue found in narrative approaches to medicine.⁴ In narrative approaches to medicine, patients and caregivers work collaboratively in order to realize a fuller picture of patients' narrative lives and their experiences of living with illness. Several theorists who adopt a narrative approach to medicine view the opportunity to share stories as being helpful for patients to make sense of, and understand, their experiences and to foster relationships between patients and caregivers that are more reciprocal between both parties. Respecting patients' experiences involves "taking them in their own terms to be precisely what they present themselves to be, in the ways in which they present themselves in patient[s'] own conscious awareness" (Davidson 2004, 155). Regardless of the truth of the delusion, it is important to treat it as an experience experienced by someone else. As an experience experienced by someone, it ought to be treated with the same basic respect that non-delusional

thoughts and beliefs are accorded. This is not to say that the fact that the delusion is happening should be ignored. In fact, some patients have reported being fully aware that they are having a delusional experience. The issue is when the presence of a delusion, within the broader scope of the patient's experience, is taken to discredit or undermine the legitimacy of whatever it is the patient is experiencing. In other words, it is important to avoid immediately reading the presence of a delusion as a sign that the remainder of the patient's narrative report should be discounted.

Husserl's phenomenological approach is more receptive to different possibilities, and can accommodate engagement with persons living with schizophrenia. Rather than viewing their condition as something which is defective or deficient, it presents an opportunity to learn more about their experiences of the world. Learning more about their experiences of the world is our responsibility. Moreover, there is a responsibility to help persons living with schizophrenia acquire new attitudes about delusional beliefs and values. One way we can do so is by remaining open-minded towards these people and to receive their experiences through mutual dialogue. Nurturing a respectful dialogue and emphasizing a collaborative exploration *with* patients as they navigate their experiences can help in supporting them through these difficult periods. By suspending preconceived notions of schizophrenia, I maintain that an application of phenomenology can help shift the harmful attitudes and stigma surrounding this condition.

4. An application of phenomenology to help shift harmful attitudes

The ways in which illness is understood and approached vary between patient and professional. According to Toombs (1987), who argues for a phenomenological account of understanding in order to reveal important insights that govern the relationship between patients and caregivers,⁵ there exists two distinct "realities" between patient and therapist and each reality is determined by the *attentional focus* of the subject. While doctors are trained in understanding

the medical facts of an illness or disorder, they may fail to appreciate the uniqueness which manifests in each individual patient and that person's subjective experiences *of* the illness, or what we call the *lived experience* of the illness. Since no two patients will have identical experiences of their diagnosis of schizophrenia, the onus on caregivers is to be receptive to the variety of the lived experience of illness and to make more of an effort to enter into these phenomenological "worlds" *with* the patient in order to bridge the gap between the experiences of the caregiver and those of the patient. While some theorists contend that persons with schizophrenia inhabit a phenomenologically alien or peculiar "world," Husserl is more receptive to the idea that we can bridge that gap through recognition of the fact that individuals can co-exist and unite in a community of intersubjective relationships.

Although individuals perceive the world differently, based on their unique temporal and historical positions, Husserl claims that the two worlds that are experienced by two different people are necessarily "*surrounding worlds*" belonging to these two intersubjectivities and these surrounding worlds are "mere aspects of a single Objective world, which is common to them. For indeed the two intersubjectivities *are not absolutely isolated*" (Husserl 1977, §60). We are not living in our own separate worlds where communication between individuals is impossible. Rather, we belong to the same external world and this world is objectively out there to be perceived. The only variations occur based on our perceptions of the world. Despite these variations which exist in the scope of our ability to perceive and experience the external world, we share more in common than meets the eye. In order to make it possible to establish a shared world of meaning between a therapist and patient, Toombs argues that the therapist must "temporarily set aside his interpretation of illness" in terms of "theoretical disease constructs" so that he can focus on the essential or eidetic characteristics of the lived experience that the patient considers

valuable and fundamental (Toombs 1987, 229). In doing so, we shift the focus of our attention to different aspects of schizophrenia, aspects which may be neglected due to the lingering effects of stigma. For example, instead of simply acknowledging that the perception of a loss of wholeness, or a loss of the sense of self, is just another key feature of a diagnosis of schizophrenia, I think Toombs is suggesting that the therapist should investigate further what the loss of wholeness or loss of self *means for the patient*. We can choose to view schizophrenia as a disorder of the self or we can choose to view it in a different way by focusing our attention on other aspects of the person's lived experiences. How can we understand schizophrenia from a patient's perspective? Patient narrative accounts provide an answer.

5. What do mental health narratives reveal about the impact of stigma?

When it comes to engaging with people living with mental health challenges in a respectful and caring manner, Patricia Deegan—a psychiatric survivor and advocate herself—correctly points out the importance of recognizing “the simple yet profound realization that people who have been diagnosed with a mental illness are human beings” (Deegan 1996, 1993).⁶ The problem with stigma is that it has transformed the idea of a ‘mentally ill person’ into someone who is completely alien to us. One of the damaging consequences of stigma and stereotypes is that those living with these harmful labels have their sense of freedom, autonomy, rationality, and decision-making capacities questioned in ways that permit those in positions of authority and privilege to forget that these individuals are human beings who possess these characteristics and capabilities just like anyone else. In fact, one of the underlying themes of Husserl's phenomenological investigations into the nature of consciousness is that, despite differences among individuals on a surface level, the underlying structures of consciousness that allows us to perceive phenomena in the first place remain the same. That said, if we want to gain a better understanding of what it is like to live with

the stigma of schizophrenia, one of the most genuine sources of knowledge we can examine are the narrative accounts of patients living with, or who have recovered from, schizophrenia. The following autobiographical accounts reveal common themes that help better illuminate the effects of stigma and how it impacts the lives of people living with this diagnosis. More importantly, my hope is to reveal the *person* embedded in these narratives.

Although I draw heavily on first-hand narrative accounts to both underscore the lived realities of the stigma associated with this diagnosis (and, as part of my larger project, to demonstrate the potential healing powers of empathetic care and interpersonal engagement), it is important for the reader to recognize that I am showcasing patient narratives which, for the most part, have been written *after* they have “recovered” from their diagnosis. While autobiographical accounts can be written, edited, and re-organized to perfectly capture the author’s first-hand experiences, the utterances and narratives of some patients, retrieved through diagnostic interviews with psychiatrists, may not be as polished, coherent, and easy to follow. Because of the nature of reflection, and the temporal distance these authors have with their experiences of treatment and dealing with their symptoms in the past, these descriptions are more polished and more easily accessible to a reader who is seeking to learn more about “what it is like” to have schizophrenia. Nevertheless, this does not mean that these narratives offer nothing of value or substance for changing how we approach people with mental illness. In particular, the recurring theme of being dismissed by medical authorities, the consistent feeling of being lost and disoriented, and the belief that others will fear them are all themes which provide us with insight into the side effects of the stigma surrounding mental illness. By raising awareness of precisely how our implicit, or explicit, behaviour towards people we perceive to have mental illness impacts them, it may give caregivers

pause to reflect on precisely how we approach others and how we can learn better ways of supporting them.

Janice Jordan (1995) offers her account of what it is like to live with schizophrenia:

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. Your thoughts race and you feel fragmented and so very alone with your 'craziness' (Jordan 1995, 501).

Another example is of Evelyn Smith (1991), who reflects on her daughter Cindy's diagnosis:

The saddest thing of all is to realize that the stories of family life and previous achievements that were a part of the past lives of each of these people are no longer important to them. It's as though their past lives never existed. They are basically alone in the world because sustaining or contributing to a relationship of any kind is beyond the realm of possibility. To see a life stopped in its tracks by this ogre, schizophrenia, is a heart-rending thing to witness (Smith 1991, 690).

Molly Watson (2015), diagnosed at age 40, describes how her mother reacts to her when she tries to discuss her symptoms. Notice how her account highlights the silencing effect of 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).

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).

Dominic Hanley (2016), someone who is living with childhood trauma and addiction, describes how learning of his diagnosis of schizophrenia 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).

Many people with schizophrenia feel that they are misunderstood by others. Whether it is family members being uncertain of how to accept the fact that their loved is living with a mental health diagnosis, a friend who is quick to lose touch, or healthcare providers failing to acknowledge and respect their experiences in an appropriate way, many narratives reflect the theme of living in a world of isolation, of lost connections, and of being alienated from one's community:

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).

Betty Blaska (1991), a mental health advocate, recounts her experiences of treatment at a psychiatric hospital. Through a series of vignettes taken from her own experiences, she outlines what it means to be labelled by healthcare professionals as a "CMI" or "chronically mentally ill":

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, 174-175).

Traditional treatments for schizophrenia have often involved isolating patients away from society, but that is perhaps the most damaging decision that impedes a person's progress and recovery from mental illness. There is a common theme of wanting to re-experience human contact, to be viewed as more than a diagnosis. Even if we cannot understand the content of the delusion, we *can* understand fundamental desires to belong, to be acknowledged, to have our voices heard. These fundamental desires are things which patients with schizophrenia struggle to

reclaim once they have been diagnosed, things which have been denied to them by their families, their caregivers, and the broader general public. Fortunately, it does not have to be this way.

The feeling of hope gives individuals a reason to continue in their process of recovery (Davidson 2003). The issue of stigma is that patients are told that recovery is near impossible. Stigma informs patients with schizophrenia that they will only reach a certain threshold in their lives and it would be impossible for them to reach certain milestones that “healthy” people take for granted. As evidenced in the small sample of narratives I provided thus far, and as is echoed in countless other patient autobiographies that are written post-recovery, persons with schizophrenia are consistently told that the prospects for living a good life are slim and once diagnosed, their future trajectory is effectively determined for them, leaving them limited room for personal choice or autonomy. When hope is instilled in patients, when there are systems of support available to help them on their journey to recovery, however, these narratives reveal the transformative effects of how interpersonal relationships positively impact their lives:

For years [Cindy’s] face was a solemn mask, and she could neither give nor receive affection. She knew something terrible had happened to her and could not understand why no one would rescue her from the hell in her head. In the past few months she has become quite loving, and the smiles that now light her face light mine as well (Smith 1991, 691).

Being diagnosed with schizophrenia made me feel out of place and not accepted among the community, but then I realized that I am who I am. Learning to accept my new self was difficult...When I stopped experiencing all of my symptoms, I found my identity. With finding my identity, came courage and hope (Hanley 2016, 1315).

Perhaps the most influential has been meeting regularly with my supervisor, an anthropologist who studies the lived experience of psychiatric illness. She has aided my journey to recovery—by listening to my experience, often validating something I say... (Anonymous 2017, 479).

Recognizing how others experience the world in new ways and not simply rejecting them altogether (which is what stigma does) can be a first step towards building empathetic and caring attitudes. Adopting a refined phenomenological account, coupled with engaging with patients and

their narratives, allows us to ascribe commonalities to others, to recognize their subjectivities, and to move away from those dehumanizing attitudes informed by stigma. By acknowledging that the phenomenological method *does not discriminate* against these kinds of different modes of experience, in a negative and judgmental way, Husserl's project has tremendously positive potential for engaging with persons with schizophrenia. Husserl's phenomenological approach is more receptive to different possibilities, and can accommodate engagement with persons living with schizophrenia, because rather than viewing their condition as something which is defective or deficient, it presents an opportunity to learn more about their experiences of the world. By engaging in this process of phenomenological reduction, we learn methods of relating to the world beyond the ways we relate to it ourselves. It is important not to dismiss immediately the narratives of others or view them with an eye of suspicion or doubt, because doing so effectively ends the conversation. Whereas stereotypes and stigma dehumanize persons living with schizophrenia, engaging with their narratives in a caring and empathetic manner respects their personhood and allows us to connect with them, to better understand them, to learn more about their experiences, and to recognize how mental illness can impact people's lives. Through this engagement we can learn more about the nature of mental illnesses, we can learn ways to improve the kinds of treatments available, and our society can begin learning better ways to support those with schizophrenia and rectify the harms brought about by stigma.

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Author Biography

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Endnotes

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² I have discussed the impact of stigma on people with schizophrenia in greater detail elsewhere. See Molas (2018).

³ As one commentator noted, sometimes we need some generalizations to attach to a notion for it to have meaning. While I agree that broad generalizations may be helpful for grouping some data sets together, and this grouping can be helpful for therapists to be able to quickly identify and assess their patients' needs based on the symptoms and behaviours they are demonstrating, I want to stress that stereotypes, within this context, are problematic precisely because they hold these negative associations and they create false beliefs and judgments about others. To overcome the problems associated with stigma and stereotypes, it is important to gather examples that more accurately describe those who have schizophrenia. As I will argue, patient narratives serve as an important resource for discounting bad stereotypes and enabling patients to be able to construct their own positive identities.

⁴ For more on narratives approaches to medicine, see Charon (2005, 2006), Childress (2002), Frank (1998), Rimmon-Kenan (2002), and Martinez (2002).

⁵ Although she is writing from her own lived experience with Multiple Sclerosis, Toombs' insights translate well to talking about psychiatric disorders because her analysis serves as an important reminder that more work needs to be done in bridging the epistemic gap between what it is like to have knowledge of a particular health issue from a clinical perspective (e.g. a psychiatrist who specializes in schizophrenia research) and what it is like to have direct lived experience of living with a diagnosis of schizophrenia (e.g. a patient).

⁶ The term "psychiatric survivor" can describe someone who has gone through the process of recovery from the symptoms of diagnosis or has reached a state where the symptoms are manageable and can live a life without significant impediment. A second, and perhaps more significant, meaning is that it refers to individuals who have experienced and "survived" instances of abuse caused by their experiences of living within psychiatric institutions and who may have been poorly treated by medical practitioners.