Title: Institution or individuality? Some reflections on the lessons to be learned from personal accounts of recovery from schizophrenia

Key words: first person authority, narrative, psychosis, social self, subjectivity, Wittgenstein

Abstract: In this paper, I argue for a social conception of subjectivity, via a philosophical reading of first person accounts of recovery from schizophrenia, published in the *Schizophrenia bulletin*. Following the hypothesis that these accounts exemplify a more general tension between on the one hand, normative and social dimensions of the self, and on the other, experiential and psychological dimensions, the first section of the paper formulates the problem from a philosophical perspective inspired by Ludwig Wittgenstein's grammatical approach. The second section explores and rejects different possible readings (sociologistic, phenomenological, or narrativist readings), as conceiving the subject in too passive a relationship with him or herself, and as leading to overly skeptical conclusions about the claims in the first person accounts insisting on the notion of recovery as a restoration of a sense of self and as empowerment. The third section suggests that a more positive answer can be given via the idea of a certain *grammar of recovery* governing these narratives, and sketches out how this relates to the more general philosophical question on subjectivity.

Introduction

In testimonies of people presenting themselves as recovering from schizophrenia, we find a recurring idea: namely the idea that they had to identify as "mad" or as "mentally ill" in order to "recover" from this madness or illness itself. This is for example what Joanna Fox, an author who identifies as a "user with schizophrenia," is talking about, in an account describing amongst other things her process of recovery. Indeed, in this text published in 2017 in the "First Person Accounts" series, which has been present in each issue of the psychiatric journal *Schizophrenia bulletin* since 1979, she writes the following:

"I believed that I had special powers to read people's minds and that I could talk to television and radio presenters. On discussing these special powers with other patients in the hospital I found I was surrounded by others with similar powers. I had never heard of psychosis or hallucinations as indeed popular classic films portrayed the possession of special powers, but few well-known films described the experience of psychosis; therefore, it was more credible to think that I was special rather than "mad". As I thought about this rationally, and reflected that I was in a psychiatric hospital, I made a conscious decision to be "mad" rather than special – and this decision were the seeds of my recovery" (Fox, 2017, p. 428).

Let us specify at the outset the sense of "recovery" that is at stake here: it is the one that currently tends to occupy a major place in the political and social organization of the care of severe mental illnesses, and which claims to go beyond an old strictly "medical" notion of "cure" understood as "mere" symptom reduction, in favor of a more global approach focusing on the "person", on the restoration of a "sense of self" and on empowerment, possibly in spite of residual symptoms (see e.g. Davidson et al., 2005; Rudnick, 2012), in tune with more general anthropological transformations concerning the extension of the ideals of personal autonomy in modern Western societies (Ehrenberg, 2018/2020). However, in the case of schizophrenia,

these symptoms are often understood as signs of an attack on the patients innermost "self" or the intimate layers of their subjectivity (e.g. Sass & Parnas, 2003; Nelson, Parnas & Sass, 2014). What meaning should then be given to this type of first person account, which is now abundant in the scientific literature? By exploring this question, this paper aims at defending a more general *philosophical thesis* concerning the importance of social and normative dimensions in the constitution of subjectivity.

To do so, I will proceed following three steps. First, I shall start by formulating our problem from the point of view of first person philosophy, and especially from a grammatical perspective inspired by Ludwig Wittgenstein. More precisely, I will show how our question about recovery accounts of schizophrenia echoes a more general tension between, on the one hand the practical subject, the subject as an agent at the center of the grammatical approach and, on the other hand, the epistemic and experiential subject which is more often privileged in the debates and research on subjectivity in the field of mental health (section 1). Next, I will examine different possible ways of reading this kind of narrative, that is: sociologistic, phenomenological, or narrativist readings. But this will be only to dismiss them because of their shared assumptions, pertaining to the tendency to construe the subject in too passive a relationship with him or herself, and leading to overly skeptical conclusions about the meaning of these authors' claims about their "selves" (section 2). Finally, I will suggest how a more positive answer can be given via the hypothesis of a certain *grammar of recovery* governing these narratives, and how this relates to the more general philosophical questions that we will have started off with (section 3).

1. Reading recovery stories from a philosophical perspective

So what are these more general philosophical issues that motivate our reflections? They aim at questioning the classical philosophical problematics of subjectivity and self-constitution through the lens of psychopathology: what can this particular pathology – schizophrenia – , which is often considered as a paradigmatic case of internal dissociation and loss of the self, teach us about subjectivity more generally?

Of course, such a question has already attracted philosophers' attention. For example, in current philosophy of psychiatry, the most striking symptoms of schizophrenia – such as delusions and hallucinations often revolving around the dispossession of thought and action – have been construed as cases potentially revealing, *via negativa*, what our relationship to ourselves consists in its "normal" or ordinary conditions (see for example, the literature on "thought insertion", recently reviewed by López-Silva (2018) and by Henriksen, Parnas & Zahavi (2019)). However, by focusing exclusively on moments of crisis – that is, on the seemingly most "purely" pathological (and also the most "psychological") aspects of this often chronic condition, which as such is inscribed in long-term social and interpersonal experiences including notably a wavering between detachment and recognition of shared common grounds – this kind of approach is in my sense problematic with regard to the generalizability of conclusions from "them" to "us". For this presupposes a *shared* element.

My contention is that situations of therapy and care, and thus recovery, are likely to provide this support. They include indeed a common normative horizon and imply concerted actions aiming at approaching it. In this way, they might give us access, as the French philosopher Pierre-Henri Castel suggests, both to "the norms of the right relationship to oneself and to others, as well as [to] the means to render them concretely active" (2012, p. 16, my translation). It is in this perspective that I am interested in a particular figure of the psychiatric patient that Joanna Fox in my opinion exemplifies, and that I will call the figure of the "person recovering from schizophrenia". This figure has been emerging in contemporary psychiatry

since the 1980s, and I have extracted its conceptual contours from a thorough reading of the archives of personal accounts published in the *Schizophrenia bulletin* since 1979. A disclaimer is required here: I do not purport to present an empirical study of these accounts, which would respect the methodological criteria of sociological or psychological investigations for example. My aim is philosophical: it concerns the *conceptions of the subject* required to make sense of these stories. From this point of view, I make the hypothesis that the figure of the person recovering from schizophrenia is potentially revealing some wider tensions which come into play in the constitution of the self more generally: tensions between, on the one hand, normative and social dimensions, linked in particular to our moral status as responsible agents, and which is what recovery tends towards; and, on the other hand, experiential dimensions, linked to personal experience – including the experience of the illness – and for which in principle might well go beyond the sphere of the intentional and what I for which I can answer for in the strong sense, i.e. by giving my reasons.

In order to see how, I also need to indicate the philosophy of the first person that underlies my arguments: namely a philosophy that is not "phenomenological" (as it is more often the case when one is interested in the "subjectivity" of patients in the field of mental health), but a philosophy that is inspired by the grammatical approach such as deployed in Ludwig Wittgenstein's philosophy of psychology (1980*a*; 1980*b*; 1982; 1992; 1953/1997). This approach is not based on the description of lived experience (as in phenomenological approaches), but rather on the exploration of the various language games in which psychological concepts can be used, in order to expound the rules that govern these uses, including the rules of self-expression. This approach leads, at least for some readers of Wittgenstein such as the American philosopher Richard Moran (2001) to put at the core of subjectivity the capacity to express our mental states, to determine them by rational deliberation and to answer for them and for the actions they inspire *by giving our reasons for having or*

endorsing them, via a reframing of the notion of first person authority. This authority – the authority that each one of us has over the expression of our own mental states – has traditionally been understood as the sign of a privileged epistemic relationship the subject would have to his or her own states, understood in turn as lived experiences. However, by insisting on the *normative* dimensions of first person authority understood as a requirement of both rationality and responsibility, Moran invites us to reconsider the *subject of experience* by placing it in a wider practical and moral framework, in which the *subject of action* takes logical precedence over the conception of what we are, i.e. it is the lens through which our experiences are conceived, evaluated and even *lived*.

Moreover, by insisting on the normative status of the subject as an agent, we also approach a certain normative and social conception of human autonomy which, according to a sociologist like Alain Ehrenberg (2018/2020), extends with the importance that the idea of recovery has taken on since the 1980s even for thinking about the populations that were formerly considered to be the most severely wounded in terms of autonomy, i.e. those said to suffer from severe mental illness, including subjects with schizophrenia. Autonomy is indeed the cornerstone of recovery in the sense that interests us here, since it emphasizes the possibilities of regaining one's self and restoring one's power to act in *spite of or independently of any residual symptoms*. The promoters of this notion of recovery do not hesitate to present it as a new general objective for the treatment of severe mental disorders, or even as a real paradigm shift, as opposed to an old medical paradigm centered on cure as a reduction of symptoms (see e.g. Davidson et al., 2005; Davidson & Tondora, 2022; Rudnick, 2012). As we know, this notion of recovery and the broadening of the perspective on care that it claims to operate as a whole is now enjoying a certain success – it is indeed increasingly imposed as a general horizon of care, notably via the recommendations of the World Health Organization (2021), and there are good reasons, I think, to join Ehrenberg in his hypothesis of an extension

of the modern ideals of autonomy (and thus of the demands of responsibility) to populations that until now were, if not excluded from those ideals, at least set at their margins.

This raises some questions, however, and especially in the particular case of schizophrenia. Indeed, if recovery means something like a reconquest of the self and an increase in empowerment in spite of or independently of residual or recurring symptoms, what can it possibly amount to in this pathology where the symptoms in question have traditionally and still are in important branches of psychiatry (notably that which claims to be based on the phenomenological tradition) conceived as signs of an attack on the most intimate self?

This tension has already been approached, within the literature in psychopathology, as a *conceptual* and *theoretical* tension between different conceptions or dimensions of the subject (Hamm et al., 2018; Nelson, Parnas & Sass 2014; Parnas & Henriksen 2014). But, embodied in personal narratives, this tension takes, so to speak, a more existential quality, which renders the problem more acute and, at the same time, potentially thwarts certain automatisms of thought, for example when it comes to speculating about the impact that either the illness or the institution of psychiatry would have on the psyche of those who are caught up in it. Next to, or opposite to, the psychiatric discourse about an illness that, by definition, would feign the moral and mental integrity of the those suffering from it, are indeed the discourses of the "constructionist" kind, that see in the psychiatric institution a tool of subjection potentially more alienating than the alleged illnesses that it takes in charge. For, whereas the "total institution" that was the closed asylum, criticized in particular by Erving Goffman for its mortifying effects on the "inmates" personal identity (1961), has currently given way to more "de-institutionalized" modalities of care and treatment, psychiatry as a *social* institution, defined by a set of norms and values that regulate practices and exchanges between individuals, remains nonetheless alive. And, as such, it continues to raise concerns about its normative force, perceived as harmful to individuals (in the case of the recovery

paradigm, see for example the criticisms the reviewed by Woods, Hart & Spandler, 2019). However, one of the interesting aspects of the personal accounts in the *Schizophrenia bulletin* is to put into question this clear-cut alternative which seems to condemn the psychiatric patient to a necessarily diminished subjectivity, be it by the illness itself, or by the simple fact of having entered the psychiatric institution.

A first distinctive feature of "the persons recovering from schizophrenia" is that they present themselves as "schizophrenics" or as "having schizophrenia", thus appropriating in a sense the classical medical idiom. From this point of view, they are in different from other figures of the patient in contemporary psychiatry who immediately present themselves as more subversive, such as the voice hearers, for example, who have a clear ambition to depathologize what in the medical tradition is called "hallucinations." "Persons recovering from schizophrenia", on the other hand, identify themselves as "schizophrenics", or, as was the case with Joanna Fox, as "users with schizophrenia", and like many others of the authors whose stories have been retained by the *Schizophrenia bulletin*, who often even begin with this strong identification, almost as if schizophrenia were part of their civil status: "I am Julie. I am 25 years old. I am a schizophrenic"... Moreover, there are decent textual and historical reasons to believe that one function of these narratives was to reinforce a "medical" conception of schizophrenia in the face of the demands coming from the militant ex-patient movements of the 1970s, by including in the academic and scientific discourse the point of view of the patients, while discarding the more radical contentions of these movements, namely the denunciation of the medicalization of madness. It is, however, beyond the scope of the present paper to enter into such broad contextual considerations. Let us simply retain that, in effect, these authors often describe symptoms typically considered as characteristic of this pathology, such as strange perceptions and sensations, delusions often with a mystical or paranoid tone, poorly correlated with reasons, action and emotions, forms of dispossession of action, thought,

and personal experience... either as a kind of latent threat that requires special caution or even monitoring (this was the case with Joanna Fox as becomes clear in another of her accounts, focusing on how her experience of pregnancy was profoundly framed, structured by various measures and dialogues with caregivers and loved ones to prevent psychotic relapse: Fox, 2012); or as still being part of their current reality. As this anonymous author writes, for example:

"The world of delusion and symbols is as real to me as the normal world. When coincidences happen or people speak in a strange way, I am very likely to take what they say as applying to my delusional world even though I do not usually act on those delusions. Most of the time I see my delusional world superimposed on the real world. At times, the network of people who watch me seem to be benevolent. At other times, I feel controlled and manipulated by my delusion and become so afraid and tormented that I have considered suicide or running away from home to escape. [...]

Several years ago, I had visual images of gross, sexual, or obscene images floated in front of my eyes when I least expected them. This mortified me, especially as I thought others could see these images of mine. The experiences really unnerved me until my therapist gave me Theodore Rubin's *Compassion and Self-Hate* (1975) to read. I learned to like myself and accept myself in spite of the ugly tricks my mind plays. Now I do not claim these images—I laugh at them and they go away. They haven't bothered me much since then." (Anonymous, 1990, p. 548-549).

One could perhaps be surprised that stories of this kind should count not as a manifestation of the illness but as a sign of recovery in the personal sense I have just indicated, that is, as a reconquest of the self. However, it is published exactly as such a recovery story, and this is also how the author herself presents it, because, she writes: "My illness has caused me to grow in my inner self to discover who I really am, with the help of my therapist"

(Anonymous, 1990, p. 549). So the question I want to raise is this: what meaning can be given to this kind of narrative, and in particular to the kind of claims about oneself (or one's "self") that they involve? What are the concepts of the subject that are effectively operative here, and what are the conceptions of subjectivity and of the relationship to oneself that would lead us to give them a positive meaning, or on the contrary to doubt about the possibilities of doing so? Let me also stress that dealing with this question from a philosophical point of view does obviously not amount to decide about the truth or the authenticity of this or that story in particular. But it is an issue of determining the conditions under which and in particular by means of *which conceptions of the subject*, of first person discourse, of the speech on one's "self" they can be held as possibly endowed with *meaning*. And I will argue that this is possible on condition that we detect a certain *grammar of recovery*: a grammar which is operative insofar as it is inscribed in a form of life. It is indeed important that we are not dealing here with isolated narratives here and there, but with a widespread and, as it were, regulated social phenomenon, but which at the same time potentially supports individualization. So that we can indeed think that, when these people speak of having restored or (re)discovered their "self", it is a way of speaking that is neither hollow nor totally out of step with what is explicitly expressed.

2. Skeptical readings: sociologistic, phenomenological, narrativist

However, defending this thesis requires challenging various assumptions about first-person discourse that circulate in scholarly debates in the field of mental health and that thus surround these narratives more or less directly; assumptions that, if pushed to their limits, would lead to various forms of skepticism of these narratives.

I say "would lead" because until very recently these first person accounts have received very little attention and have been scarcely exploited in research. If they are sometimes quoted, this is typically for merely illustrative purposes, and the few studies that have sought to extract the main themes present in these accounts have concentrated on a limited number of texts (e.g. Gaenellos, 2005; Gumber & Stein, 2013; Hayne & Yonge, 1997). They have not had any significant impact on research more generally. This is rather surprising since, in principle, there is a strong moral consensus on the importance of including the patients' perspective in research and clinical practice. A recent study, however, fills this gap. Published in 2022 in *World Psychiatry* (the official journal of the World Psychiatric Association), by a multinational team of psychiatrists, professional researchers and "experts by experience", led by Paolo Fusar-Poli from King's College, the study includes a thematic analysis of personal accounts published in *Schizophrenia bulletin* between 1990 and 2021, supplemented by autobiographical books and narratives from clinical records or from user magazines. It presents an innovative methodology, whose originality is to start not from theoretical statements to conceive of the experiments likely to verify them, but from the patients' own experiences, where the "experts by experience" – patients' representatives – carried out the first selection of the significant themes in the accounts. Further, the patients were involved even until the writing of the article itself. The study thus makes a step forward in the integration of the "first person perspective" in research. It provides an interesting synoptic view of this corpus of narratives, displaying the diversity of symptoms and of modalities of lucidity and recovery, from the pre-morbid phase to the recovery phase, through the phase of prodromes, the first psychotic episodes, the relapses and the management of chronicity (Fusar-Poli et al., 2022).

However, this study is based on certain biases which it seems important to put into question. The first is to not consider the specificity of the corpus of accounts taken from the *Schizophrenia bulletin*. Indeed, these are treated indistinctly with the other sources examined.

This leads to evacuating – without really dealing with them – two things that seem nevertheless important to consider more attentively, and which in my opinion are intimately tied up. First, there is a certain indecisiveness pertaining to the status that should really be ascribed to these discourses that the authors of this study do not mention, but which is often transpiring when discussing more informally with professionals in the mental health field: that is, a certain suspicion of a hollowness, for example that the claims that these authors have on their "selves" are – as psychiatrist colleague once said – only "performative" and that, therefore, their accounts are not very "informative" to quote another psychiatrist and furthermore promoter of the recovery paradigm. Second, there is no consideration of the context of production of these specific discourses on the self.

I do not think that these are necessarily empty words. Nevertheless, there are indeed elements that should incite, if not such skepticism, at least some more caution towards the corpus of personal narratives published in a journal like *Schizophrenia bulletin*. One of them certainly pertains to the fact that they were produced in a highly normative context. The *Schizophrenia bulletin* is indeed a prestigious journal, and it is run by psychiatrists who occupy an asymmetrical and overhanging position in relation to the authors in many respects, who had to go through various stages of evaluation to have their accounts recognized and published as recovery stories in the particular sense that interests us here. This is pointed out notably by Angela Woods, a medical humanities scholar who, prior to the study by Fusar-Poli and his team (2022), was one of the few who to have proposed a targeted analysis of these particular archives. She draws attention to the danger of granting *per se* a kind of transparency to these narratives, as if they could give a direct and unproblematic access to the author's experiences, experiences that the accounts would describe as such, as a mere window on the world as the authors live, or have lived, it (Woods, 2013). What Woods has in mind then are some of the few studies mentioned above that have been conducted on these archives by researchers in

psychology or in nursing sciences, studies that typically consist of rather partial thematic analyses. The recent study published in *World Psychiatry*, which is more encompassing and methodologically more interesting, does not escape this criticism, namely the criticism of relying on the assumption of the narrative as a "mechanism for *direct access* in coming to know people's life, their circumstances, and the meanings they associate with a life of persistent and enduring mental illness (Hayne & Yonge, 1997, p. 314, quoted in Woods, 2013, p. 40). To be guided by such a assumption is, on Woods' account, to miss the fact that these authors have very particular expectations to respond to in their writing, which would necessarily inflect the meaning of their words.

This is probably true, at least in part. It is important to take into account this context of these narratives. But this also holds for any discourse... For the question that arises here, and that Woods does not ask – is whether there really is such a thing as a "pure" description of lived experience: of course, not because there are no experiences or that one could not describe them; but because insofar as the need to describe them is felt or becomes pressing, they are already invested with a certain interest (or concern), such that they are already wrapped up in evaluative attitudes held by the subject him or herself and by others, which modify the described experiences at the same, or at least the total description that one could make of the subject as a person. And what motivates in this particular case the description of the lived experience is less the quest for the recognition of the experience for itself, than that of the capacity to act by and for oneself. For instance, Joanna Fox wrote not just simply to display her personal experience, but to argue for the inclusion of patients' point of view and implication in the organization of treatment (Fox, 2017). In all likelihood, there is a strategic selection of accounts to be included in the *Schizophrenia bulletin*, accounts which are probably sufficiently original, but without deviating too much from prevailing "medical" discourses. This immixture of self-description, political claims and normative constrains present in these accounts leads

Woods to the idea that their function would less be to express and recognize the individuality and singularity of each person, than to reinforce certain norms of recovery for others, potentially dictated by the medical body to which the accounts are partly addressed (Woods, Hart & Spandler, 2019). What is problematic here, in my view, is precisely this assumption of a pure self-description, which certain collective norms of self-expression would warp, in principle and in a necessarily pejorative sense, which amounts in fact to adopting a purely instrumentalist conception of rules and normativity. However, in my opinion, it is precisely because there are pre-existing social norms that recovery in this sense is possible and, as I will shortly argue, relying on such norms does not fatally reinforce them; it is also what is necessary to make them evolve. For this reason, one should discard the skepticism implicit in Woods' account, which could be described as *sociologistic* (in the sense that it emphasizes the social and institutional dimensions, wrongly contrasting them with the personal and individual).

On the other hand, to pursue in this direction also requires to reject the same kind skepticism in its *psychologistic* forms. "Phenomenological" approaches in psychopathology (in the broad sense of approaches focusing on the "lived experience" of the illness) is one of them. On the basis of these approaches, one could indeed be tempted conclude on the semantic vacuity of the claims in question, given the presence of certain symptoms and provided that one accepts the description of these latter as pertaining to a disturbance or loss of self themselves analyzed in purely experiential terms. But one can only arrive at such a reading if one remains within a purely psychologistic framework: the one which, precisely, that the Wittgensteinian perspective invites to surpass. It is well known that Wittgenstein (1953/1997) criticizes a certain mythical conception of interiority as a sphere of private internal experiences to which the subject has a privileged epistemic access. We find such a conception notably in the "new" phenomenological psychopathology defended notably by Josef Parnas and his numerous collaborators who speak of a mode of donation of experience in the first person

which would be the most fundamental layer of subjectivity, the one which would be disturbed in schizophrenia (e.g. Henriksen, Parnas & Zahavi, 2019; Nelson, Parnas & Sass, 2014; Sass & Parnas, 2003). Without seeking to contest that this revival of phenomenology can indeed capture something of what happens in schizophrenia, there is however a problem in giving such a weight, indeed a *fundamental* weight, to lived experience in its dimension of pure *givenness*. For this happens to the expense of an adequate assessment of the active role that each one of us has to play with regard to his or her own mental life, and of the responsibility that is incumbent upon us as a result. This is highlighted in particular in the relation to beliefs and intentions (which are not, according to Wittgenstein and I think he is right, concepts of lived experience, see e.g. Wittgenstein 1980*b*, § 43-57; §63; §178; §197**,** but also Anscombe, 1981, p. 57-63) as we suggested earlier in evoking Moran's account (2001), but in a way that one can then think modifies the relation to oneself as a whole, including in its lived and thus more passive dimensions. For what I experience is not for me something purely "given", as a mere "data" to discover and to contemplate. But it is *at the outset*, as Moran writes, "subject to my evaluation, correction, doubts and tensions" (2001, p. 37). This, indeed invites, following my suggestion stated above, to reconsider the experiential subject in a broader moral and practical framework.

And, it is also in this way that the skeptical tendencies in their double sociologistic and psychologistic forms can and should be equally dismissed, since the "simply given" experience and its "pure" description are but two sides of the same coin.

Moreover, we should also, for similar reasons, discard the explanation, seemingly less skeptical, of self-recovery in narrativist terms. This is the solution often adopted by the promoters of recovery in psychiatry or in psychology in order to account for the self-restoration claimed by persons recovering from schizophrenia. In this perspective, the narrative – understood as the result of a process of integrating in one's self-understanding the qualifier

"schizophrenic" – would possess a therapeutic virtue for the person, as long as this understanding of oneself as schizophrenic is coherently articulated with other personality traits that one self-attributes. This idea can be found, for instance, in Larry Davidson, the American psychologist based at Yale who contributed greatly to the conceptualization of the so-called recovery "paradigm" and to its international dissemination (see e.g. Davidson, 2003; Davidson, Rakfeldt & Strauss, 2010). In his view, the crucial operation for the person in recovery would be to consider some of his or her past and present behaviors attached to different social groups, to redescribe them as belonging (or not) to schizophrenia in a way that would be able to compensate for the limitations that schizophrenia imposes on the individual or for the harmful effects that result from it, particularly in terms of discrimination and internalized stigma (e.g. Davidson, 2019; Davidson & Strauss, 1992). And in effect, these accounts are full of descriptions lending themselves to interpretations of this kind, descriptions in which the so-called *insight* or awareness of the illness is presented either as dampening the harmful impact of a too strong, a too exclusive identification with the illness, or as an arm to fighting the illness itself, for example in the face of recurring delusions. Here is indeed what one of the authors of a first person account writes:

"My name is William D. Bowden. I am 35 years old. I'm a paranoid schizophrenic. Many psychologists and psychiatrists have told me this over the years, but I am just coming to the point where I actually believe it. This reluctance to believe that I am schizophrenic is due to the intensity of my belief in my "delusional system." My delusional system leads me to be lieve that I am *not* schizophrenic; I believe that I am a psychic, that I "broadcast" my thoughts to anyone who is – what? In my immediate vicinity? Mentally focused on me? Maybe even anywhere on Earth? I don't know. I have believed all of these possibilities and more, but presently I believe that people can "read my mind" only if they are in my immediate vicinity." (Bowden, 1993, p. 165).

However, it seems that a narrativist conception – understood as the "right" integration of "schizophrenia" among the set of attributes that define the individual in a larger moral self-portrait – is again running the risk of reducing the relation to oneself to something too passive, and hence of obscuring the active involvement of the subject in his or her own mental life, for instance in this case the sense of effort and even struggle that seems present in the narrative, consisting in maintaining one's mental and moral integrity while being torn between, on the one hand, what William Bowden calls his "delusional system" and, on the other hand, the demands of the common world coming from others.

3. Towards a grammar of recovery?

Yet, in order to account for this, one must also put into question the Wittgensteinian framework from which we started off, and on which I have largely relied to operate these successive criticisms. For what are presented as *exceptions* to the rules of self-expression in Wittgenstein and others obtain, one might say, the status of a *rule* in the grammar of recovery. An important dimension of these accounts is indeed the presence of what the authors call their "delusions". This is clear, for example, in William Bowden's story. As the anonymous author quoted at the beginning also said: "The world of delusions [...] is as real to me as the normal world is" (Anonymous, 1993, p. 548). And the delusions, idiosyncratic statements sometimes discrepant with the common or "real" world, remains firmly in place despite the recognition of that very discrepancy itself. One author, Patricia Ruocchio, for example, describes this as a problem of recognizing not *reality*, but *truth*: oscillating between the "shared" world and "crazy" ("unreal" she says) thoughts, she is well aware that latter do not merge with the former. However, she does not know how to tell what is "true": "I have two equally tenacious parts of my mind that are often in odds with another. I go back and forth endlessly, never able to resolve the struggle,

because I do not know which part is true ... I often know deep inside what is real and what is unreal, but I don't know which is true" (Ruocchio, 1989, p. 164-165).

But determining one's belief by turning to the external world is a crucial feature especially in the reappraisal of the notion of first person authority as taken up notably Moran in the wake of Wittgenstein, leading to the normative conception of the subject as a responsible agent that we started from in the beginning of our paper. Moran calls the "transparency condition" the requirement of being able to answer the question of one's belief (i.e. one's state of *mind*) by treating it as, in a transparent way, a question about the very object of the belief, i.e. typically about a state of the *world*. To use a well-known example, I comply with the transparency condition by answering the question of whether I think it is raining by considering the facts about the weather, rather than by probing the deep layers of my inner consciousness. The ability to conform to the transparency condition, Moran points out, is both a *normative requirement* (i.e., a rule) and, he says, a *condition of* one'*s health* and *internal unity* (e.g. Moran, 2001, p. xxx; p. 8; p. 107-108). In fact, for Moran, someone who could not determine what he or she believed by looking outside, or whose belief would remain insensible to this process and to considerations about the truth of what the belief is about, would be in a state of alienation: unable to assume my belief by considering the objective reasons for having it, I would, as Wittgenstein suggests, be like that "hybrid being that might pronounce: 'I don't believe it is raining, but it is raining'" (Wittgenstein, 1980a, § 495). A remark of this kind serves in Wittgenstein's philosophy of psychology as a "borderline-case" to elucidate the concept of belief, which has this particular functioning only for first person utterances. Indeed, no oddness, no suspicion of hybridity or internal split is in principle attached to the corresponding statement in the third person: "He does not believe it is raining, but it is raining." Now, this particular feature of the grammar of the first person reveals something of the person in the moral sense: namely that it is incumbent on me and on me alone to answer for what I think and do. Moreover,

one could relate these grammatical and philosophical remarks to well-known psychopathological phenomena of schizophrenia as approached in psychiatry and psychology (especially in their phenomenological versions), such as the tendency to hyper-reflexivity, i.e. a misplaced tendency to introspect, and to introspect what does not need to be introspected (e.g. Sass, 1994; 2018), as well as to the phenomenon of double book-keeping, i.e. the tendency of the so-called schizophrenic persons to recognize at the same time the distinction between their "delusions" and the real world, holding frequently however the latter as "unreal" (e.g. Parnas, Urfer-Parnas & Stephensen, 2021; Sass, 2014). In this way, one could maintain the idea of a disturbance of a basic and foundational experiential self in these accounts.

Nevertheless, if one wanted to make sense more positively of what recovering schizophrenics are saying about their selves – or what these accounts invite us to consider – we cannot restrict ourselves to an analysis that remains only in the sphere of the psychological, even when approached by grammatical means. Moran's (2001) proposal is built around an analysis of the authority attached to certain first person psychological statements, especially when they express attitudes such as beliefs or intentions. But it seems that we cannot be satisfied here with a notion of first person authority that is simply attached to this or that conscious state. What is needed is rather a notion of the authority of the *person* and not simply of *consciousness*; a notion that takes into account the fact that one can lack authority over the expressions of some experience or a certain thought, without the authority that I exercise and that I am credited with as a person, and in particular as an interlocutor expressing this experience or this thought to others, not being necessarily *suspended*. And what counts then is not so much the presence of this or that mental state or the difficulty of answering for it in particular, as the capacity to rely on certain norms, and thereby also to make them evolve – by contributing, for example, to the cultivation of a greater tolerance in the face of certain ideas which, for reasons that may remain opaque, one cannot or not yet renounce. Nor is it necessarily

to gain "insight" by identifying oneself as "schizophrenic", or to acquire the ability to move smoothly on the social chessboard by mastering the places one can reasonably occupy, as Davidson's reasoning implied (Davidson, 2003; Davidson & Strauss, 1992). It is also to give a structural place to the other or otherness (which can be occupied by a doctor, or a therapist but also any relative or significant other) in the relationship to my own intimate experiences and beliefs. And to the extent that this situation – construed as a clash and a negotiation between normative and experiential dimension at stake in our relation to ourselves and to others – is sufficiently close to something we may all experience, it might also learn us something about subjectivity (and intersubjectivity) more generally: that is, it points to the depth of institution and of sociality in very constitution of what and who we are.

Conclusion

In this paper, I have argued for the need of a social conception of the self in order to make sense of recovery accounts of schizophrenia, and more precisely of the claims of the authors of such accounts about their "selves". A solution in terms of a grammar of recovery was sketched out and presented as a potentially fecund alternative to prevailing conceptions of the first person in the debates currently surrounding such accounts, i. e. phenomenological, narrativist and sociologistic (or constructionist) conceptions, especially insofar as it does not opposes the individual or purely experiential to the social or the institutional. Understanding this relationship is crucial both for the philosophical comprehension of subjectivity "in general", and for the practical concerns of enhancing the perspective of "personal recovery" for people with severe mental illness, by reflecting on what that really means. Of course, an overall solution of these issues cannot be reached in a single paper, and further research should explore the issue further, by considering first person accounts in their context of production. But the

present article does have contributed, or so I hope, to point out some blind spots in the ongoing dialogues on the matter, and have provided some new conceptual tools that should be useful to overcome them.

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