Schizophrenia, social practices and cultural values:

A conceptual introduction

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Be plural as the universe.

– Fernando Pessoa

Schizophrenia is usually described as a fragmentation of subjective experience and the impossibility to engage in meaningful cultural and intersubjective practices. Although the term schizophrenia is less than 100 years old, madness is generally believed to have accompanied mankind through its historical and cultural ontogeny. What does it mean to be "mad"? The failure to adopt social practices or to internalize cultural values of common sense?

The nonspecific concept of madness has been around for many thousands of years and "schizophrenia" was only classified by Bleuler (1857-1939) in 1907. It is normally accepted that it was a renaming of the dementia praecox of Kraepelin (1859-1926), who already derived the term from previous authors (Morel (1809-1873), Pick (1851–1924) see Garrabé, 2003)). However, one should consider this theoretical concept with caution, since many psychiatry historians do not accept the idea that schizophrenia is an illness that has always existed and that has been progressively discovered. Berrios, Luque and Villagrán (2003) hold that the history of the concept of schizophrenia should not be described as a progressive continuity, for it only serves to justify the current concept. In the opinion of these authors, schizophrenia should be described not as a unitary disease but as a collection of symptoms, and its history as a set of different research programs running in parallel. With this in mind, we shall consider some important moments in the history of schizophrenia. According to Garrabé (2003), 1911 was an important year in the history of psychopathology because Bleuler published Dementia Praecox, or the Group of Schizophrenias, Freud published Psycho-

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Analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides) (better known as "the case Schreber") and Jung published Symbols of Transformation (also about schizophrenia?). Bleuler coined, as we mentioned, the term "schizophrenia":

> I call dementia praecox schizophrenia because, as I hope to show, the splitting of the different psychic functions is one of its most important features. In each case, there is a more or less clear splitting of the psychological functions: as the disease becomes dis-tinct, the personality loses its unity (Bleuler (1911), cited in Ashok, Baugh and Yeragani, 2012, p.1).

According to Bleuler, the schizophrenias were a nosological group of diseases that had a similar clinical evolution and expression. This group of diseases have in common the splitting (spaltung) of psychic functions in independent complexes and some affective and associative disorders. Bleuler considered that his theory of schizophrenia was an application of psychoanalytic ideas to Kraepelian's dementia praecox. The primary symptom of loosening the association of ideas would have an organic origin but from there on a psychogenic explanation was required. In this psychogenic explanation, Bleuler used the concept of "primary process", already proposed by Freud, to explain unconscious drives. He also used for the first time the concept of "autism" to describe schizophrenics who were isolated from external reality, and this concept is similar to psychoanalytic "self-erotism". In turn, Jung, Bleuler's assistant, developed a different conception of schizophrenia. He desexualized the Freudian concept of "libido" turning it into a form of energy that can be invested in reality. In the case of schizophrenia, this energy is withdrawn from reality, and the mind of the patient becomes dominated by the collective unconscious, filled by "imagos", archaic universal structures of the human psychic.

In that same year, Freud published an analysis of a book of memoirs of a patient that today is considered schizophrenic, the judge Schreber. His delusion is interpreted as a projection of unconscious homosexuality. Later, the book Memoirs of My Nervous Illness (1903), became subject to different interpretations, inclusively the current influential study by Louis Sass in The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic Mind (Sass, 1995). Freudian theory is highly complex and has developed into several different schools. According to Freudians Nacht and Racamier (Nacht, 1971, pp. 80-188) schizophrenics, while denying the common sense reality, do not bear the feeling of loneliness, so they create an alternative reality as an attempt to self-heal. The French psychoanalyst Jaccques Lacan (see Vanheule, 2011) elaborated a different theory that has had great influence (inclusive in Deleuze). His starting point is schizophrenic verbal discourse. This discourse is not used to communicate anymore; one can say that the schizophrenic is out of discourse and consequently out of the social link.

Another line of thought that, along with Psychoanalysis, has had a great influence is Phenomenology. These two Schools have in common the emphasis placed on the subject and the wealth of personal history. Jaspers introduced phenomenology in Psychiatry taking inspiration from

Husserl, although according to some authors his main influence was the Kantian theory of knowledge (Chung, 2007). His work General Psychopathology (1913) is, still today, a major reference in Psychopathology. He distinguished the empathic understanding of patients from the objective description of their symptoms. Concerning schizophrenia, Jaspers thought that it was not susceptible of understanding, only of causal explanation. Psychiatric phenomenologists who followed him were less pessimistic and tried to understand schizophrenia, rather than only researching its neuronal correlations. Tatossian (2002) considered that phenomenology, as Jaspers understood it, was only a method of data collection and it was different from phenomenological psychiatry, which began properly in 1922 with Minkowski (1864-1909) and Binswanger (1881-1966). Minkowski was not a direct disciple of Husserl or Heidegger, but his analysis of psychiatric patients does bring him closer to phenomenology (see Sass 2001). Influenced by the Bergsonian distinction between intellect and intuition, Minkowski holds that there are two layers of the self. One registers and replies to external stimulus and the other, which is deeper, is the place of feelings and experience. In schizophrenia, there is a split between these two parts. There is a loss of vital contact with reality and an exaggeration of the intellectual and spatial sides. This leads to a continuous interrogative attitude and rigidly abstract thought. Minkowski had a great influence on authors from several countries such as Blankenburg, Kimura, Tellenbach, Tatossian, Lacan, Rollo May, and R. D. Laing among others. However, Binswanger sustained that he was still too much of a "psychologist" (Chung, 2007) and that solely with Heidegger's work does one begin to have really intellectual instruments for an analysis of human existence. He called his method Daseinanalysis, receiving influences from Husserl, Freud and Heidegger. In one of his works directly concerning schizophrenia (Binswanger, 1956), he holds that schizophrenia can be described in three modes of existential failure: extravagance, perverseness, and mannerist behaviour.

Along the same lines, Blankenburg (1928-2002) develops the concept of "natural evidence" and of its loss in schizophrenia (Sass, 2001). Schizophrenics lose common sense, meaning the capacity to see what is obvious as obvious, in a process that can remind us of a philosophical attitude (as Wittgenstein also pointed out in his work). One main difference between the two is that, while philosophy is a deliberate, theoretical, and experimental position, a schizophrenic cannot avoid his own state, becoming, in this way, isolated from others and society. Another phenomenological psychopathologist, Kimura Bin (b. 1931), considered that schizophrenia is a self-disorder. The patient does not feel himself to be the owner of his representations and he resists being absorbed by others, that is to say, by the "pure and absolute otherness" (Sass, 2001, p. 265), and losing his personal identity.

As we can see, these psychiatrists abandoned the epistemological pessimism of Jaspers and endeavoured to succeed in interpreting schizophrenia, at least partially. In the 1960s and 1970s, a critical movement regarding institutional psychiatry emerged. It was known as "antipsychiatry", although not all proponents of the new approach accepted that label. The so called "antipsychiatrics"

were clearly influenced by phenomenology and psychoanalysis. From this approach, we will focus on R. D. Laing, a Scottish psychiatrist who, influenced by Minkowski's ideas, attempted to reconcile existential philosophy with the British School of psychoanalysis (especially Bion and Winnicott). He also defined schizophrenia in terms of a self-disorder, as a "divided self" (Laing, 1960). His basic concept is "ontological insecurity", highlighting the distress of the schizophrenic experience.

Phenomenologists and also antipsychiatrists have been very influential regarding today's interpretation of schizophrenia as a self-disorder. Sass, Parnas and others (Sass, Parnas and Zahavi, 2011) uncovered that which is now common to several sets of symptoms grouped as "schizophrenia". These symptoms become more understandable and explainable if one sees this as a radical disorder in the sense of self. Sass (1995) applied Wittgenstein's analysis of solipsism to schizophrenia. The patient is not, obviously, a solipsist but a quasi-solipsist (Sass, 1995) in the sense that several symptoms become intelligible if one understands that he himself feels as if only he and nobody else exists in the world. More recently, Sass presented a model (see for example, Sass and Byrom, 2015) in which the core of schizophrenia is a disorder of the minimal self, or ipseity, meaning the crucial sense of existing in each moment or the vital centre of subjectivity. This self-disorder is identified by three basic characteristics: hyperreflexivity, where processes which normally are in the background become vividly focalized by consciousness; diminished self-presence, meaning a decline in the sense of existing and being an agent; a disturbed grip or hold that results from the other two characteristics and is a confusion in spatiotemporal structure and in the distinction between perceiving, memorizing, and imagining. Sass also elaborates on the relation of these three aspects providing not only a description of schizophrenia but also advancing forward to the level of explanation (Sass 2010).

Stanghellini (2000), taking up Kant's position (2006, p. 113) that "the only universal characteristic of madness is the loss of common sense (sensus communis) and its replacement with logical private sense (sensus privatus)" and continuing the ideas of the phenomenologists (with the concepts of "natural evidence", "natural attitude" and others) and antipsychiatrists (who provided evidence regarding the concept of "social normality"), stresses the importance of the concept of common sense in understanding schizophrenia. He thinks common sense is an adaptive instrument that the members of a given community share and that allows them to discern relations of physical causality and social motivation in the subject's context. The loss of common sense becomes evident in a lack of intuitive attunement and in a failure of practical capacities necessary to an everyday integration in a social context (Stanghellini, 2000, p. 783).

Related with this theme of common sense, Sass (1992) holds that there is a parallelism between schizophrenia and modernism, the latter having a main tendency to go against what is culturally established. Modern art aims to shock social consciousness. An example is Antonin Artaud (Sass, 1996), whose work was very influential in the areas of contemporary theatre, cinema, and poetry, and who was diagnosed as schizophrenic. According to Sass, Artaud described his altered

states of consciousness, revealing a poetic dimension in schizophrenia. The existential angst present in schizophrenia is a paradigm of several modern art works.

The lines of thought that we have briefly outlined to this point are mainly centred on the analysis of subjectivity. In a different line, there are approaches that focus more on a third person perspective, looking for identification of typical symptoms, discovering neuronal correlations of these symptoms and prescribing chemical treatments. Psychopharmacology has gained prominence since 1952 with the discovery of neuroleptics. The Diagnostic and Statistical Manual of Mental Disorders (DSM) has reflected this evolution since its third version, which radically changed its orientation. It is only a diagnostic manual, but it created a new paradigm in Psychiatry that funded the psychiatric taxonomy; this is in line with Hempel's logical empiricism (1966), including only descriptions of symptoms and syndromes, in opposition to a theoretical approach (Chung, 2007). In order to be as consensual as possible, any explainable theory should prevail over others. The diagnostic criteria were initially chosen in accordance with the principles of the Saint-Louis school (see Feighner et al, 1972). Nevertheless, some criticisms have emerged about this orientation of the DSM. From a scientific point of view, its categories would be unclear and would not allow for a reduction of clinical uncertainty (Poland, 2006). Furthermore, it is not as atheoretical as might be thought. As a matter of fact, DSM is very permeable to cultural factors, specifically reflecting American culture (Garrabé, 2003), and a mixture of theories (Ghaemi, 2012). It has also been stated that the DSM created too many symptoms and it has benefitted psychopharmacology (and the pharmaceutical industry) to the detriment of other forms of approach to mental disorder. Another aspect is that the use of DSM could lead to a neglect of personal history in favour of a search for typical symptoms, becoming somehow dehumanizing (Allen, 2015). In spite of these criticisms, the DSM continues to be the most widely used diagnostic manual, especially due to its capacity to unify psychiatric language, or so we think. In relation to schizophrenia, in the DSM the theories also disappear, giving place only to consensual knowledge. Thus, Bleuler´s terms such as Spaltung, autism, and ambivalence are no longer part of the diagnostic criteria. On the other hand, the meaning of "schizophrenia" is more restricted in the DSM than it is in American psychiatry, becoming limited to a specific syndrome. In the latest version, the DSM 5, schizophrenia is included in "Schizophrenia Spectrum and Other Psychotic Disorders."

As mentioned above, the concept of "schizophrenia" as an illness is still today a topic of debate among authors who claim that Schizophrenia does not correspond to any coherent diagnosis (Berrios et al, 2003). However, one knows that the symptoms are real and are related with the distress of the patients or with their social maladaptation (Chung, 2007). This is why, recently, some authors prefer to focus on the symptoms themselves, leaving open whether "schizophrenia" is really a syndrome and its respective explanation. To explain the thought-insertion symptom, for instance, researchers focus on the agency of the self: Stephans & Graham (1994) concentrate on the experience of patients, while others look for cognitivist explanations (Frith, 1992). Delusions in general, not only associated with schizophrenia, have also been investigated (including in this volume) from a cognitive perspective

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(Bortolloti, 2010), combining cognitivism with neurophysiology (Spitzer & Casas, 1997) and phenome-nology (Gallagher, 2009).

In the last two decades, advances in neuroimaging, electrophysiological and neuropathological approaches have enabled us to find several neurobiological correlations with the symptoms of schizophrenia. Alterations at the level of the genes, the size of the brain ventricles, and neuronal activity were associated with schizophrenia. However, it was not yet possible to establish the "biological markers" (biological indicators of the disease, which may or may not be causal). Ford (2017) investigated the obstacles that have been confronted during the research into neurobiological bases and proposed some solutions to overcome them. These obstacles are, according to the authors, samples that are too small, questionable reliability and validity of measurements, medication confounds, failure to distinguish state and trait effects, correlation–causation ambiguity, and the absence of compelling animal models of specific symptoms to test mechanistic hypotheses derived from brain-symptom correlations. At present, several researchers hope that these obstacles will be overcome and that schizophrenia can be definitively reconceptualized as a brain disease rather than a psychological condition caused by the relationship with the social environment, especially family. Nevertheless, authors such as Fuchs (2011) argue that one should not start from a one-way causality, as if the brain were the creator of experience. Actually, the brain is a mediating organ between the mind and the environment. Experiences also imprint their mark on the brain yet a reductionist model denies this. For his part, Gerrans (2014) maintains that there are several explanatory levels, and although the neurobiological level is the last of the chain, it does not make sense to talk about schizophrenia, or about another mental disorder, without reference to personal and mental levels.

Towards Interdisciplinarity

Despite the vast amount of literature and research, it seems that the study of schizophrenia and of the psychoses is suffering from a generic disintegration. As shown within the historical overview, there are a variety of theories and approaches to schizophrenia. One of the few unifying themes is that schizophrenia is considered, by many, the prototypical disturbance for the study of both the ill and the healthy mind (e.g. Parnas, 2012). Regarding Schizophrenia, ICD-8 states that it is “the fundamental disturbance of personality, involves its most basic functions, those that give the normal person his feeling of individuality, uniqueness, and self-direction”. As a concept and as a phenomenon, it has generated interest for many years and within several study areas. Ranging from film, the arts and religion, to philosophy, psychology, psychiatry and molecular biology, is has been argued and debated from several different perspectives and points of view. Despite the vast amount of information and knowledge gathered in the field of schizophrenia, clinical practice is still poor and ineffective in many cases, whether at pharmacological, psychological or social level. If, on the one hand, biological psychiatry and empirical psychology are looking for biological and behavioural

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markers, psychoanalysis or other relational psychotherapeutic approaches are more concerned with "ways-of-being-with" others (Stern, 2003) and how these were internalized during infancy and then generalized during adolescence and adulthood. From the point of view of clinicians, philosophical studies and argumentation are sometimes presented with little or no connection to clinical practice resembling, at times, the very process of psychotic delusion (i.e. no empirical data is used to back up or validate subjective arguments). Looking at schizophrenia at the conceptual and phenomenological levels (e.g. Hipólito & Martins; Lalumera; Boncompagni; Thoma & Fuchs; Bizzari; in this volume) can be of extreme value to free our minds from clinical pre-conceptions, personal assumptions or social constructions. A "free" mind is a mind that is able to think creatively about a problem, and possibly get closer to finding solutions or insightful answers. However, one should also note, if little or no connection to "reality" is left, one is unable to use such knowledge for the benefit of people diag-nosed with schizophrenia, their families, teachers or even politicians. Even the debate about whether schizophrenia is an illness or not would lose common sense if no connection to people's lives was made.

A number of authors in this volume (e.g. Pereira & Debanné; Hipólito & Martins) attempt an integrative view where training, practice, theory and research are considered as parts of a larger whole. These chapters lack, however, the conceptual debate of other chapters (e.g. Gonçalves; Thoma & Fuchs; Sass; in this volume). This is a varied and pluralistic volume, and it is up to the reader to make use of different chapters according to his or her own needs.

Historically, it is possible to find good examples of integration in the work on psychosis. For example, the Society of Psychological and Social Approaches to Psychosis (ISPS) has, for around 40 years, presented integrative accounts of research, theory and practice, showing how good results can be achieved if enough time and dedication is given to people diagnosed with schizophrenia and to their families. The examples of Soteria (Mosher, 2004) or Open Dialogue (Seikkula et al, 2006) are also testimony that psychosis and schizophrenia are not life sentences or irreversible chronic illnesses. It is, rather, the "dis-ease" presented to families and to society in general that dictates the failure of most current approaches to psychosis. The urge for (only) quantitative measuring, Randomized Controlled Trials (RCTs) and other "gold-standard" research methods is only favouring "large enterprises" that promote quick fixes, such as the pharmacological industry, hospital beds or generic clinical management. Specialist interventions such as the examples mentioned above are expensive (although money-saving in the long-term) and take time (usually no less than five years). Such investments are usually difficult political decisions, since they overrun the lifetime of democratic governments and do not deliver results in the short-term. But how dissembling can we continue to be, whilst knowing the possible answers but repeatedly investing in failure and repetition? We hope that, in this volume, the reader is able to start reflecting more deeply on the problem of psychosis, schizophrenia, and common sense, enabling them to innovate, rather than to repeat, and to collaborate, rather than to compete.

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The overview of the book

Part 1: *Phenomenological approaches*

Samuel Thoma and Thomas Fuchs, in their chapter, Inhabiting the shared world: Phenomenological considerations on sensus communis, social space and schizophrenia, draw phenomenological considerations on sensus communis, social space and schizophrenia. Thoma and Fuchs point out that due to the increasingly intersubjective focus of psychopathology, common sense has become one of the most important research topics in contemporary phenomenological psychiatry. In their article, they firstly develop a tripartite concept of sensus communis in order to describe the fundamentally social nature of human experience, ranging from sensory, intercorporeal and cognitive capacities that are acquired in social interactions. To give a concrete example of their theory, they then look at sensus communis under the aspect of spatiality, i.e. as a means of inhabiting different domains of social space, such as inti-mate, private, communal, public, and also virtual space. They combine their reflections with considerations on schizophrenic experience, offering the reader a discussion on therapeutic consequences.

In Chapter 3, following the same phenomenological line, Schizophrenia and Common Sense: A Phenomenological Perspective, Valeria Bizzarri focuses on the role of the body, arguing for the existence of an embodied Self that is necessary for our "being-in-the-world" and for our common sense. Her hypothesis is that our lived body is the main instrument for the organization of experience, intersubjective interaction and our understanding of the world. The contribution of such a view is twofold: on the one hand, it exposes the central role of corporeity in the understanding of self, otherness and objective reality as it emerges from the analysis of psychopathological disturbances; on the other hand, it shows that a phenomenological perspective could be helpful not just in the understanding, but also in the treatment of similar pathologies.

That is what Inês Hipólito and Jorge Martins, in A second-person model to anomalous social cognition, (Chapter 4) propose by asking how anomalous experience can be investigated both from qualitative and quantitative viewpoints. The chapter claims that qualities of perception and kinaesthetic phenomena are central features when considering human experience in general, and anomalous social cognition in particular. Hipólito and Martins thus attempt to bring forward what they call a second-person scientific design, accounting for both the first-person enactive experience, and respective third-person neurobiological correlates. From this proposal, they further explore the consequences for clinical and research practice.

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Part 2. The self-disturbance hypothesis

In Chapter 5, "Negative Symptoms," Commonsense, and Cultural Disembedding in the Modern Age, Louis Sass offers a cutting-edge interpretation of the so-called “negative symptoms” of schizophrenia, considering these symptoms in relation to key aspects of modern culture and consciousness. Sass evidences how many “negative-symptom” experiences in schizophrenia comprise forms of subjectivity characterized by hyperreflexivity and alienation. The exacerbation of various kinds of self-consciousness, often involves disengagement from the grounding frameworks, assumptions, and bodily dispositions that would normally serve as the taken-for-granted background of practical action and experience. Sass points out how modern society might contribute to, or at least exacerbate, certain characteristics of schizophrenia. The person with schizophrenia seems an anomalous yet also an exemplary figure: a person who fails to adopt the social practices or internalize the cultural frameworks essential to normal existence, yet who, in this very failure, typifies some of the most distinctive features of the modern age.

In Chapter 6, Klaus Gartner focuses on Conscious Experience and Experience Externalization (Chapter 6). Gartner notes that the main characteristic of conscious experience is its phenomenology, and that recent interpretations claim that the phenomenal character involves two kinds of features: qualitative and subjective. Some think that the latter is the essential feature in phenomenal consciousness. This goes hand in hand with the neo-phenomenologist claim that conscious experience necessarily involves a form of pre-reflective self-consciousness. Gartner defends a naturalized view of conscious experience that straightforwardly fits Sass & Parnas's interpretation of schizophrenia.

Clowes’ ground-breaking paper, The Ipseity Disturbance Theory of Schizophrenia and Predictive Processing, in chapter 7, takes a new look at the ipseity distortion hypothesis (IDH) to schizophrenia. He argues that while the IDH provides a powerful attempt to characterize prodromal schizophrenia it needs to be constrained and sharpened by an encounter with the best current mechanistic theories of psychopathology. After offering a detailed discussion and critique of the explanatory concepts of ipseity theory, Clowes shows how they can be grounded in the recent theoretical approach of Hierarchical Predictive Processing (HPP) (Clark, 2015). Especially, Clowes shows how the phenomenology of prodromal schizophrenia can be explained in terms of HPP theories of presence (Seth, Suzuki, & Critchley, 2011), how the brain´s persistent problem of explaining away disturbed presence is naturally linked to a theory of emergent hyperreflexivity, and how, because of the tight links between belief and perception on HPP models, the development of delusion can also be explained. Clowes argues ipseity theory is much deepened by this encounter with HPP and new lines of empirical investigation are suggested.

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George Carpenter's Mind as Madness: Louis Sass and the horizonal concept of experience, chapter 8, focuses on the Husserlian horizonal conception of experience, which in Valberg's perspective, presupposes direct realism, and offers the only mean-ingful explication of knowledge and consciousness. Nevertheless, he effectively concedes that these latter are dependent upon the proper functioning of the brain and nervous system. Changes in brain functions supported by experience would have effects not only phenomenologically, but would be epistemologically indistinguishable from changes to the external world itself. Carpenter points out that Louis Sass finds strikingly similar paradoxes in the experiences of schizophrenic patients. Carpenter, hence, investigates the parallels between what Valberg thinks is our common-sensical human condition, and what Sass regards as psychopathology. He asks whether Valberg's position is really indicative of the psychological traits Sass analyses. Ultimately, Carpenter appears to conclude that the question is whether physicalism can be rendered free of contradiction, or without appeal to psychological explanations for competing metaphysical positions.

Part 3. Emotions and Delusions

Dina Mendonça, in Chapter 9, asks what Can Schizophrenia Teach Us About Emotions? The chapter remarkably argues that the contradiction of emotional experiences identified in schizophrenia is a normal part of emotional life. Building on Ratcliffe's idea of thinking of schizophrenia in relational terms and taking up the claim that the minimal self reflects a fundamental orientation to the world and the social world, this enables us to consider schizophrenic emotional life as a way to offer insights about emotional life. Mendonça endeavours to show how the visibility of contradiction seen in schizophrenia patients brings to the surface some aspects of the complexity of emotional life and offers insights into some of the processing of emotional experiences. Consequently, taking the contradiction of emotional experience in schizophrenia as familiar instead of strange shows that emotional life entails experiences where there is an inconsistency between first order emotions, moods and the emotional episode as well as experiences of conflict between first order emotions and meta-emotions. Accepting that the emotional processing is similar, although the outcomes are different for schizophrenia patients, raises novel questions about the difficulty for patients and caregivers to share and mutually understand emotional experience.

Jorge Gonçalves, in Chapter 10, Why are delusions pathological?, aims to identify a characteristic of delusions: what makes them pathological? It may appear at first a bit strange because one believes that delusions are just a pathological alteration of the mind. However, Gonçalves will positively point out how some authors show that although pathological delusions are the most studied, not all

delusions have necessarily harmful consequences for the delirious subject or for others. Hence it seems pertinent to question what makes delusions a pathological state.

Jose Eduardo Porcher, in Chapter 11, The doxastic status of delusion and the limits of folk psychology, follows the same line, however focusing mainly on clinical delusions and doxasticism, further presenting the main alternative characterizations that have emerged in its wake. He questions the validity of the debate between doxasticists and non-doxasticists by stepping back and assessing the meaning and relevance of the question 'are delusions beliefs?' He argues that, by focusing on what appears to be a merely terminological dispute, the theorists engaged in this debate have lost sight of two desirable features of a precise characterization of delusions, namely, its use in the development of a scientific theory of the relevant phenomena and, finally, its ability to account for the experience of the patients.

Part 4: Therapeutic and clinical methods

João G. Pereira and Martin Debbané, in Chapter 12, An integrative-relational approach in Schizophrenia: from philosophical principles to mentalization-based practice, discuss mentalizing in training, practice and supervision. This chapter remarkably explains how Mentalizing, par excellence, a relational concept, can be usefully applied in clinical practice when understood contextually within the history of psychological therapies. In the final sections, the chapter explores psychosis and schizophrenia as prototypical disturbances, where mentalizing failures are widely seen. They further attempt to describe how the process of rekindling mentalizing within attachment relationships (here, the patient-therapist relationship) can have a protective effect not just at the onset of the disturbance, but also when psychosis is already actively installed.

Adam Timlett, in Chapter 13, asks Is a therapy for fostering common sense possible?, and devises a useful approach to the study of common sense by considering a model of knowledge-gathering. This offers the possibility of therapeutic interventions for individuals who appear to engage in highly unreliable knowledge-gathering. The requirements of such a model are the drawing up of the concept of 'personal epistemologies' that vary in the population, leading away from, or to, common sense knowledge and praxis. It is argued that education theory and science can inform and fulfil these broad requirements, specifically the theory and science based on Piaget's constructivism and Vygotsky's social constructivism, by providing a normative standard for knowledge-gathering praxis. Interesting and significant parallels are found with phenomenological theories of schizophrenia, which

investigate the loss of common sense. These parallels emphasise common ground between these different domains of research and can provide a starting point for enriching existing therapeutic models for certain targeted groups.

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Part 5: Wittgensteinean outlook

Anna Boncomplagni, in Chapter 14, Common Sense, Philosophy, and Mental Disturb-ance: A Wittgensteinian Outlook, examines an interesting focus on common sense, philosophy, and mental disturbance, from a Wittgensteinian Outlook. Boncompagni asks why Wittgenstein likens philosophy both to an illness and to a therapy. What kind of relationship is there between these two sides of philosophy? The chapter answers these questions by focusing on common sense, which plays a key role in the dialectic between illness and therapy, and by comparing Wittgenstein's outlook to some studies in psychopathology. After introducing the issue of radical doubt as a manifestation of philosophical disease, Wittgenstein's notion of 'hinges' is explained in terms of common sense certainties. Building on prior literature in psychopathology and philosophy of psychiatry, the author argues that doubts regarding 'hinges' can indeed characterize the early stages of schizophrenia. If this sheds lights on the insane side of philosophy, its therapeutic side finds its task in the rediscovery and strengthening of practical trust, a task that the author describes as one of 'de-epistemicization' of life.

In the same line, Elisabetta Lalumera, in Chapter 15, Understanding schizophrenia through Wittgenstein: empathy, explanation, and philosophical illustration, encouragingly considers two different "positive" wittgensteinian accounts: (1) Campbell's idea that delusions involve a mechanism of which different framework propositions are parts, and (2) Sass' proposal that the schizophrenic patient can be described as a solipsist; and a "negative" wittgensteinian account, in which epistemic aspects of schizophrenia are explained as failures in the ordinary background of certainties. Lalumera shows that none of these wittgensteinian accounts succeed in empathic-phenomenological understanding, contrary to a widespread reading. Rather, they provide examples of how philosophical concepts can contribute to model-building explanation, and to philosophical clarification, respectively.

We hope this overview gave a satisfactory explanation of the interdisciplinarity effort at hand in this volume, towards the difficult understanding of plurality – and the fragmentations – of the self, or of the soul. As in Pessoa's words,

I don't know how many souls I have.
I've changed at every moment.

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I always feel like a stranger.
I've never seen or found myself.
From being so much, I have only soul.
A man who has soul has no calm.
A man who sees is just what he sees.
A man who feels is not who he is.

We hope that the interdisciplinary work described in this volume stimulates researchers and clinicians to reflect on our ability and responsibility to build a twenty-first century conception of schizophrenia that is embedded on social practices and cultural values.

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