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Interpersonal Experience and Psychopathology

Abstract:
The article deals with relational aspects of mental disorders. The author takes into account the influence of mental illness on intersubjectivity and interpersonal relations in three aspects: (1) "attitude to the illness," that is, changes in the functioning of the subject and difficulties in dealing with the experience of mental illness; (2) "dialogical relationship" in the form of difficulties in maintaining social cognition and entering into relationships with others; (3) "social consensus," that is, difficulties in adapting to the social world and a common sense deficit. The analysis is made with reference to phenomenological research in contemporary philosophy of psychiatry. The result of this study is a reconstruction of a "different existence," in other words, presentation of the transformation of the life-world and the specific way of inhabiting the world of a person in a mental crisis. Symptoms and experience of the illness are presented in the light of human possibilities of transformation. The analysis emphasizes the role of patients' subjectivity and their efforts to find the meaning of a painful situation. The study of subjective aspects of disorders aims to reveal their consequences for understanding how to deal with mental crisis and to understand the positive aspects of the recovery process.

Keywords:
experience of mental illness, phenomenological psychopathology, intersubjectivity, social cognition, common sense, recovery process

Mental disorder transforms the whole human experience, especially the sense of personal identity, the feeling of reality and interpersonal relations.[1] The sense of personal identity, normally coherent and rooted in the body, can be changed through the loss of the obviousness of the self, the feeling of inconsistency, and disintegration of the ego. The sense of reality concerns not only the embodied self, but also the sense of reality of the world; a world in which we engage in constant interaction and dialogue. In this article I would like to focus on the third aspect of possible transformation, that is, relational aspects of mental disorders. The following questions should be taken into account when fully addressing the problem: How does mental illness (psychosis) affect interpersonal relations? How does it contribute to changing the functioning of the subject? How does it make it difficult to cope with oneself, to enter into relations with others, and increase the difficulty of adapting to the social world?[2] In my research, I emphasize the role of patients' subjectivity and their effort to find the meaning of the painful situation. The analysis of subjective aspects of disorders reveals their consequences for the understanding of ways of dealing with mental crisis and the course of the recovery process.

A Return to Intersubjectivity

The intersubjective turn was undertaken in phenomenological psychopathology several decades ago.[3] Many researchers have emphasized that a mental disorder always has an intersubjective dimension. This is particularly manifested by the difficulty of entering into full-scale relationships with people affected by the disorder and impossibility of creating a safe and complex interpersonal relationship. This is evident in the case of delusions, which, although classically defined as a kind of false irrational beliefs, fundamentally affect the intersubjective experience and are basically associated with the inability to accept or consider someone else's perspective. As Thomas Fuchs states: "delusions appear primarily as a specific disturbance or breakdown of communication: the mutual comparison and alignment of perspectives fails."[4] Similarly, Matthew Ratcliffe recognizes in mental disorder characteristic ways of relating to others: "without a certain way of relating to others, the sense of being rooted in a public world would be compromised from the outset, leading to epistemic dispositions and a more general way of finding oneself in the interpersonal world that could render one susceptible to further unpleasant social experiences and, ultimately, to psychosis."[5]

The relational nature of mental disorders has already been pointed out by a Dutch psychiatrist and phenomenologist Jan H. van den Berg, who calls psychopathology "the science of loneliness and isolation."[6] When presenting a clinical case of his own patient, he notes: "Loneliness is the central core of his illness, no matter what his illness may be. Thus, loneliness is the nucleus of psychiatry."[7] Of course, the level and type of loneliness and isolation of a person in a mental crisis depends on the type and intensity of the disorder.[8] Separation

1) Kapusta, *Szaleństwo i metoda*.

2) The concept of mental illness is very broad. Only a detailed analysis of the transformational experience of selected types of mental disorders would allow us to capture the more subtle aspects of this experience. Natural candidates for such analyses are: schizophrenia, depression, personality disorders and a number of anxiety-related disorders. A detailed list of possible disease units would be quite long.

3) Thoma and Fuchs, "Inhabiting the Shared World," 20.

4) Fuchs, "The Intersubjectivity of Delusions," 178.

5) Ratcliffe, "The Interpersonal World of Psychosis," 177.

6) Van den Berg, *A Different Existence*.

7) Ibid., 105.

8) Van den Berg is aware that the feeling of loneliness in moments of total lack of insight may not be recognized by the patient. However, we can regard his general thesis as a general statement in the anthropology of psychoses.

and isolation appears, as van den Berg says, in different dimensions of the patient's experience: in relation to the world, in the experience of one's own body, in relation to others, and in the way one experiences time. The very category of relationships toward others is not specifically distinguished since the problem of loneliness is complex and can only be fully grasped from the perspective of the patient's overall experience.

Phenomenological Description

A world of a sick person may be unrealistic, unintelligible, unstable, permeated with fear or unmeasurable sadness. The only thing that a phenomenological therapist can do is to make a reliable description of patient's experience, and especially his way of seeing things and other people. It is striking how difficult it is to penetrate this altered world. The reality of a patient's illness is demonstrated by his bodily experience – which during the course of the illness becomes so distorted that it begins to constitute a barrier between him and the world.[9] The closeness between the body and the world becomes more intense thanks to a good and intimate dialogical relationship with other people. Another person can have an active influence on how we see the world and can brighten or darken the surrounding objects. Also disturbed contact with others becomes visible through a change in the experience of the body.

A complete description of the structure of someone's experience requires its inclusion in relatively ordered categories. Capturing the real course of experience allows the world to be revealed in its full complexity. Often there are hidden sources of experience, habits and automatisms, drives, and emotional aspects that the person does not notice. A description, deepened by the interpretation of experience, allows for the attitude toward someone's experience to be grasped – with particular emphasis on the role an individual plays in shaping pathological experience and how the symptoms and pathological sensations are mediated by social and cultural relations. The research enables demonstration of the active attitude of the patient and the environment in the formation of painful symptoms and to emphasize factors important in the recovery process. The description of the illness reaches beyond the biomedical categories and indicates the role of the attitude toward the illness; of how important are difficulties in communicating with others and the importance of social attitudes toward people with psychiatric disorders. It also allows for revision of the existing attitude of the patient toward the condition and strengthens the patient's sense of subjectivity and responsibility for him/herself. Phenomenological analysis of the pathological experience consists in searching for a comprehensive structure of the patient's experience. Symptoms and ailments are perceived in their interrelation. Symptoms are not isolated elements, the interconnection of which would refer to a manifestation of a hidden biological process.

The starting point for the phenomenological description is to capture the personal style of patient's experience;[10] to study different forms of perception, thinking, emotions, feelings, actions and their meaning for the patient himself.[11] Within the framework of the "pathographic" approach, "pathogenic situations" and possible

9) According to van den Berg (1972), the relationship between the body and the world is visible in more everyday situations, such as the simple and unambiguous attitude of a soldier and the clumsy and asymmetrical attitude of a shy teenager. In psychopathology one can imagine the patient's immobile attitude in catatonia. The equivalent of this immobile bodily posture is a world without purpose, direction or utility. The world of a depressed patient, in turn, is a situation of slowness, hardship, tiredness and passivity. A heavy material body corresponds to this.

10) Irarrázaval, "Phenomenological Paradigm for Empirical Research in Psychiatry and Psychology."

11) Researching the base structure of experience is possible from a phenomenological perspective. Ratcliffe, see "Understanding Existential Changes," emphasizes that this type of analysis requires an approach other than psychological, which contrasts the mental aspects of experience with physical/neurobiological aspects. Also insufficient is a personal attitude contrasted with an impersonal perspective characteristic of natural sciences. The psychological and personal approaches are not capable of capturing certain subtle

susceptibility to injury are sought or indicated. Specific life situations of the patient and relations with others may make him/her vulnerable to an existential crisis. The therapeutic relationship itself can also be the subject of reflection as a form of dialogue that can change the patient's experience. An important part of the therapeutic relationship is the reconstruction of the patient's vision and life project aimed at the recovery process.

Van den Berg's phenomenological investigations show how the researcher operates on different levels. The author of *Different Existence* comes from a single clinical case and refers to the many examples of everyday situations. However, he emphasizes that alongside the patient-specific narrative of the pathological condition, the task of phenomenological psychopathology is to search for a hidden "basic" structure of the pathological experience through analyses of temporality, spatiality, corporeality, self-experience, or intersubjectivity. The result of such analyses is a reconstruction of "different existence" – a presentation of the transformation of the patient's life-world and his/her specific way of inhabiting the world. What is more, someone's symptoms and experience of illness can be related to more general anthropological assumptions. In this way, the situation of the patient is also presented in the light of human possibilities of transformation.[12]

Philosophical and Everyday Intersubjectivity

Before proceeding to the analysis of various aspects of interpersonal relations, it is worth emphasizing that the problem of intersubjectivity in psychopathology can be examined both on an empirical (everyday) and philosophical (transcendental) level. Both of these levels touch and condition each other. On the one hand, we can treat the problem of relationship with a person affected by a mental disorder as the occurrence of a number of real symptoms visible in a direct encounter with a person in a clinical trial. On the other hand, we can look for a hardly identifiable overall change in the patient's world, his or her "different existence," which is difficult to grasp by describing single and easily recognizable symptoms.

Only a more philosophical perspective can reveal that the holistic changes of pathological experience may be treated as an effect of the intersubjective conditions of our experience, and as a deformation of the process of co-creating a common world of meaning. Therefore, it is difficult to fully understand pathological change without understanding the (transcendental) conditions necessary for the appearance of experience as such. For example, Jaspers describes "delusion proper" as "a transformation in our total awareness of reality" and as a "transformation of basic experience which we have such great difficulty in grasping."[13]

Modern disorder classification systems (DSM-5) do not attach much importance to the description of patient experience. The vast domain of human experience, like notion of the self, self-identity was deleted from the classification systems because it did not fit into the simple and technical language of operationalized and reliable definitions. According to Parnas: "No account of human subjectivity and intersubjectivity is to be found in the contemporary psychiatric manuals, not even in the textbooks specifically dedicated to the nature of psychiatric interviewing."[14]

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elements of human experience, which are particularly emphasized in a pathological change. This is about the sense of realness of one's self and the world, a background sense of belonging to the same world, see Ratcliffe, "Understanding Existential Changes," 225, which is beyond mental/neurological and personal/impersonal comparisons (see also Kapusta, "Transformative Experience and Psychopathology."

12) See Fuchs, "Existential Vulnerability," and Plessner, *Levels of Organic Life and the Human.*

13) Jaspers, *General Psychopathology,* 95.

14) Parnas and Zahavi, "The Role of Phenomenology in Psychiatric Diagnosis and Classification," 140.

The problem of relations with a patient affected by a mental illness is often illustrated by the example of schizophrenic disorders. Symptoms of "schizophrenia" involve a range of cognitive, behavioral, and emotional dysfunctions: delusions, hallucinations, disorganized speech, disorganized catatonic behavior or negative symptoms in the form of diminished emotional expression or avolition. No single symptom is pathognomonic of the disorder.[15] According to criterium B: "Level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset."[16] In such cases, the lack of adaptation/adjustment of the patient to others is particularly evident. There are difficulties in communication and language understanding as well as depersonalization and derealisation in the form of objectification (de-subjectionalization) of other people. Persons with schizophrenia lack social competences and have difficulties in playing social roles and following social rules.[17] The difficulty in maintaining relations with others may result in compensatory strategies, such as social withdrawal.[18]

The DSM-5 defines depression in an equally precise way. To diagnose "major depressive disorder" we have to recognize two core symptoms: depressed mood or loss of interest/pleasure, along with at least four others from a list of seven (weight and/or appetite changes; insomnia or hypersomnia; psychomotor changes; fatigue; worthlessness and/or guilt; lack of concentration; thoughts of death or suicide). A direct reference to the social aspects of a patient's functioning can be found in the form of criterion B where "the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."[19] From a phenomenological point of view, such a list of symptoms is immersed (appears in the context) of the more general "existential change," and "shift in the person's overall sense of belonging to the world."[20] There are estrangements from others and the loss of significant possibilities from the world. This is accompanied by a change in body experience and a sense of agency.[21]

Apart from the symptoms visible during a direct encounter with the patient and easily objectified and grasped by means of psychopathological criteria, we can also talk about more general changes concerning the intersubjective (not only subjective) dimension of the experienced reality. It is about explaining aspects of the sick experience that relate to changing the way we experience ourselves perceiving the world and entering into relationships with other people, and which is particularly evident when we lose our sense of reality. Such a troublesome and painful transformation is particularly visible in the situation of losing the sense of reality, for example in social derealization and delusional perception. That is why van den Berg, who wants to describe the "different existence" of psychiatric patients, points out that their loneliness and life in isolation is primarily due to the difficulty of penetrating their way of experiencing the world and lack of access to their different being in the world. This kind of global change cannot be described by means of objective language that does not touch the real world of the patient. Such a notion as "projection" may misleadingly suggest that the patient has imposed his erroneous subjective internal image (projection) on an objective and ready reality. From a phenomenological and hermeneutic perspective, the world is never ready. The objectivization and sense of the world is co-created

15) American Psychiatric Association, 100.

16) Ibid., 99.

17) The problem of relationality in psychopathology is particularly visible in the case of delusions, whose contents most often relate to social and other people's situations (for example reference delusions, paranoid delusions). However, we are dealing with a kind of pseudo-relationship in which there is no mutual interaction and dialogue exchange.

18) Corin and Lauzon, "From Symptoms to Phenomena."

19) American Psychiatric Association, 163.

20) Ratcliffe, *Experiences of Depression,* 6.

21) See Kapusta, "Experience, Depression and Decision-Making."

only in relation to other people and as a result of observing and sharing social rules of common sense. In one of his texts, Gallagher suggested a similar division into a relational "social cognition theory" within which we interact with others and thus get to know their embodied emotions and intentions and a more holistic dwelling of the common world of meaning – "participatory sense making."[22]

Three Aspects of Relationships

The psychopathology of interpersonal experience should be explored on a multi-level basis in order to identify aspects visible at the individual and socio-cultural level.[23] In other words, we can capture the situation of a patient in a mental crisis as a disorder of dialogue with oneself, a disorder of dialogue with another person and a lack of trust in the rules and principles governing the social world.[24] I will analyze the problem of relationship in three aspects: (1) Attitude toward the illness;[25] which consists in the patient's interpretation and attempts to make sense of his or her own difficulties and disorders, (2) Dialogical relationship, also referred to as perspective taking, is the ability to adopt the perspective of the other person – the ability to read other minds (mindreading), (3) social consensus (*sensus communis*/common sense), that is, the ability to follow social rules and understanding the social norms and patterns of behavior.

1. Attitude to the Illness

The patient's attitude to the illness is a subjective position toward his or her own mental disturbances which does not seem to require direct reference to relationships with others.[26] A systematic review of the position taking of people experiencing mental disorders is taken by Karl Jaspers in *General Psychopathology.*[27] Patients deal with the situation of a pathological change in different ways. They generally have limited awareness of the change – limited insight – but always try to interpret their own experiences in some way.[28] Particularly dramatic can be the first episode of the illness, which makes the patient uncomfortable and lost, makes it difficult to understand new information and feelings, leads to internal incoherence, and difficulties in paying attention. This may lead to puzzling expression, intensive personal investigations, and an "uncanny feeling of change,"[29] which is not so

22) See Gallagher & Varga, "Social Cognition and Psychopathology." Gallagher asks how we create a common world together: "How do we, together, in a social process, constitute the meaning of the world? In contrast, the problem of social cognition is centered on the following question: How do we understand another person?" Gallagher, "Two Problems of Intersubjectivity," 305. From this perspective, the understanding of the other person is possible if we include the common world and the world of objects, in the mutual exchange. Without the feeling of inhabiting the common world, dialogue is either impossible or flawed. In a similar vein, Duppen defines the philosophical dimension of relativity as "transcendental intersubjectivity" in opposition to "mundane intersubjectivity" which "involves difficulties and disturbances in the interpersonal sphere" (Duppen 2017, p. 406).

23) Also very interesting is the research on neurocognitive science, which focuses on context-dependent competency, communicative pragmatics and narrative competency. (See Gallagher and Varga, "Social Cognition and Psychopathology.")

24) Stanghellini, *Lost in Dialogue*.

25) Japers originally described it as: "Die Stellungnahme des Kranken zur Krankheit." (Jaspers, *General Psychopathology*, 414.)

26) Describing the patient's attitude toward his or her own illness implies that the patient has an insight into his or her own experience. The way of experiencing and coping with the illness should depend on its character or style of thinking, which in turn is conditioned by its social resources. This type of analysis undertaken by Jaspers, among others, seems clear to the reader. Indicating the intersubjective and social conditions of this change requires taking into account less obvious aspects of the illness experience.

27) Jaspers, *General Psychopathology.*

28) Marková, *Insight in Psychiatry.*

29) Jaspers, *General Psychopathology,* 415.

much an opinion on the upcoming crisis, but rather a description (often *post factum*) of the patient's actual experience. Overworking the effects of acute psychosis, like any significant but traumatic experience, can significantly change the patient's personality or ultimately remain indifferent to him; the illness can cause despair, be a kind of life renewal, or even a kind of internal conversion.[30] In the case of the chronic course of the illness, the patient develops various forms of adaptation, that is, by development of the delusional system[31] and the use of various forms of coping, which allow to distract attention or minimize the symptoms.[32] Indifference or submission to symptoms may also occur. All this depends on the character of the patient and his or her different adaptation strategies. Attempts to interpret the pathological complaints can be very extensive and in some aspects reliable. However, the patients' insight is never complete, which nevertheless shed some light on their life situation. The point of reference for insight is an average normal individual who comes from the same cultural environment. Much depends on the environment, origin and education of the character of the sick person. The patient is generally not completely aware of mental illness, except in case of personality disorders. A temporary, deepened or only illusive insight is also possible. The assessment of one's own personal situation may be accurate in many aspects, but many aspects of the illness are generally unrecognized. Interestingly, self-observation can be a painful manifestation of the illness, it can be compulsive and interfering with normal life activities. However, it does not lead to the illness itself, but to an "abnormal kind of self-observation."[33] The patient takes an attitude toward the illness also during remission, after recovery. He can speak freely and at a distance about his former symptoms. Sometimes, however, the personality is permanently influenced by psychotic content.

Jaspers, on the one hand, as befits a serious textbook, is organizing the knowledge about patients' attitudes at that time and on the other hand, presents his existential interpretation of the pathological experience. The author of *General Psychopathology* is referring to people's different attitudes toward the illness and emphasizes that psychopathological (scientific-medical) categories are not able to fully grasp someone's existential situation.[34] The patient's attitude toward the illness is, in a way, between two poles: between objective and medical knowledge and understanding the purpose of own existence. It is characteristic for a human being to distance oneself from one's own life situation, from one's origin, age, gender, mental illness, while at the same time identifying oneself in part with one's own condition. One is always doomed to a constant interpretation of one's own life, to distinguish what comes from nature (it has an inborn, biological character), and what depends on one's own personality or acquired qualities.[35] The search for the meaning of illness cannot be treated as a manifestation of a lack of insight, as one never deals with the fullness of self-knowledge: "The constant search for meaning, interpretation and inclusion in respect of everything that seems objectively in the disease process, does not immediately signify lack of insight into the illness."[36] It follows that understanding the nature of symptoms cannot be reduced to searching for the neurobiological causes and mechanisms, because the whole of experience of an illness also consists of an attitude toward one's own illness and symptoms.

From the above description of Jaspers' perspective, the vision of individuals struggling alone with the symptoms of their own illness may arise. However, the patient's situation is never isolated and depends on relationships with others and the social context. Jaspers wrote about it by explaining the way in which delusions

30) Ibid., 416.

31) Interesting cases of "philosophical" transformations of delusional systems are reported by Kępiński, *Rytm życia*.

32) For comparison, see also Biringer, Davidson, Sundfør, Lier, and Borg, "Coping with Mental Health Issues."

33) Jaspers, *General Psychopathology,* 420.

34) Kapusta, "Karl Jaspers' Psychopathology and Contemporary Psychiatry."

35) Jaspers, *General Psychopathology,* 426.

36) Ibid., 427.

are created: "Normal convictions are formed in a context of social living and common knowledge. Immediate experience of reality survives only if it can fit into the frame of what is socially valid or can be critically tested… . The source for incorrigibility therefore is not to be found in any single phenomenon by itself but in the human situation as a whole, which nobody would surrender lightly. If socially accepted reality totters, people become adrift? What is left to them? A set of habits, survivals, chance events?"[37] In the above commentary, Jaspers underlines that separation of experiences and beliefs from their social and relational context condemns the individual to habitual random and only current reactions.

Marková and Berrios[38] emphasize how difficult it is to define mental symptoms. They point to the troublesome status of patients' subjective complaints, which does not allow to consider disorders in purely biological/objectivistic and subjective/individual categories. Subjective changes in the patient's experience in the form of a sense of depression, a state of suspicion, a feeling of depersonalization, a sense of inner emptiness, or hearing voices are difficult to verify whether it is at the level of the specifics of the experience itself or the reliability of its description. Moreover, the appearance of new unusual and bizarre sensations in the form of a specific "symptom" would require the ability to internally identify these new experiences. Mental symptoms are a type of personal construct, which is the result of a process that aims to "catalogue them in terms of available categories – constituted and governed by personality factors, education, imagination, adaptive capacities, socio-cultural factors, and so forth. In other words, whether a subjective experience is articulated as a depressed mood, a feeling of fatigue, a pain or even a sense of dread may depend less on some specific (biological) invariant than on a host of personal and cultural factors."[39] The fact that someone has a symptom is the result of a personalized interpretation of often unclear, ambiguous and underdeveloped experiences and events. The articulation of these experiences, despite their uniqueness and difficulties in understanding them, is based on social and cultural influences (anti-solipsism). Symptoms are not only private constructs, because their manifestations are also based on social external criteria (for example observable behavior and patient's language).[40] It follows that the formation and perception of symptoms is influenced not only by the biological or psychological pathological process or individual personality factors, but also by the relations one takes toward the other and socio-cultural conditions.

2. Dialogical Relationship/Taking Perspective

Taking an attitude toward one's own illness is taking a stand, evaluating and trying to understand and make sense of one's own changing experiences; it is taking an attitude that is somewhat like an intrapsychic "internal" process. On the contrary, taking a perspective presupposes considering the point of view of another person. Capacity of shared intentionality or perspective taking means, according to Fuchs, "To transcend one's primary, egocentric perspective and to grasp others' intentions and point of view."[41] Intersubjective experience is possible thanks to the ability to shift between egocentric and allocentric perspectives, to adopt a decentralized attitude

37) Ibid., 104.

38) Marková and Berrios, "Epistemology of Mental Symptoms."

39) Ibid., 344.

40) From the perspective of an observer or clinician, for a given symptom or syndrome to be considered a disease, it must not only be classified as a symptom but also interpreted on the basis of external factors (in the practice of interpreting a patient's social functioning).

41) Fuchs, "The Intersubjectivity of Delusions," 178.

without losing the sense of corporeal rootedness in the world.[42] Interacting with each other and adopting the right perspective enables individuals to create meaning together. However, the presence of obstacles in this path can lead to disorders and failures in mutual understanding. Mental disorders can even result from a lack of understanding of the language spoken by the interlocutor.[43] In the case of the early stages of schizophrenia, the emerging loss of meaning is primarily social. Sometimes the faces of others and their eyesight appear as ambiguous and incomprehensible. In this way the presence of others turns out to be particularly acute and excessively present.

Perspective taking assumes that only the contact with the other, a dialogical relationship, allows someone to take a surprisingly different perspective on himself. The recognition of the limitations of one's own perspective and the awareness of one's own location in a certain place and time, also evokes the awareness of the presence of other persons' points of view and the need to undertake attempts to understand them. While in the case of the (previously discussed) position taking it is possible to build awareness of my own experiences, perceive a change in my own experience, and even look at my past experiences in a different way – the perspective taking allows for taking the attitude of the other person seriously. This is connected with the issue of mindreading and the dispute about the nature of mechanisms responsible for the ability to read other people's mental states. From a phenomenological and embodied perspective, the cognitive concepts of mindreading are too distanced and over-intellectualized. This is because attributing mental states to other persons is a kind of practical skill rather than specific knowledge, or the result of conclusions about hidden mental properties. The everyday relationship with another person is associated with a "personal attitude"[44] which consists in experiencing someone else as a person. This relationship is pre-conscious and embodied and is based on the synchronization of mutual gestures, spontaneous movements and expression. The importance of such an attitude becomes apparent when the interpersonal relationship fails, for example, in case of mental disorders. Matthew Ratcliffe highlights the importance of affectivity in the experience of intersubjectivity.[45] A particular example of this is the feeling of unfamiliarity that occurs in the case of Capgras delusions and in the case of a depersonalization. Capgras delusions consist in a bizarre loss of relationship with a close person: "Normal feeling of familiarity has been replaced by a disturbing feeling of unfamiliarity and estrangement."[46] To explain the statement "this person is not my spouse but an impostor" one has to appreciate the role of bodily feeling and feeling of relatedness on interpersonal experience. In fact, we are dealing with a change in the structure of the experience in the form of a modification of the affect which Ratcliffe defines as "existential feelings," that cannot be put in terms of propositional content (beliefs and desires). The change of this affective structure can be so strong and dominant that it is difficult for someone to take into account other (alternative) explanations of their own feelings and to take into account the critical opinion of others (concerning irrationality and absurdity of these beliefs). Thus, we are dealing with a situation where there is no concrete physical change in the other person's appearance and, at the same time, the unreliable belief that we are dealing with some other person. The appearance of such an incredibly improbable belief about such a change is due to the transformation of the structure or horizon of the experience, which sets the contextual background for perception and recognition. While objects appear in their appearances (aspects), which can be gradually defined or modified in the horizon of experience, the potentiality and space of possibilities is particularly important in interpersonal relations. Perhaps a change in

42) "Eccentric Position," see Plessner, *Levels of Organic Life and the Human.*

43) For example, due to deafness; see Fuchs, "The Intersubjectivity of Delusions."

44) Husserl, *Ideas Pertaining to a Pure Phenomenology.*

45) Ratcliffe, *Feelings of Being.*

46) Bayne and Pacherie, "In Defense of the Doxastic Conception of Delusions," 4.

a person's recognition of Capgras delusions is possible as a result of losing a certain dimension that is part of any intimate/deep interpersonal relationship. The horizon of interpersonal experience seems to be based on a space of possibilities and mutual expectations, which are somehow inscribed into the structure of our experience. The space of possibilities opens for us a variety of life scenarios, different relationship stories. When the awareness of choice disappears and we are convinced of the permanence and unchangeability of the depressive experience, the world appears as dead and the person feels strange and separated from others.

The possibility of adopting a different perspective takes place in the light of the horizon of expectations, which assumes different looks of things, different aspects of experience, different behaviors and ways of seeing the world; and which goes beyond the perspective and the place where a certain individual is located. Only in relation to others and in the presence of norms or patterns of behavior and expectations can a personal identity (person, self) be created. The understanding of other people's perspective may appear without losing its own coherence and integrity. The effects of losing the ability to accept other perspectives can be seen in the experience of crisis and mental disorders. In such cases, the difficulties of empathy, dialogical attitude, and maintaining interpersonal relations are particularly visible.

There are probably many ways in which the horizontal structure of experience transforms. The loss or breakdown of the horizon is particularly evident in the experience of mental crisis. In this way, a sense of strangeness appears (identity problems); there is a loss of the sense of reality of the world – a limitation of the possibility of entering intersubjective relations (narrowing the space of intersubjective possibilities) and difficulties of playing social roles freely. Under normal circumstances, experience develops in a structured way and gradually reveals its hidden possibilities. When the horizon is curved or deformed, the hitherto existing "flow" is lost, and there is a break with the hitherto socially accepted pattern of relevance and expectations. Earlier, a relatively coherent space of possibilities and a coherent pattern of meanings is shaken.

In the language of existential feelings one can speak about the fragmentation of the structure of experience. A patient with schizophrenia does not possess a coherent structure of experience that would give him a sense of belonging and stabilization of his own self, and that would determine the practical possibilities of coping with the world and entering into relationships with others. Such a person has little sense of agency as well as control over his or her own life, and is doomed to be passively subjected to the influences of the environment and the sensations and ideas he or she encounters. It can be assumed that we are dealing with such a mild form of schizophrenia that a weakened (not chaotic) horizon still offers some possibilities (relations and actions). They often take the form of coercion, against which the patient turns out to be powerless and vulnerable. Existential feelings, properly structured, create a sense of reality, which in schizophrenic experience is deformed (diminished). As a result, previously tamed objects lose their practical meaning, previous possibilities of action disappear, everything becomes artificial and mechanical.[47] Only the full horizon of expectations allows us to perceive others as persons, and not as manipulable objects. Only in the case of persons does the unlimited space of possible relationships updated in the course of mutual (online) interactions appear. Without feeling the possibility of communicating and entering into complex relations, the other person may appear in an objectified and anonymous way, for example, as an imitation or a dummy.

The ability to recognize other people's states, the so-called mindreading, is considered to be the basis of social cognition. This ability is significantly limited in many mental disorders. From a phenomenological perspective, the dysfunction of the embodied self in schizophrenia – disembodiment, in other words, the loss of the elementary basis of intersubjectivity, is emphasized: "If this embodied involvement in the world is disturbed as in schizophrenia," Fuchs says, "it will result in a fundamental alienation of intersubjectivity: the basic sense

47) Sechehaye, *Autobiography of a Schizophrenic Girl*, 31.

of being-with-others is replaced by a sense of detachment that may pass over into a threatening alienation."[48] The loss of basic intersubjective harmony results in the removal of the boundaries of one's own ego and the difficulty of distinguishing oneself from the interlocutor. When interacting with another, a sense of loss of one's own subjectivity (agency) may occur. Schizophrenia is often accompanied by the difficulty of simultaneous maintenance of relations with another person and the establishment of a sense of one's own identity. Margaret Warner,[49] referring to the practice of person-centered therapy, speaks of a kind of "tunnel vision," which occurs in clients with the so-called "fragile process" who intensively experience their sensations and reactions while not being able to go beyond their own perspective. What is more, they feel threatened to take into account the experiences of others or to adopt their own perspective.[50]

The issue of social cognition concerns the problem of reading other minds, described for example in terms of relational theory.[51] According to this approach, we get to know other minds through dynamic interactions. However, it should be emphasized that mutual understanding is possible if we perceive the world in a similar way and share a number of experiences or ways of thinking. Therefore, mutual dialogical understanding is possible through "participative sense making." The task of the subject is to make the world meaningful and to recognize and acknowledge the norms and patterns of behavior already present in the world. As Gallagher says: "Making sense of the world together (in a social process) is not the same thing as making sense of another person within our interactive relationship, even if that interactive relationship is one of participatory sense making. One process may contribute to the other."[52]

3. Social Consensus

The process of transition from single individual interactions to more general social relationships and behaviors is gradual and constitutes a complex overall phenomenon. Also the failure of individual relationships or the trauma caused by the actions of particular individuals can affect the overall relationship with the world, dramatically undermining social confidence. The individual in the process of education and socialization quickly recognizes social expectations and deeply contextual patterns of behavior, which are expressed in the form of an adequate sense of social situation or the occurrence of social sensitivity and tactful behavior. A person who is unable to follow these socially accepted rules experiences a number of social failures and disappointments. The social dimension of mental disorders was emphasized by Wolfgang Blankenburg,[53] who interpreted mental illness in terms of a loss of natural self-evidence and a common sense deficit. A common sense is a series of automatic and pre-reflexive rules and conclusions that mediate the ordering of daily experiences and serve to stabilize and make relationships between individuals in a given group more coherent. The principles of common sense are obvious to all members of a community; they form the basis for human expectations and assigning mean-

48) Fuchs, "The Intersubjectivity of Delusions," 199.

49) Warner, "Toward an Integrated Person-Centered Theory of Wellness and Psychopathology."

50) Fuchs, "The Intersubjectivity of Delusions," 200: "I don't really grasp what others are up to… I constantly observe myself while I am together with people, trying to find out what I should say or do. It's easier when I am alone or watching TV" (Quotation from a schizophrenic patient, Psychiatric Clinic, Heidelberg).

51) Gallagher and Varga, "Social Cognition and Psychopathology."

52) Gallagher, "Two Problems of Intersubjectivity," 299.

53) Blackenburg, "Anthropological and Ontoanalytical Aspets of Delusions"; and Blackenburg and Mishara, "First Steps Toward a Psychopathology of 'Common Sense.'"

ings to them.[54] Common sense is also understood as intuitive attunement, a kind of pre-conceptual perception (intuition) rooted in intuitive experience, corporeality, and affective life. In the case of schizophrenic disorders, a common sense deficit appears in the form of "hypotypification" – lack of knowledge and interpretative skills concerning social beliefs and rules; this is accompanied by a lack of trust in social knowledge and criticism of all conventions. It seems particularly useful to try to describe in these categories the behavior and experience of people with mental health problems in order to understand the dynamics and complexity of their symptoms and coping strategies. Thus, the patient is not only a passive recipient of the pathological process, reactively responding to emerging difficult situations, but also an active self-positioning agent, locating himself outside the common sense social conventions. Gallagher describes the schizophrenic condition in a similar way,[55] treating it as a kind of alternative reality that can dominate the patient's world. In this way, delusions become a kind of experience that does not coincide with commonly accepted and dominant social reality; although it appears that the delusional separation from everyday social reality does not have to be complete. That can explain the phenomenon of "double-bookkeeping" consisting of distance or temporary return to the common reality and lack of consistency in behavior. The patient seems to live in two worlds simultaneously. However, the delusional reality from the perspective of social conventions remains bizarre and unreal.

Social consensus and social context contribute to creating a sense of trust in the world: to confirm, share, interpret or reinterpret one's own experience. From this point of view, the direct, "naked" face-to-face relationship appears particularly uncertain and reveals human vulnerability to injury, the danger of being hurt. Therefore, interpersonal encounters are generally governed by "shared practices and conventions," which facilitate building confidence relations. Ratcliffe assumes that individual interpersonal relationships shape (regulate) our general understanding of the world and the level of trust in it.[56] It refers both to the way social norms and principles are acquired and recognized in the process of upbringing and socialization, but it can also concern dramatic situations (for example terror and violence) that undermine trust in others and in the world. Also in the case of mental disorders, trust in others and in the world can be very limited. Blankenburg underlines that in the case of schizophrenia there is a loss of common sense based on both intersubjective relationships and the general pattern of social relationships. More specifically, in the case of schizophrenia, the common sense deficit manifests on three levels.[57] Thus we are dealing with a disruption of the bodily relationship with the world in the form of intermodal disintegration of the ability to create a coherent relationship with the world, a loss of the elementary bond with the world. We are also dealing with a disruption of the basic relationship with others in the form of the so-called intercorporeality (Merleau-Ponty), which in turn manifests itself in the form of lack of closeness and resonance with others and, consequently, lack of an elementary form of empathy (autism). Finally, in the case of schizophrenic delusions, we are faced with difficulties in reading social roles, rules and axioms. A person with schizophrenia has difficulty in inhabiting the social space, understood as a whole of interpersonal relations and situations that create meaning, possibilities, habits and norms that are important for the person, starting from the elementary sense of corporeal rootedness (mineness) as a condition of other experiences and relations.[58]

In addition to the disturbance of personal space in the form of derealization and depersonalization (lack of sense of reality), there is a difficulty in preserving private and family space, that is, an intimate and open rela-

54) Kapusta, *Szaleństwo i metoda*.

55) Gallagher, "Delusional Realities."

56) Ratcliffe, *Real Hallucinations*.

57) Thoma and Fuchs, "Inhabiting the Shared World."

58) Ibid.

tionship with significant others (especially the nearest family and friends). Also in the social space (work, club, and so forth) people can be more or less tolerant of bizarre and unusual behavior of people known to them. In a public space, where we are generally anonymous and unknown, there are a number of expectations and prohibitions regarding norms of behavior (for example behavior in the subway, on the street, and so forth). What is more, in the public space there are hidden mechanisms of power in the form of discrimination and exclusion not only of people with disorders, but also those stigmatized because of their origin or gender (cultural).[59] The presented circles of space often overlap and influence each other, although essentially in the centre there is an embodied identity (self) with its elementary experience of itself and openness to experience the world and other people. Openness and penetration into subsequent circles of space is connected with the process of socialization and education and has its negative side in the form of possible weaknesses: vulnerability to injury and inability to cope with certain social situations. The loss of common sense refers to the inability to adapt to social norms and expectations. At the same time, individuals undertake certain coping strategies in such a difficult situation. Interestingly, the lack of consonance and automatic immersion in social roles and conventions results in excessive reflection and attention directed to these rules. Excessive focus on social rules does not necessarily help the individual to function better. The mere fact of not adapting to the social environment is not a simple determinism because the environment itself can help an individual in the process of dealing with the situation of discomfort and embarrassment (suffering). Lack of understanding can be irritating for an ill person, who perfectly senses the reactions of other people to their bizarre and misadapted behavior. On the one hand, the environment can minimize the stress and embarrassment of people and on the other hand, as a therapeutic community, support the recovery process by accepting the person and understanding his or her position.

Relational Recovery

Taking into account the relational nature of the experience of mental illness has consequences both for the sick person and the course of the recovery process – as well as for the challenges and tasks set for the therapist. A therapist ready to adopt a relational attitude has not only technical knowledge, but also an appropriate humanistic attitude and social sensitivity.[60] During the description and interpretation of the patients' experience, their resources and chances for strengthening their subjectivity are revealed. Thanks to the development of an appropriate narrative, the patients' situation takes on a unique/exceptional form.[61] At the same time, the patient's pathological feelings appear in the light of the overall structure of the world of experience as "different existence" and in the broader context of understanding human nature (for example Plessner's anthropology). Pathogenic situations indicate not only crisis factors but also crisis opportunities.[62] In the experience and narrative of people affected by a mental crisis, values in all their complexity and conflicting nature become particularly visible.[63] Where human expectations, needs, and desires are revealed, there is also vulnerability to injury, the sense of frustration, and a sense of danger.

The attempt to reconstruct the three intersubjective dimensions of the illness experience presented in the article also has practical consequences for understanding the recovery process. As Jaspers states, the atti-

59) Learning about the social aspects of mental health requires more detailed demographic, socio-organizational and legal research. An example of such publication is research report by Moskalewicz, Kiejna, Wojtyniak, "Kondycja psychiczna mieszkańców polski."

60) Szawarski, *Mądrość i sztuka leczenia;* and Kępiński, *Poznanie chorego.*

61) See Parzuchowska, "Standards of Psychiatric Care."

62) Fuchs, "Existential Vulnerability."

63) Kapusta, "Psychiatria oparta na wartościach."

tude toward the illness is often accompanied by a search for the meaning of this liminal experience beyond and despite diagnosis. This gives you the opportunity to redefine (reorient) yourself through a transformative experience.[64] The memory of a mental crisis usually does not allow for a return to the pre-crisis state, but it causes a change in one's attitude and way of functioning.[65] Difficulties in relationships with others and in moving around in the maze of social conventions is a source of loneliness and alienation of patients. However, in this intersubjective area individuals can make their own change. This can manifest itself in the acceptance of one's own experience as a problem of relations with others and the world. Acceptance of illness is acceptance and recognition of the real course of painful experience, building one's own narrative. Recovery is also based on building a healthy relationship with others, especially regaining mutual trust.[66] An important element of the illness transformation is also involvement in social roles and an attempt to transcend the stigma and social stereotypes surrounding the individual. The difficulty of dialogue with oneself, with others, and with the social world is inscribed in the question of one's own authenticity.[67] It seems wrong to look for authenticity beyond social relations in some hidden private area. Self-transformative possibilities[68] are available in relation to others. Others have the potential to shape our attitudes, even if this process is never simple and fully conscious.

64) Matthews, *Body-Subjects and Disordered Minds*.

65) Davidson, *Living Outside Mental Illness*.

66) Schlimme and Schwartz, "In Recovery from Schizophrenia."

67) Stephensen and Henriksen, "Not Being Oneself."

68) Ratcliffe, "Depression, Self-Regulation, and Intersubjectivity."

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