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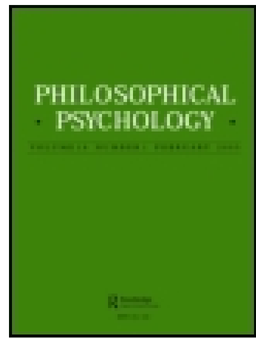

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ARTICLE

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The person's position-taking in the shaping of schizophrenic phenomena

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ABSTRACT

Traditional psychopathological approaches to modelling the evolution of mental disorders, such as schizophrenia, often rest on the assumption that symptoms are the passive expression of an underlying disease process. In contrast, phenomenological approaches have highlighted the role that the person, as a meaning-making agent undergoing basic anomalous experiences, plays in the construction of their worlds – thus partly shaping the manifestation and course of illness. However, it remains to be explored how specific patterns of interaction between the person and his/her basic anomalous experiences unfold and play out. We appeal to the Husserlian notion of "position-taking" (*Stellungnahme)* to provide a framework for the investigation of the person's attempts at healing as a fundamental component of the dialectics of symptom formation in the psychoses. Within this framework, psychotic symptoms are understood as the expression of the person's efforts at making sense of, and adapting to, the existential challenges associated with the onset of anomalous self- and world-experiences. We draw on selected case studies and the testimony of one of the authors, to illustrate the potential clinical applications of this model. Finally, we outline some advantages of this approach, including its potential to address oft-neglected troubling experiences without threatening the person's epistemic agency.

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Psychoses; position-taking; meaning-making; phenomenological psychopathology; lived experience

1. Introduction

Built upon systems of nosology that claimed to be "atheoretical," modern psychiatry largely relies on descriptive psychopathological models based on the assumption that psychotic symptoms (such as delusions or hallucinations) are the passive expression of an underlying neurobiological dysfunction. In the history of psychiatry, an early example of this view is

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Tamburini's (1881/1990 idea of hallucinations as the product of irritation of the nervous centers involved in the processing of perceptual inputs (for a critical-historical overview of the madness-as-dysfunction paradigm, see Garson, 2022). More recently, the widely accepted distinction between "negative" and "positive" symptoms of schizophrenia was based on a similar assumption taking mental symptoms to be the product of, respectively, hypo or hyperactivity of brain functions (Crow et al., 1986). In line with methodological advances spurring neurobiological and neuroimaging research to faster growth in the past 20 years, contemporary psychiatry is still heavily influenced by this historical perspective and underlying assumptions (for instance, see Upthegrove et al., 2016).

In contrast, phenomenological approaches to psychopathology have historically highlighted the active role that the person, as a meaning-making agent, plays in the unfolding of his/her psychopathological symptoms – thus shaping (at least partly) the manifestation and course of illness within a given socio-cultural context. Some early examples of this view can be found in Bleuler's (1911/1950) account of "secondary symptoms" in the group of schizophrenias as arising from the psychological reaction of the person affected by "primary symptoms" (e.g., dissociation); or in Minkowski's (1968/1970) "phenomenological compensation" as a reaction of the schizophrenic person to a "trouble générateur". Huber (1983) also understood the development of full-blown psychotic symptoms as "psychoreactive" coping in the face of basic symptoms (i.e., substrate-close anomalous experiences appearing in the early stages of schizophrenia). These ideas have been developed further in the contemporary phenomenological psychopathology literature, where researchers have discussed the role of disruptions in the common-sense appraisal of distressing self- and world-experiences (Stanghellini, 2004), the patient's attitude toward perplexity and basic abnormal experiences (Stanghellini et al., 2013), and the interplay between different levels or dimensions of self-disturbance (Sass & Parnas, 2003). For instance, the Bio-*Pheno*-Social Model of schizophrenia has laid emphasis on the bidirectional relation between diminished self-presence (as the pre-reflective and immediate awareness of being the subject of one's own experience), and hyperreflexivity (as an exaggerated form of self-consciousness involving self-alienation)—the latter developing from and reinforcing the former (Sass et al., 2018).

However, less attention has been paid, in phenomenological psychopathology, to the different ways in which the person – both as subject of experience and self-interpreting agent – interacts with, and reacts to, basic anomalous experiences arising in schizophrenia-spectrum disorders (such as self- and world-disturbances). The unanswered questions being: how are anomalous experiences, such as those that commonly attract a diagnosis of schizophrenia, *lived through* phenomenologically? How do they unfold

from the perspective of the person, as autonomous giver of knowledge and meaning-making agent?

Here, we propose that this *self-hermeneutical* or interpretive activity of the person can be explored through the concept of "position-taking" (*Stellungnahme*), which was originally conceived by Edmund Husserl in *Ideas II*. According to Husserl, consciousness is given in three different profiles: a) consciousness as lived experience (*Bewusstsein als Erlebnis*); b) consciousness as intentionality (*Bewusstsein als intentionales Bewusstsein*); c) consciousness as both attentional consciousness (*attentionales Bewusstsein*) and as position-taking (*Bewusstsein als Stellungnahme*) (Husserl, 1989).

In the present article we focus on the last profile. Firstly, we describe the notion of position-taking, and we refer to commonly experienced medical symptoms, such as itching and scratching, as a useful analogy for understanding the interplay between basic psychopathological disturbances and the way the person takes position in front of them. Secondly, we outline a conceptual framework built around what we call the "dialectical principle" to reinterpret certain schizophrenic phenomena in light of the person's efforts at compensating more basic disturbances of subjective life. Lastly, we apply this alternative model to the analysis of selected case studies, to further explore the phenomenological features that underpin different kinds of position-taking as well as their clinical relevance.

2. 'Position-taking' and its application in phenomenological psychopathology

2.1. What is 'position-taking' and why does it matter?

By "position-taking" (*Stellungnahme*), Husserl means a class of intentional acts which are not merely restricted to being conscious of a given object but entail an active and, to a certain degree, free *orientation toward* that object. In this sense, Husserl posits an interpretational schema which is operative in all consciousness, and which includes theoretical stances (such as in acts of judgment, volition, evaluation, *etc.*) as well as practical comportments (such as in conscious, goal-directed and motivated actions) (Belt, 2019). In other words, when we encounter other persons, things or state of affairs in our everyday lives, we do not passively face them in a pre-given manner (Arango, 2014). Rather, we (at least partly) actively orient ourselves towards a certain situation so that we become acquainted with it perceptually, affectively, cognitively, and the like. As a result of this taking of position, the situation is then constituted as such in its meaningful structure and drives explicit actions. Thus, position-taking sets the tone for the essentially interpretive acquaintance between subject and worldly entities and events.

The very definition or thematization of oneself as a subject of experience, and of worldly entities and events depends on position-taking, and position-taking maintains or changes that tone through ensuing comportments (Aragona et al., in press).

In phenomenological philosophy, Husserl's notion of position-taking has been used to illuminate the relationship between passive and active dimensions of selfhood – where selfhood is couched as both passively constituted and actively shaped. According to Belt (2019), this relationship between passive dimensions (e.g., enduring habits) and active dimensions (e.g., the normative interpretation of experience) of the self, can help us understand the uniqueness of a *person* as the agent of position-takings with an experiential history of its own, sedimented into traits, dispositions, and character peculiarities. Thus, personal life is constantly and dynamically developing on the basis of previously sedimented experience and new position-takings, in a process of permanent *becoming*.

These philosophical considerations have motivated the development of person-centered dialectical (PCD) approaches to the study of psychopathological syndromes such as schizophrenia-spectrum disorders (Stanghellini & Aragona, 2016; Stanghellini et al., 2013; Stanghellini and Rosfort, 2015a). In line with a vast phenomenological and empirical literature (for recent reviews see Henriksen et al., 2021; Nordgaard et al., 2021) situating the origins of many "surface-level" psychotic symptoms at the level of the "minimal" or "basic" self, PCD models are also concerned with structural changes at this basic level of selfhood – intended here as pre-reflective and immediate awareness of being the subject of one's own experiences, thoughts and actions (cf., Nelson et al., 2014). However, PCD models go beyond the simple investigation of these basic aspects of subjective life, holding that surface-symptoms (such as delusions or hallucinations) do not map onto basic self-disturbances in a straightforward manner – their phenotypic manifestation being highly heterogeneous and difficult to predict. Rather, full-blown symptoms emerge through a complex and dynamic interaction between anomalous changes in implicit aspects of experience (i.e., self-disturbances or anomalous world experiences) and the person's various self-interpreting attempts enacted in the face of those uncanny experiential changes. In this sense, anomalous world- and self-experiences represent the rugged terrain within which delusions and hallucinations may develop through a re-active or inter-active process that leads from deep to surface phenomena. In Huber's words, this process refers to the "psychoreactive coping of the anthropological matrix" (Huber, 1983).

Importantly, the idea that the patient's attitude or stance toward their illness plays a significant role in the onset and course of mental illness is not unique to the phenomenological tradition. It is present within cognitive psychological models of psychosis, where it has been operationalized as

"appraisal" (e.g., Brett et al., 2007), and some may object that a less technical folk-psychological notion of "stance" or "personal attitude" may do all the conceptual work needed for our purposes. However, by this point, it should have become clear that key distinctions exist between the phenomenological notion of position-taking and alternative non-phenomenological conceptions. Firstly, as previously suggested (Ritunnano et al., 2021), position-taking goes beyond folk-psychological or meta-cognitive notions of "stance" or "appraisal" as belief about the origin, significance and meaning of an experience. Indeed, it takes into account the "background states of the person that exist before the experience and contribute to determining the experience itself" (Woods & Wilkinson, 2017) (p. 891). Secondly, position-taking should be understood as a multi-layered and dynamical construct entailing, at a minimum (this is further expanded in §3.1): a) the person's emotional tone, i.e., the background feelings associated with basic anomalous experiences, and b) the person's working-through, i.e., the cognitive and narrative elaboration of the same experiences. Lastly, our proposal should be seen as situated within the clinical phenomenological tradition (namely, the aforementioned PCD model) where a fundamental assumption is made about the nature of personhood: "the complexity of my identity as a person consists in the fact that apart from the impersonal changes that I undergo as a consequence of the sheer fact of being a developing biological organism, I also autonomously relate myself to these changes, and these personal attitudes, in turn, affect the person that I am" (Stanghellini & Rosfort, 2015a; p. 3).

2.2. The itch-scratch-scar model

To help us illustrate the points touched in the above section, take the "itch-scratch-scar model" as a highly simplified analogy of this dialogical process. This is, of course, not meant to trivialize highly distressing experiences, such as those associated with psychotic phenomena, but is rather intended as a pedagogic attempt to summarize complex and interacting components involved in the personal thematization of the illness experience, in the context of a clinical encounter. If a patch of skin on my leg feels itchy, I may scratch my skin hard enough to induce skin damage and produce a wound, which then turns into a scar. At my doctor's appointment, I may then ask the doctor to treat my skin problem. If we assume that itching, scratching and excoriation respectively represent: a) distressing experience, b) attempt at healing, and c) secondary epiphenomenon, it would be more appropriate for my doctor to: 1) prescribe a remedy which acts directly on the itch, or 2) a topical treatment to apply on the wound caused by scratching, or else 3) help me modify my reaction to the itching? Quite obviously, the best intervention would be a combination of (1) and (3), unless the wound urgently needs medical

attention (for instance if it is bleeding or infected). In addition, an adequate diagnostic assessment would require the doctor to undertake a full investigation of both the distressing experience (itching) and the patient's attempt at healing (scratching), as opposed to their clinical decision-making simply relying on the secondary epiphenomenon (scar) (Aragona et al., in press).

The central concern of traditional descriptive approaches to psychopathology, informed by a standard biomedical framework, are full-blown symptoms (e.g., delusions and hallucinations in the case of schizophrenia-spectrum disorders). Figuratively speaking, the focus here is on analyzing the features of the "scar" and establishing effective treatment to reduce the skin's inflammation, pain and discomfort. Alternatively, in the case of behaviorist approaches, the focus may be the "scratch" and treatment may be targeted at minimizing the scratching behaviour. Yet, scratching is only one of the manifold reactions a person may enact when faced with an itching condition, depending on where the itch is located, how frequent and intense it is, previous experiences of the same kind of itch, knowledge of the causes of the itch, *etc.*

There is another kind of consideration to be made at this point, which provides us with further proof that the phenomenological-dialectical model is preferable to descriptive approaches, or behaviorist takes on the matter. It is our contention here that position-taking (in this case, the person's reaction to an itching condition) not only varies among people, but that it may vary so deeply and radically as to affect decisively the manifestation and course of the ensuing pathological condition. It may determine illness in one case, or no illness in other cases, or a different kind of illness, or finally chronicity or recovery from illness. Different kinds of position taking may also affect different degrees of adherence to treatment, a crucial issue especially in the care of psychotic conditions and especially in early stages of psychoses (Daneault et al., 2019; Novick et al., 2010).

Thus, the phenomenological approach in psychopathology targets the itch itself as it is lived through as an uncomfortable and unexpected sensation that draws attention to a specific (previously unattended) patch of skin. Within this framework, the evolution of the resulting skin condition over time is understood as the product of the interaction between the itch (as the basic anomalous experience) and the varying responses that a person may enact to cope with it. This process is governed by what we call the "dialectical principle."

3. The 'dialectical principle' in phenomenological psychopathology

3.1. *How are psychopathological symptoms constituted?*

> In order toknow the truth of the pathological fact, the doctor must abstract the patient [. . .] Paradoxically, in relation to that which he is suffering from, the patientis only an

> external fact; the medical reading must take him into account onlyto place him in parentheses. Of course, the doctor must know 'the internalstructure of our bodies'; but only in order to subtract it, and to free to thedoctor's gaze 'the nature and combination of symptoms, crises, and othercircumstances that accompany diseases'. (Foucault,2012; p. 8)

This extract from Michel Foucault's *The Birth of the Clinic* (2012; originally published 1963) aptly explicates and contextualizes the "naturalistic" principle[1] at play in the assessment of psychopathological phenomena through the standard biomedical lens. Although Foucault is here referring to some kind of somatic illness located within the "internal structure of our bodies", the same kind of naturalistic attitude is often adopted in mental healthcare in the process of assessing and describing psychopathological symptoms for the sake of diagnosis and treatment. Just as in the examination of the scarring tissue in the simplified itch-scratch-scar model discussed above, the clinician may be trained to (exclusively or predominantly) attend to the patient's presenting psychopathological phenomena through a naturalistic stance: that is, by placing the person "in parentheses", the aim is to isolate the discrete manifestations of the disease entity. In the case of delusions for instance, a purely descriptive psychopathological approach may attempt to isolate the epistemic features of the person's extreme beliefs (e.g., their evidence-resistance, incorrectness and bizarreness) or their clinical severity, as if these phenomena happened in a vacuum – the person being, in this case, merely a translucent screen onto which meaningless utterances are projected (for an extended discussion of meaningfulness in delusions see Ritunnano & Bortolotti, 2022).

By contrast, a phenomenological-dialectical approach would not consider the person as a mere "external fact," but rather attend to the ongoing interaction between the person and the illness process – as it unfolds within a given historical and socio-cultural context. In this view, the person is at the same time a passive *and* active agent (with respect to the illness process), interacting with and shaping the meaning of symptoms as they are co-constituted and expressed over time. Thus, what we call psychotic "symptoms" are not single, well-defined and stand-alone entities – that can be mapped straightforwardly onto an altered neurobiological network. Rather, they are the final expression of the person's efforts at compensating, making sense and adapting to the challenges of meaninglessness, hopelessness, passivity and despair that often characterize his/her basic distressing experiences. Especially in the domain of schizophrenia, these basic phenomena may include strange, uncanny and almost ineffable experiences of depersonalization and derealization (Sass et al., 2013), self-disturbances and anomalous world experiences (Sass et al., 2018). Schizophrenic symptoms – both "positive" and "negative" ones – thus derive from an attempt at position-taking with respect to these experiences.

In this view, when we talk of a "dialectic" between the person's position-taking and his/her basic distressing experiences, we do not necessarily refer to a conscious and voluntary interaction. Position-taking can be understood as enacted at two levels of embodied self-awareness (often as highly intertwined processes but not necessarily inseparable or always co-occurring): a) an implicit, pre-reflexive and non-deliberate "default" level where basic experiences are shaped by the emotional and cognitive "common-sense" tools available to the person, as part of the broader hermeneutical resources shared by her/his socio-cultural group to understand and express bodily, perceptual, emotional anomalous experiences); b) an explicit, reflexive and deliberate position-taking in front of these experiences, enacted as an active search for the meaning, cause, or reason for these basic experiences – including the evaluation of their significance in the context of one's life trajectory and insight into their pathological or other nature. The latter reflexive process of searching for meaning and meaning-making can, in and of itself, be a source of suffering – especially when accompanied by perceived incomprehensibility or uncontrollability of the original basic experiences leading to the distress (Griffiths et al., 2019). The quotes below provide a powerful example of this ongoing, emotionally-charged hermeneutical labor:

> I was just staring at a blank white paper. I really didn't know what was happening anymore. My consciousness and subconscious had been drawn close to each other, dream and reality blended into one another and I just wasn't sure anymore.
>
> *(Feyaerts et al., 2021; p. 8)*

> Yes, you are afraid, but it is much bigger than fear. [. . .] Nothing is right anymore. The entire world . . . seems to implode upon you . . . Nothing is as you thought it was anymore [. . .] You can't trust anything anymore. Is this a table? It might seem so, but is it really the case? Probably not (laughs). These people are sitting here, but are they really people or is it my imagination, or . . . ? Pff . . . everything is possible . . . everything is possible . . .
>
> *(Sips et al., 2021; p. 6)*

3.2. *The dialectical principle at work in the constitution of psychotic symptoms*

Thus, to gain a deeper understanding of the lived experience of psychopathological phenomena, it is then paramount to consider their processual, dialectic and dynamic nature as part of the extended and evolving relationship between persons and their (pathological and non-pathological) experiential worlds. Attending to the individual's cognitive-emotional-ethical framework as well as socio-cultural context is therefore indispensable for understanding the constitution and meaning of the psychoses (Ritunnano

et al., 2021). In the process of interacting with, and reacting to, a wide range of possible experiential anomalies, symptoms can be better understood as constituted *via* the person's cognitive resources, feelings, meanings, and values. Cognitive impairment (if and where present) may also play a role in the process of position-taking by shaping the interpretation of previous experiences, expectations, and reactions to symptoms.

To delineate these patterns of mental constructions that are keys to understanding psychotic experiences (and of mental symptoms in general), we need to obtain richer and more in-depth knowledge of how people interpret and act upon their illness experiences. The contribution of lived expertise and genuine involvement of patients and service users in phenomenological research is key to this endeavor, aiming at the development of more clinically sensitive interventions tailored to meet individual needs. On the one hand, we need to try and discriminate the sources of distress (in relation to clinically relevant full-blown psychopathological experiences). On the other hand, we need to map out the different ways in which the person engages with the process of making sense of, and responding to, such distressing experiences – including their individual elaboration and explanatory insights. Recognizing the patients' efforts at healing is quintessential to understand the process that takes place between the onset of distressing experiences and the development and solidification of full-blown symptoms.

There is now a small, though growing, body of qualitative research that explores the lived experience of psychosis, schizophrenia, as well as positive and negative symptoms including delusions and hallucinations (for qualitative reviews of this literature, see Holt & Tickle, 2014; McCarthy-Jones et al., 2013; Moernaut & Vanheule, 2021; Noiriel et al., 2020; Ritunnano et al., 2022; Walsh et al., 2016).

Through their analysis of first-hand accounts of symptoms as they are *lived through* by the person, these studies precisely highlight the complex interplay between intrapersonal and interpersonal sources of distress and healing attempts, aimed at reducing meaninglessness and re-stablishing coherence, belonging, identity and control. A common theme emerging across all studies investigating the lived experience of psychoses points, as expected, to a qualitative shift in the person's experience and perception of their surrounding world, so that the very existential ground under one's feet is lost (McCarthy-Jones et al., 2013). Yet, what happens next is difficult to predict, due to the vastly heterogeneous and idiosyncratic factors that may play a role in the interpretation of this existential shift, including affective, behavioral, intersubjective, social, cultural, narrative, and normative factors. Some people, for instance, may deny that there is a medical problem at all and appeal to alternative sub-cultural interpretative resources to make

sense of their experiences (for example those linked to conspiratorial, religious, mystical or occult narratives). Others may seek professional help but still develop different position-takings for dealing with radical psychotic doubt, which will necessarily impact on the subsequent course of the illness. Jeppsson's powerful first-person account is instructive in this sense (Jeppsson, 2022). As a 45-year-old Swedish philosopher who had received a diagnosis of "schizo-something"—as she explains, not ticking enough boxes but being somewhere in the ballpark – Jeppsson first had to make a complete leap of faith and deliberately *choose* to believe in psychiatry and take her medications instead of dealing with a squad of murderous demons (a strategy which she calls "Jamesian" after William James):

> When I first became a psychiatric patient, I worried about taking antipsychotic medication. This was my problem: Either the mainstream world is real, I am mentally ill, and antipsychotics will help me, or the demon world is real, demons are out to get me, in which case antipsychotics might hide them from me, making me a much more vulnerable target. What should I do?
>
> *(Jeppsson, 2022; p. 1)*

Later on in her life, however, having to deal with the side-effects of her medication, she changed her strategy to Pyrrhonian (after the Ancient Greek philosopher Pyrrhos and his follower Sextus Empiricus) because the Jamesian one was no longer successful:

> [. . .] I realized that I now had strategies open to me that makes sense regardless of which world is real. Either the demons can not kill me because they are not real, or they very likely would not kill me because they have been stalking and threatening me for decades and I am still alive, so those threats seem pretty empty. This thought is much more soothing to me than insisting over and over on only the first part. Furthermore, I have ways of dealing with them, either by talking back to them and trading jokes for their threats, showing I am not that scared anymore, or engaging in little magic rituals to keep them at bay. If they are real, I am justified in handling them like this; I am also justified if they are not real, because these actions keep me calm, keep me from spiraling into ever higher stress levels and fear levels, and thereby keep me from a full psychotic break-down.
>
> *(ibid. p. 2)*

This is just one example of how one may take an (adaptive) position in front of their anomalous experiences, keeping a flimsy world from falling apart. In the next section, we draw on other first-person accounts from the published literature and on the lived expertise of one of the authors, to provide further examples of different position-takings and their relationship with psychopathological phenomena.

4. Drawing near schizophrenic phenomena through the dialectical principle: a case series

Valid and reliable knowledge on the dialectics between distressing experiences and position-takings as attempts at healing based on empirical studies is still missing. Nevertheless, we can gather relevant information from several sources such as through text mining (e.g., classics in psychopathology) and data mining (e.g., research on coping mechanisms in people who have attracted a diagnosis of schizophrenia or other psychoses), from personal testimonies (e.g., memoirs and other first-person accounts of schizophrenic experiences), and other forms of anecdotal personal narratives (e.g., narratives from clinical files or service users' self-descriptions).

Although quantitative approaches to the analysis of position-taking may add valuable information once suitable measures are developed, we see qualitative methods as best suited to provide rich, in-depth and nuanced data on these dynamic processes – beginning with the full description of single examples (ideal types, or paradigmatic cases, e.g., Schwartz & Wiggins, 1987). This approach is built upon a deep respect for the individual as an epistemic agent (that is, as an authoritative giver of knowledge) and privileges the centrality of the person's position-taking as a way to access and better understand psychotic phenomena as they are lived through and communicated in the clinical encounter.

Each case study is structured as follows: it includes the description of a distressing experience and its theme, and the description of the person's position-taking and its theme. Each case study has a title; next to the title we mention the source of the case study. The spoken words of patients or the written extracts are kept as much as possible unaltered and copied verbatim. Interpretative comments have been added where relevant to draw near the person through an exploration of their position-taking.

4.1. Detachment from one's body to defend oneself from the anguish produced by feeling disembodied (L.G.'s personal testimony)

4.1.1. Distressing experience

> The first disturbing experience I remember was discomfort in my very own body. Because I didn't feel it. I didn't feel alive. It didn't feel mine. I was just a kid, but ever since I never felt a feeling of fusion or harmony between "me" and "my" body: it always felt like a vehicle, something I had to drive like a car.

The basic abnormal bodily experience is a sense of being a disembodied Self: the naturalness of the body, its spontaneity that normally doesn't need reflection and goes unnoticed, is lost.

4.1.2. Position-taking

As a way of coping with this distressing bodily experience, L. explains: "Detachment has always been my main instrument to deal with estrangement from my body: treating it as an object, going along the feeling I had/have of it." Quite paradoxically, his attempt at coping with the feeling of estrangement from his body consists in trying to further detach from it. This apparent paradox works as healing strategy because it transforms a passive experience into something which is enacted through a deliberate activity (i.e., the decision to detach from the body and treat it as an object).

4.2. Outward compliance and petrification of the other as defences from ontological insecurity (Laing, 1959)

4.2.1. Distressing experience

> In contrast to his own belittlement of and uncertainty about himself, he was always on the brink of being overawed and crushed by the formidable reality that other people contained. In contrast to his own light weight, uncertainty, and insubstantiality, they were solid, decisive, emphatic, and substantial. He felt that in every way that mattered others were more "large scale" than he was. *(p. 48)*

Laing refers to "ontological insecurity" when describing this feeling of extreme personal fragility that here is highlighted by the contrast with the others' "normal" solidity.

4.2.2. Position-taking

This patient's way of coping with the fear of being overwhelmed by others is described as a "petrification" of the Other:

> He used two chief maneuvers to preserve security. One was an outward compliance with the other. The second was an inner intellectual Medusa's head he turned on the other. Both manoeuvres taken together safeguarded his own subjectivity which he had never to betray openly and which thus could never find direct and immediate expression for itself. Being secret, it was safe. Both techniques together were designed to avoid the dangers of being engulfed or depersonalized. With his outer behavior he forestalled the danger to which he was perpetually subject, namely that of becoming someone else's thing, by pretending to be no more than a cork. (After all, what safer thing to be in an ocean?) At the same time, however, he turned the other person into a thing in his own eyes, thus magically nullifying any danger to himself by secretly totally disarming the enemy. By destroying, in his own eyes, the other person as a person, he robbed the other of his power to crush him. By depleting him of his personal aliveness, that is, by seeing him as a piece of machinery rather than as a human being, he undercut the risk to himself of this aliveness either swamping him, imploding into his own emptiness, or turning him into a mere appendage.
>
> *(p. 48)*

4.3. Robotization of the other as a response to the unbearableness of person-to-person relationship (Laing, 1959)

4.3.1. Distressing experience

In another case, Laing tells the story of a man who was

> married to a very lively and vivacious woman, highly spirited, with a forceful personality [. . .] He maintained a paradoxical relationship with her in which, in one sense, he was entirely alone and isolated and, in another sense, he was almost a parasite. He dreamt, for instance, that he was a clam stuck to his wife's body.
>
> *(p. 48)*

Laing describes the man's struggles in sustaining a person-to-person relationship, due to feeling overwhelmed by the intense emotional and relational stimuli: "What he could not sustain was a person-to-person relationship, experienced as such." (p. 49)

4.3.2. Position-taking

To counteract these distressing experiences, Laing describes that the man felt the

> need to keep her at bay by contriving to see her as no more than a machine. He described her laughter, her anger, her sadness, with "clinical" precision, even going so far as to refer to her as "it", a practice that was rather chilling in its effect.
>
> *(p. 49)*

To him, her emotional expressions all became a predictable, "entirely conditioned" response of a "robot-like nature"—"a sort of robot interpreting device to which he fed input and which after a quick commutation came out with a verbal message to him." (p. 49)

4.4. Compensating one's sense of isolation with feelings of centrality (Ritunnano, Humpston & Broome, 2022)

The sense of centrality (being intentionally watched by unknown others, who often laugh, criticize, comment, etc.) and the related ideas of self-reference are usually considered as a basic distressing experience within the psychosis spectrum. In this case, we consider these "symptomatic" manifestations as the expression of the person's way of coping with something more fundamental.

4.4.1. Distressing experience

The theme is a painful feeling of isolation from the others; it emerges retrospectively when the expected feeling of centrality recedes.

4.4.2. Position-taking

> If I went out one day and I realized that people weren't expecting me to be there, it would be a real shock again . . . I would be. . .I don't know. . .?! I got so used to people expecting me to be there and lash out with them . . . I would feel alone again, which is what everyone else feels, like alone. So people are like a family for me, it's like a safety blanket, they make me feel so comfortable now . . . If I found out that they are not watching me and reading my mind, I would feel alone and crazy like everyone else.
>
> *(p. 110)*

Paradoxically, feeling at the center of the others' gaze (centrality), rather than a mere upsetting experience, is for this patient a welcome compensation to separatedness.

4.5. Identification with an external organism to compensate one's loss of vitality (Henriksen & Nordgaard, 2016)

4.5.1. Distressing experience

> I remember it very precisely. I must have been 4 or 5 years old. I was starting dance class and I was looking in the mirror. I was standing next to the other kids and I remember that I looked alien. I felt like I sort of stuck out from that large wall mirror. As if I wasn't a real child. This feeling has been very persistent from very early on.
>
> *(p. 265)*

This is a typical description of estrangement from one's body and loss of sense of being a living organism that can be easily differentiated from the experiences of detachment and depersonalization also found in anxiety and other disorders. Here it is the naturalness of the experience that is lost: the person has the immediate and painful awareness that there is something radical that makes him an alien compared to the other children.

4.5.2. Position-taking

> When I am alone, I must have a plant or pet in my room. You know, like a physical watermark, reminding me that the world is still spinning, that time passes [. . .] The flower needs water. I too am a living organism, so I also need water.
>
> *(p. 267)*

In this case the patient tries to cope with her sense of estrangement from her own body, and from the natural flux of life, via the identification with an external living organism (e.g., a plant). In this way, she can infer her needs as a physical and embodied organism. This allows her to partly compensate for the lack of natural embodiment through a cognitive kind of hyperreflexivity.

4.6. Active concentration on a delusional key symbol to manage kaleidoscopic sensorial inputs (Anonymous, 1990)

4.6.1. Distressing experience

> I was 22 years old and was experiencing a schizophrenic psychotic episode. The trouble started 5 weeks before I was to graduate from college. I lost the ability to concentrate on my classwork, I lost weight, and I began having difficulty sleeping.
>
> *(p. 355)*

The patient describes a delusional state shortly following these initial difficulties, a mystic delusion that she tried to keep hidden for a while. At the onset of a new psychotic crisis, she was admitted to the hospital ward, where she had the following experience:

> The bright lights and shining metal apparatus in the Emergency Room swam before my eyes, and a confusion of echoing voices hummed in my ears, but I did not fall asleep. I closed my eyes tightly to rest in the blackness. Soon the blackness began to manufacture shapes, images, and entire scenarios from my life.
>
> *(p. 355)*

4.6.2. Position-taking

As a reaction to this unmanageable overstimulation, she actively focuses on one particular point that in her delusion had a specific meaning. Here is how she described this way of handling the distressing experience:

> The best thing I could do was to keep my eyes on the Cross; it symbolized so much; it represented my only hope now, in this pit of confusion, so I pictured in my mind a brilliant white Cross of light, and to this Cross, I clung, blocking everything else from my mind.
>
> *(p. 355)*

4.7. "Conglomeration" as a compensation to the lack of smooth relatedness to the others (Minkowski, 1968/1970)

4.7.1. Distressing experience

> In life "knowing one another" and "speaking to one another" are the elementary and ordinary forms of expression by which men are brought together. This smooth way of relating to the others and of relating things and persons in the world to each other was missing in him.
>
> *(p. 410)*

4.7.2. Position-taking

In Minkowski's words, the patient's way of compensating this lack of relatedness was a kind of "conglomeration":

> He had a tendency to relate external events to himself. He believed that the official notices placed at the entrance of the hospital concerned him and were put there expressly for him. For this reason, he hesitated to come for consultation. Our schizophrenic expresses his tendency for conglomeration in lived space, [...]. The morbid tendency we observed in our patient to relate everything to himself (for example, the notices placed along his way expressly for him); here, too, it really seems to be a question of a deficiency of lived distance, resulting in the impression that ambient life "touches" the individual in an immediate way, that it is in direct, almost material, contact with him.
>
> *(p. 409)*

4.8. Shutting down as a response to social hypersensitivity (Minkowski, 1968/1970)

4.8.1. Distressing experience

In another case study, Minkowski describes a patient affected by extreme social sensitivity: "A schizophrenic whose illness evolved slowly, over many years, on a basis of schizoid hyperesthesia, as Kretschmer described it." (p. 411)

4.8.2. Position-taking

This patient's attempt at healing was a form of "shutting down":

> He had neither hallucinations nor delusions, but, in order to shelter his excessive sensitivity from the possible blows of life, he progressively put himself at a distance from reality, shutting himself up in an autistic attitude which became more and more marked.
>
> *(p. 411)*

4.9. Social withdrawal as a way to manage painful feeling of detachment from others (L.G.'s personal testimony)

4.9.1. Distressing experience

> I felt inferior to the others, that I was not up to them, I grieved for not belonging, like I came from a different planet and was headed toward another... I longed for relationships, friendships and love. But I was too afraid: I felt my whole being put at risk of dissolution in front of others...

4.9.2. Position-taking

> I kept my distance in the real world while engaging in the private one... My distance from my peers grew greater, and I couldn't conceal it anymore: I left university and closed myself in my room. Did I feel lonely? Of course. But I felt (and feel), even lonelier when in the company of other people. When I am physically alone, I don't feel my distance, my strangeness, my detachment from reality; when I am with other people, I feel it extremely painfully.

In this case an active social withdrawal is less painful than the exposition to the lived experience of the ontological difference from other people and the consequent risks for one's own identity.

4.10. Delusional explanation of uncanny bodily experiences in several ways in different moments of the psychosis (Stanghellini, 2016)

4.10.1. Distressing experience

> I had these strange energies inside. It all started like this. I felt as if my body was sending me messages from another place. I was different from all the others. Distinct from them. Separate from my body and from them. A funny funny feeling, although it made me feel very vulnerable in front of others as it in most cases happened when I was with others.
>
> *(p. 370)*

This man was in his twenties when he had such uncanny bodily experiences, which were related to sexual arousal although he was not fully aware of it.

4.10.2. Position-taking

In this case, different ways of making sense of these bodily sensations at different times across his life led to development of different delusional themes: "At first, I thought they were poisoning me" (hypochondriac explanation). "Then I realized that I lacked the 'internal wisdom' that leads you in life" (p. 371; this may correspond to an insight into his lack of common sense). Later on, he reports that "all of a sudden there came this 'intuition': that *They* had chosen me for the experiment. I was chosen to incarnate myself in one body and come to earth. That explained why I felt a stranger in my body. And a stranger on the Earth too." (p. 372). This corresponds to an experience of revelation (*Aha experience!*) of being an alien on planet Earth that helped him understand why he felt so different from all the others. Finally, he "realized" that the meaning of his journey on the Earth was reaching his final destination:

> It was worthwhile. The Earth is a very elite place to go through to reach a planet that is higher in evolution. My destination after this is a place where everything is vibration, a pure state of consciousness, so elevated that everything is peace.
>
> *(p. 372)*

This spiritual explanation of his sufferings on planet Earth gave new meaning to his life.

5. Discussion

> When I was a child, I had a fever. My hands felt just like two balloons. Now I've got that feeling once again. I can't explain, you would not understand. This is not how I am. When I was a child, I caught a fleeting glimpse, out of the corner of my turned to look, but it was gone. I cannot put my finger on it now.
>
> *(Floyd, 1979)*

Fans of rock music will easily recognize the source of this quote, describing an experience of depersonalization and derealization. This uncomfortable experience is contrasted with a *comfortable kind of numbness*: "The child is grown, the dream is gone. I have become comfortably numb" (Floyd, 1979). Numbness is often described as a psychopathological symptom; yet, it is also one of the many ways in which people may respond to and cope with distressing experiences (Stanghellini & Rosfort, 2015).

This article offers some examples, based on first-hand accounts, of how people may react to, cope with, and make sense of their basic uncanny experiences in the context of schizophrenia and related psychoses. Drawing on and further elaborating Husserl's original conception of "position-taking" (*Stellungnahme*), we have illustrated how the dialectical principle, as opposed to a naturalistic one, may help deepen our understanding of the person's interaction with their (pathological/non-pathological) worlds.

By reading the above case studies through the lens of position-taking, the benefits of applying the dialectical principle within the clinical encounter should become clear. A phenomenologically-informed practice of this kind involves not only an accurate assessment of signs and symptoms, but a recognition of the person's position-taking (including the dynamical effects of such position-taking on the manifestation and course of psychopathological phenomena). This is relevant because it can modify the understanding and treatment of the patient's condition. In addition, we believe it can further improve standard conceptualizations of the nature and meaning of psychopathological "symptoms".

On a standard biomedical account, symptoms are defined as outcomes of putative subpersonal anomalies; they are indexes for nosographical diagnosis and expression of dysfunctional phenomena to be "fixed" or eliminated. The understanding of symptoms in the light of position-taking contrasts with the standard understanding in two main respects.

Firstly, as we have highlighted throughout the paper, symptoms are conceived here as the outcome of a dialectic between a vulnerable self, and the person who is affected by this vulnerability and tries to cope with the disturbances arising from it. It follows that, seen through the conceptual lens of position-taking, the person is not simply a passive recipient of "symptoms", but is actively engaged in constructing and deconstructing

their different expressions. As a result, the interplay between the person's position-taking and his/her basic anomalous experiences can – at least partly – contribute to different clinical outcomes such as maintenance and chronicity of symptoms, recurrence, or recovery. This understanding of the constitutive fabric of a symptom may be translated into a different therapeutic focus within the clinical encounter, beyond the simple reduction or elimination of symptoms. In this context, clinicians and patients may engage in a joint effort aimed at modulating the intensity of certain symptoms through the modulation of the person's position-taking in front of his/her experiences of vulnerability. To this end, we believe that the psychological and psychotherapeutic dimensions of psychiatric care need to come to the fore.

Secondly, it should become evident – in the light of position-taking – that symptoms do not simply have a subpersonal cause, they also have a personal meaning. Translated into practice, the person-centered dialectical model of care should include an exploration of the different ways in which the person apprehends and makes meaning out of her anomalous experiences, across the pre-reflective, personal and interpersonal levels (see, for instance Ritunnano et al., 2022 for a comprehensive review of meaning in delusions). In this view, symptoms do not just act as diagnostic indexes; rather, they can be conceived as having an expressive and communicative function which provides access to the patient's subjectivity. Symptoms may show what, without them, would remain implicit. They are special kinds of phenomena through which the hidden, yet operative (perplexing and disturbing) dimension of existence is made manifest. Rather than being accidental, they are the manifestation of some implicit and quintessential dimension of the person's subjectivity as situated in relation with their intersubjective and interpersonal worlds.

The main limitation of this paper is that it does not include a complete list of possible forms of position-takings. Yet, since there is no available systematic work on this topic (and there may never be, provided that people may react to basic experiences in infinite ways), the main strength is that it may encourage researchers, clinicians and experts by experience, to cooperate in the search for and description of further examples of position-takings.

We showed that there are basically two general categories of position-taking. The first one is characterized by passivity, leading to forms of withdrawal from the shared world and to "negative" symptoms, rather than to "positive" or psychotic ones. This is the case with "shutting down" as a response to social hypersensitivity, "social withdrawal" as a way to manage painful feeling of detachment from others, and also with being "comfortably numb." A similar form of position-taking is the "detachment" from one's body to defend oneself from the anguish produced by feeling disembodied,

which includes both passivity and activity. In these forms of position-taking, dominant emotional features appear to include, among others, apathy (absent or flattened emotions), anxiety (worry about anomalous experiences, inability to cope or make sense of them), depression (shameful concern about anomalous experiences), despair (hopelessness linked with meaninglessness and inability to cope).

A second category of position-taking is of a more "active" kind, leading to the construction of "new" and idiosyncratic worlds and the development of "positive" psychotic symptoms. In these cases, the person may embark in a "fight" for meaning to try and make sense of their distressing experiences. This form of position-taking includes (in our examples) the "petrification" of the Other as a defense from ontological insecurity, "robotization" of the Other as a response to the unbearableness of person-to-person relationships, compensating one's sense of isolation with "feelings of centrality," "identification with an external organism" to compensate one's loss of vitality, "active concentration on a delusional key symbol" to manage kaleidoscopic sensorial inputs, "conglomeration" as a compensation to the lack of smooth interpersonal relatedness, and several kinds of "delusional explanations". These include hypochondriac delusions, such as the "objectification" of one's sufferings conceived as symptoms of a somatic illness, and "revelatory" delusions (i.e., *Aha!* experience) implying a kind of "conversion" to some superior spiritual truth, or the discovery of a "mission" to be accomplished. In some of these cases, the emotional tone may reflect a sense of exaltation and euphoria linked to a syntonic relation between the person and the positive significance of their anomalous experiences.

Our perspective is consistent with other models of mental symptom formation (e.g., Aragona & Marková, 2015), suggesting that certain psychotic "symptoms" are better understood as the expression of the person's manifold reactions to anomalous basic changes in implicit aspects of experience. By focusing on the underlying dynamic and interactive processes of symptom formation, including adaptive attempts at coping with distress, the dialectical-phenomenological approach described here can provide a way for clinicians to co-construct a shared understanding of psychopathological experiences. In this sense, it goes beyond "surface" state-like features to hone in on the complexity of mental life looked at through the lens of the person in relation to his/her world. A further application of this model concerns the development of a two-tier descriptive system, integrating standard diagnostic procedures with a comprehensive assessment of the person's position-taking (Stanghellini & Rosfort, 2015; Ritunnano et al., 2021). Achieving an integrative synthesis of these two levels of clinical and personal knowledge may contribute to the development of novel theoretical and explanatory models of psychopathological experiences. In addition, it

has the potential to improve communication and therapeutic trust in clinical encounters, by supporting the persons' sense of epistemic agency (Houlders et al., 2021) and their ability to feel capable, in control and efficacious.

Finally, our perspective changes the focus of the treatment itself. As in the itch-scratch-scar model, we could say that targeting the "scar" is sometimes crucial to avoid serious problems; it is often necessary to relief the immediate suffering, but is insufficient to understandthe patient's suffering (Gilardi & Stanghellini, 2021). Similarly, the reduction of secondary symptoms such as delusions and hallucination through the use of antipsychotic medications may be crucial in some cases but may not target what – for the person – is the primary source of distress. Patients may benefit from discussing basic anomalous experiences and position-takings in a de-stigmatizing and de-shaming manner, as these may be central concerns for the person, though often left unaddressed or only superficially attended in the clinical encounter.

Note

1. To avoid an over-simplified understanding of the "naturalistic" principle, it is important to clarify the notoriously vague notion of "naturalism" and thereby arrive at a better understanding of what it means to adopt a naturalist stance. For a good introduction to, and critical discussion of, the question of naturalism, see (Baker, 2007; De Caro & Macarthur, 2008; Papineau, 2009). The philosophical debate about naturalism deals with, roughly speaking, the question of whether or not philosophical inquiry (and the humanities and social sciences in general) should model their methodology on, and construct its ontological assumptions in continuation with, the research done in the natural sciences. As one of us has written some years ago (Stanghellini & Rosfort, 2015), there are currently three basic positions at work in this debate: anti-naturalism, strict naturalism, and relaxed naturalism. Anti-naturalists reject the idea of naturalizing traditional philosophical problems. They argue that there are real entities in the world (e.g., persons, numbers, values, colors) that cannot be assessed and examined with the methodological tools and ontological assumptions of the natural sciences (e.g., Goetz & Taliaferro, 2008; Swinburne, 2013). Strict naturalists, on the other hand, argue that everything can and should be naturalized according to the best available scientific knowledge. Traditional philosophical and ethical conundrums, they argue, can be assessed and solved more satisfactorily if philosophy follows the lead of the natural sciences (e.g., Churchland, 2013; Dennett, 1994; Thagard, 2010). The relaxed or liberal naturalists take a completely different approach. They reject the ontological approach of both anti-naturalism and strict naturalism, and argue for a pragmatic naturalism that looks at actual human experience and practice instead of wasting precious philosophical energy on trying to make sense of how a seemingly immaterial mind fits into (or does not fit into) a material world (Kitcher, 2014; McDowell, 1996; Price, 2011; Putnam, 1999). While this last solution may seem attractive because it by-passes the hackneyed problems that have

haunted philosophy for more than two millennia, such as the relation between mind and body, the distinction between fact and value, and skepticism concerning the external world, and although one may appreciate the philosophical appeals to pragmatism and common sense, the fact is that such appeals do not have much effect in psychiatry.

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