The Clinical (non)Decision-Making Process in Understanding Schizophrenia: Looking to be Spontaneous and Carefree

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> "The most useful is the useless. But to experience the useless is the most difficult undertaking for contemporary man."
> M. Heidegger, 1963, *Zollikon Seminars*, p. 159.

> "Yet a man who uses an imaginary map, thinking it is a true one, is likely to be worse off than someone with no map at all; for he will fail to inquire wherever he can, to observe every detail on his way, and to search continuously with all his senses and all his intelligence for indications of where he should go."
> E.F. Schumacher, *Small is Beautiful*, 1973, p. 196.

Abstract

The clinical picture of schizophrenia questions an essential aspect of decision-making in the clinical process, particularly with regard to the narrative expression of personal experience. Traditionally, it has been believed that an interpersonal interaction centred around one's innermost core can be crucial for an individual, whether mentally ill or not. This therapeutic approach, certainly influenced by Freudian psychoanalysis, enables the individual's inner world to unfold, implicitly suggesting that a more liveable world is revealed once this process occurs. It is important to notice that the therapeutic benefit is achieved through a collaborative process and a dialogue constructed between the individual and the therapist.

However, individuals in distress often rely excessively on narrating their own experiences. This is known to be particularly the case in schizophrenia because of the now familiar phenomenon of hyper-reflexivity. It is concerning to observe that the main therapeutic approach—discussing one's experiences—overlaps with a cardinal symptom of the disorder (even though this of course needs to be nuanced).

In this contribution to the debate on clinical decision-making in psychopathology, I propose that a coherent therapeutic approach for patients who question life rather than live it is to help them engage less in analysing their experiences and instead to connect with them on a pre-

reflective level. The goal is to provide them with opportunities to rediscover the carefree nature of life and experience a spontaneity that does not constantly call things into question. This clinical approach, which should be intuitive for any therapist, is unique in that it is inherently therapeutic, yet it is pursued without any specific therapeutic objective. In these instances, clinicians may not fully understand why they are engaging in certain actions. They are living life alongside their patient, rather than simply analysing things. In this context, I present a series of clinical scenarios that highlight the informal moments between therapists and patients, during which therapists may appear to be deviating from their role although in fact they are engaging in the most subtle ethical aspect of the clinical experience.

Keywords: schizophrenia, psychotherapy, phenomenology, self, territorial self, clinical decision-making process, spontaneity, carefreeness, uselessness.

Introduction

The clinical treatment of schizophrenia raises questions about an essential aspect of choices and decision-making in the clinical process, particularly in relation to narrative verbalization about lived experience. It is classically thought that an intersubjective encounter around deep experience is a moment that can be decisive for people (whether they are mentally ill or not). This aspect of therapy (certainly influenced by Freudian psychoanalysis) enables the world in which the subject expresses themself to be unfolded by implicitly suggesting that the world, once unfolded, is then more liveable. This therapeutic gain is achieved through a collective relational act, through a discourse that is jointly constructed between the subject and the therapist.

That said, people in distress often display an excessive recourse to the narrative part of the self and it is now clearly established that this is particularly the case in schizophrenia based on the famous phenomenon of hyper-reflexivity (Sass, 2013; Sass & Feyaerts, 2024; Englebert et al., 2018). From this point of view, we will discuss the point that the main therapeutic solution—discourse about experience—is superimposable on the cardinal symptom of the disorder (although there are obviously nuances to be made to this observation).

I would like to suggest in this paper on contributions of phenomenology to the personalization of mental health care that a coherent therapeutic approach, for patients who question life rather than live it (Englebert, 2022), consists in helping them to participate less in this technical knowledge of experience and to meet with them at the pre-reflexive level. The aim is then to offer sequences that enable people with schizophrenia to rediscover the carefree nature of life, the naivety and spontaneity of an experience that finally stops questioning itself.

This clinical move, which is self-evident for any therapist, is based on the particularity that, although it is intrinsically therapeutic, it is made without any underlying therapeutic purpose. In this context, I will mention several clinical situations that highlight the many informal moments between therapist and patient in which the therapist might give the impression they are not doing their job, when in fact they are probably ethically the most deeply engaged in the clinical experience.

1. Contributions and limitations of assessment scales and the use of narrativity in phenomenology

A fruitful and now recognized form of clinical practice regarding schizophrenia from a phenomenological perspective is to use the Examination of Anomalous Self-Experience (EASE) (Parnas et al., 2005) and Examination of Anomalous World-Experience (EAWE) (Sass et al., 2017) scales. Centred on the first-person perspective, EASE and EAWE are tools based on the narrative that the subject produces about their experience (I will not detail these two well-known tools here but refer readers to the original articles). The scoring and interpretation of the various items are based on descriptions of the subject's experience. While this approach is valuable, and the narrative dimension plays a fundamental role in understanding how the subject functions, it is clear that it is not the only source of information about the concrete ways in which a person comes into contact with their interlocutor and their environment. The non-verbal dimension, bodily interactions and the forms of relational exchanges are all decisive indicators of subjectivity and experience. The clinical approach is generally enhanced by a meticulous analysis of this essential dimension of the subject's experience, revealing information that is at least as valuable as first-person speech, but a priori of a different degree.

The decisive contribution of the EASE and EAWE scales signals precisely their methodological difficulty, because both are directed at the narrative dimension and the subject's discourse. These two scales are based on the implicit assumption that there is a sufficiently close

correlation between what the person experiences and what they think and express about that experience—these two dimensions are not, moreover, themselves superimposable. It is reasonable to assume that a person will never verbalize perfectly accurately what results from their ideational activity, just as their reflective activity is not strictly superimposable on the complexity of their lived experience. Furthermore, and I shall come back to this point, these scales are also based on the convincing assumption that this verbalization has a beneficial effect on the patient or, at least, that the exchange that emerges from the interaction between the patient and the clinician is likely to promote patient care (if only because a common discourse on the experience is initiated with patients who are often at odds on this subject).

In other work (Englebert et., 2019), we have highlighted and discussed the contributions of the EASE and EAWE scales but also the limitations inherent in the first-person perspective. In that work, we suggested that adding an "observed" dimension to the items in these scales would improve the overall understanding of the person by providing insight not only into the patient's experiential account, but also into the lived experience of space and social or behavioural interaction. In this context, it seems reasonable to think that one of the challenges of phenomenological psychopathology is to integrate clinical observation into studies focusing on the first-person perspective (Baiasu & Messas, 2024; Pienkos & Messas, 2018; Pienkos et al., 2023). The experience of "loss of common sense" (which is a central item in the EASE scale) is perfectly suited to this reflection. The centrality of such an experience in the lives of people with schizophrenia is frequently (if not systematically) emphasized (Stanghellini, 2004). This can be verbalized and described by the patient ("I find it hard to understand others, to know how to behave in their presence"; "Social rules are a problem for me because, if they are not clearly verbalized, I can't guess them"; "I never know how to position myself properly when I am in front of someone, I have trouble with the expected distances" (clinical material from Englebert & Valentiny, 2017)), but the loss of common sense is often experienced as a priority in the relationship between clinician and patient. If it is not to be found in the *content* of the clinician's discourse, it may appear in its *form*. It is not uncommon, moreover, for a subject, when asked about the presence of this item in their experience, to answer negatively, whereas the clinician observes the presence of this disorder through the form and coherence of the discourse and in the relational attunement difficulties that the subject manifests to their interlocutor.

This development echoes the difficulties in using these scales noted in the literature (Nordgaard & Parnas, 2012; Nordgaard et al., 2012; Pienkos et al., 2018; Pienkos & Sass, 2018; Englebert & Cermolacce, 2024; Delcourt, 2024) based on the fact that the experiences they target are difficult to articulate, having, in most cases, often not been put into words beforehand: "One reason for this is that many of these experiences possess a prereflective quality. They are not explicit in the focus of thematic attention but constitute more the overall background of awareness" (Parnas et al., 2005, p. 122). Verbal expression of these experiences, which are close to the "unspeakable", therefore requires a certain ability to use language and to articulate discourse around one's own experience. In a study of anomalies in the experience of the world in schizophrenia, Elisabeth Pienkos observes a *gestalt* underlying schizophrenia that she calls "*Unmooring of the World*" (Pienkos, 2014), meaning the loss of "anchoring" in common sense. The author points out that this "unmooring" may have been present in the subjects of her study in the form of their responses and not in their content. She explains this phenomenon as follows: "Without an implicit, common-sense awareness of what counts as typical experience and what might be unusual or strange, a research subject may be unable to catalogue or talk about particularly unusual experiences" (*Ibid*., p. 31).

This observation reinforces the hypothesis that it is difficult to identify experiences which, by their very nature, are pre-reflexive and therefore cannot be readily formulated in the first-person. In addition to the benefits for research and the contribution to knowledge of schizophrenic subjectivity, it is interesting to consider the benefits for the patient of administering the EASE scale (Englebert & Cermolacce, 2024). It is common to hear people suffering from schizophrenia say after an EASE interview that they had never been asked about these aspects, which they nevertheless consider to be very important, and to express relief at knowing that they are not alone in having these experiences and that other people have already described them:

> It did me good, it's good to talk like that, you know your questions aren't weird. At least not for me. In fact, I've never been asked these things. It helps me because the questions you ask, I ask myself too. (Example given by Samiah, from Englebert & Valentiny (2017))

> I'm not schizophrenic, I've always been convinced of that… But what you're talking about through your questions, this loss of the obvious and this hyper-attention to things in the world, the great sensitivity we're talking about, that corresponds to what I'm living. If that's what schizophrenia is, I'd be happy to discuss it again. (Example given by Attila, from my clinical practice)

For the clinician, being familiar with these significant aspects of the patient's experience strengthens the therapeutic relationship and enables the two protagonists linked by this interview to co-construct knowledge about the schizophrenic experience. However, it is reasonable to suggest that, as well as discovering various experiential subtleties, EASE more fundamentally enables the clinician to show the subject suffering from schizophrenia that they are able to understand, that they have the tools to encounter the degree of complexity of their existence, that their experience can be apprehended by others and that this has already been done for other patients. My aim is not, therefore, to call into question the first-person perspective and the essential dimension of helping patients to describe the anomalies in their experiences that are central to schizophrenia. The aim is to point out the presence of an unspeakable dimension to this experience and the *gaps* between language, observation and experience (the experience of the schizophrenic subject and that of the clinician). In this context, a complete phenomenological approach must integrate this ethological and pre-verbal dimension which, although important, de facto escapes discourse and the self-description of experiences.

2. Proposals for a "territorial self"

Contemporary reflections and debates about the notion of *self* are polarized around two specific forms of self: the minimal self and the narrative self, which can be defined as follows:

(1) The minimal self corresponds to the sense of self in its implicit, non-conceptual and primitive dimension. The *minimal self* is generally credited with the competence of *agency*, which enables the subject to feel that they are the subject of their actions, and *ownership*, or *the sense of mineness*, which indicates the subject's ability to conceive of their experiences (sensations, actions, thoughts) as their own (Gallagher, 2000; Gallagher & Zahavi, 2012; De Haan & de Bruin, 2010). This dimension of the self is pre-reflexive and embodied, in the sense that it is the body that is at the origin of this *primary* experience, making the subject aware of their status as a "conscious subject". In a pre-cognitive, pre-reflexive and pre-thematic way, but also in a certain immediacy, the minimal self gives the subject the intuition of what they are at their most fundamental and most original, enabling the premises and conditions for the possibility of first-person experience.

(2) The narrative self, on the other hand, is the actualized capacity to refer to oneself and to direct one's reflexive attention towards certain aspects of one's own mental life and subjectivity. It is an explicit experience, incorporating a conceptual and discursive dimension (Zahavi, 2007; 2008; 2014). This is the part of subjective experience that involves the autobiographical field of the person and is based,

> following the work of Ricoeur, on the idea that biographical consciousness, while disseminating its identity, simultaneously invents and creates it (Ricoeur, 1985). Thanks to the narrative self, the individual is inscribed in history and constitutes themself through engagement in a variety of personal and interpersonal forms of narrative activity.

It is clear, however, that there is a gap between minimal self and narrative self, so that there is never a perfect syntony between experience and lived experience on the one hand, and the discourse about them on the other. A gap, and undoubtedly a kind of *delay*, which means that the linguistic and narrative appropriation of experience suggests an act of mediation involving a temporal distance in relation to the pre-reflexive experience, whose greater immediacy it is reasonable to postulate. The minimal and narrative dimensions are separate facets of the same self and present a degree of organized complementarity. The presence of a minimal level of self-consciousness should be seen as a condition for the possibility of a narrative self to emerge; the latter is, in other words, founded on the former, although in ordinary experience they are generally integrated with each other.

My hypothesis (Englebert, 2022) is that the experience of the self, if it is to be fully described, must include an intermediate dimension that I would describe as territorial, ethical and ecological. Indeed, it seems simplistic to think that subjective experience can be reduced to two extremes: a pre-reflexive extreme, consisting of the minimal dimension of conscious experience, and a reflexive extreme of a subject who contemplates and comments on their life and experiences through discursive and linguistic capacities. It seems that we need to think about a third polarity of the self: one that is shaped through experience, in the encounter with places and others (what Deleuze and Guattari (1980) call territorialization). This facet of the self is also pre-conceptual within the body, but is not as primitive as the minimal self. It is pre-narrative, but inscribes the subject in worldly history. The “territorial self” is that of the lived experience of life. It corresponds to the individual’s way of being, their styles of existence, their character and their habits: my way of interacting with others in a shared space, while it is an experience of self in its own right, cannot be reduced to the minimal and narrative dimensions of this self.

The territorial self[1] discusses the being that reveals itself through its experience of the world and through the practice of life, through its conduct and actions in a given environment. It is about the ethical way of being oneself, through one's style and ways of moving, expressing oneself, acting and reacting, moving and feeling. This experiential, practical and relational shaping comes after the minimal experience of the self and before the discourse of narrative identity. The territorial subject is not so much the person they claim to be, as the person who engages in existence and in social and inter-corporeal exchanges; it is the person who acts, lives and "territorializes", being enthusiastic, carefree and spontaneous.

3. The experience of the self in schizophrenia

Contemporary research considers schizophrenia to be a disorder of the self, and the most commonly accepted model is the Ipseity-Disturbance Model (IDM) by Sass and Parnas, which suggests that people with schizophrenia have a minimal disorder of the self (Sass & Parnas, 2003; Sass, 2013; Sass & Feyaerts, 2024). The ipseity disturbance described by these authors, which combines clinical data and sophisticated theoretical arguments, is based on anomalies in the experience of the self and is expressed in three interdependent facets:

(1) *Hyper-reflexivity* refers to exaggerated self-consciousness and a tendency to direct attention towards phenomena or processes that should normally be *inhabited* or experienced tacitly.

(2) A *diminished sense of self*, which refers to a decline in the experience of existing as a conscious subject or agent of one's actions. This intimate connection with oneself is experienced in a diminished way, and may even be considered to have disappeared.

(3) In addition to these two aspects, there is a *disturbance in the grip or hold on the social world*. This is undoubtedly the most difficult aspect for schizophrenics to objectify and verbalize.

If we take each of these three categories of self-disturbance in schizophrenia and observe how they are broken down in the experience of the three forms of self, we see that (see Table 1):

[1] I must stress that this hypothesis has been greatly influenced and clarified by numerous exchanges with Hubert Wykretowicz in the context of what he calls the "dispositional self" (Wykretowicz, 2018; 2021). In addition, with regard to the affective dimension of the practical and relational experience of the self, reference should also be made to the work of Anna Bortolan (2020), and to the concept of life as developed by Thomas Fuchs (2017). The notion of the territorial self also resonates with the concept of "enaction", stemming from "embodied cognition", developed by authors such as Varela et al. (1991) and Noë (2004), studying the interactions between cognition, the bodily experience of it, and the environment.

(1) Hyper-reflexivity probably consists in the reflexive and narrative interrogation of pre-reflexive phenomena stemming from the minimal self, but also from the territorial self—this first facet therefore summons up the three facets of the self.

(2) The diminished self-presence primarily calls on the minimal self, while bearing in mind that these disorders are verbalized and, therefore, secondarily call on the narrative self.

(3) The disturbance in the grip or hold on the social world is more in line with a disturbance in the territorial self, although it is also verbalized via the narrative self.

Table 1 (published in Englebert, 2022)

Three facets of the *Ipseity-Disturbance Model*	1/ **Hyper-reflexivity**	2/ **Diminished self-presence**	3/ **Disturbed grip or hold on the world**
Respective Presence of the Three Forms of Self	Narrative self which interrogates: - minimal self - territorial self	Minimal Self (can be verbalized via the narrative self)	Territorial Self (can be verbalized via the narrative self)

It is interesting to note that the phenomenon most easily verbalized (and very often expressed) is that of *hyper-reflexivity* (questioning phenomena that are generally pre-reflexive, this phenomenon falls nevertheless well within the reflexive register). The *diminished self-presence* is at an intermediate level, since it involves pre-reflexive phenomena, but the schizophrenic subject often expresses this experience with greater difficulty, however, in finding the words that adequately express their feelings. Finally, the *disturbed grip on the world*, the pre-reflexive dimension of the relationship to the world, is undoubtedly the most difficult facet to express, signalling a limit to the possibilities offered by language for expressing an anomaly of experience that globally cannot be put into words. It might be suggested that this third facet is the most difficult to verbalize because it is experienced by the subject as the characteristic that is most dependent on the external world, whereas the first two facets, although having to do

with the pre-reflexive, nevertheless concern an experience that is a priori more internal to the subject and, even if the subject feels deprived of it, they probably retain a more precise memory of these more personal and internal experiential modalities.

These paradoxes once again highlight the gap between the discourse on experience and experience as such. They evoke a double polarity or, better still, the hypothesis of two worlds or two universes. If Kurt Schneider has already told us that "psychotic experience is a sign or message from another world" (1950, p. 106), we need to ask ourselves which world the schizophrenic subject is in. Are they in the world they name, or in the world they do not name? A number of contemporary studies have identified this phenomenon through the notion of *double bookkeeping*, which consists of living in two universes, responding to two different experiential logics (Parnas et al., 2021; Henriksen & Parnas, 2014; Stephensen & Parnas, 2018; Stephensen et al., 2023; Sass, 2014). Two patients from the Copenhagen School are worth mentioning:

> When I'm with others, there are two *Is*: the *I* who is among them, and the *I* who objectively looks at this *I*. No matter how absorbed I am in something, there is always an *I* that looks on from the outside dispassionately. This latter, outer self is always managing and controlling me. Even when I talk with others, the outer self listens to their words and tells them to the inner self. After listening to this, the inner self starts to talk. (Nagai patient, 1991, quoted in Stephensen & Parnas, 2018, p. 242).

> There are two worlds. There is the unreal world, which is the world I am in and the world we are in. And then there is the real world. The only thing that is real in the unreal world is my own self. (Patient quoted in Parnas and Henriksen, 2016, p. 83).

As Stephensen and Parnas suggest, this feature of experience (which is basically only very difficult to verbalize in a strict first-person discourse) is probably a structuring dimension of schizophrenic experience and it is reasonable to think that "Many, if not a majority of patients with schizophrenia appear to simultaneously live in two different worlds or in two different ontological dimensions" (Stephensen & Parnas, 2018, p. 248).

Another hypothesis is that, rather than being confronted with two worlds that are occupied alternately, the schizophrenic is above all de-situated (Englebert, 2020),[2] i.e. "situated" outside

[2] The concept of "de-situation" appears in Sartre's work when he describes the lived experience of Gustave Flaubert (Sartre, 1971).

the social experience that they seem to contemplate (and analyse) using their hyper-reflexivity. Laurent, in an EASE interview, makes the following point:

> You know, there are several realities, several universes… There's the reality of thought and there's the reality of existence… [Do you have the feeling that you're in one at the expense of the other?] … (silence) … But no-one can be in both realities. You're either a spectator or an actor… Since I've had schizophrenia, I've often been a spectator. A bit outside the universe where everyone else is… Where everyone else lives. It's not that I don't understand them, I understand them better.

The *double bookkeeping* hypothesis can therefore undoubtedly be enhanced or clarified. The schizophrenic may not be faced with a choice of universe alternating between that of madness and that of common sense, as this hypothesis suggests. They are, above all, outside the situation. Rather than being confronted with two worlds and occupying them alternately, the subject is supposedly above all outside the worldly situation whose characteristics are the spontaneity of the experience, a primarily pre-reflexive lived experience, and an untroubled attuning to others. The place of de-situation, on the other hand, appears as a world that does not have this carefree experience and is dominated by reflexive interrogation (hyper-reflexivity) of the situated world from which it escapes:

> Our feelings belong to one world, our ability to name things and our thoughts belong to another; we can establish a concordance between the two, but not bridge the gap. (Proust, 1944, p. 50)

The subject suffering from schizophrenia can then be understood as an individual confronted with an experiential dead-end characterized by the fact of being, in a way, richer in worlds than the subject who is spared these questions.

4. Consequences for personalized mental health care

These theoretical contributions have important consequences for the clinical encounter and the psychotherapeutic experience. They allow us to analyse the use of discourse as a dimension of the treatment of schizophrenic patients. I would like to stress that maintaining a narrative dimension, which consists of offering the patient the opportunity to talk about their experiences and to integrate these experiences into their biography, obviously remains one of the pillars of phenomenologically inspired therapeutic action. An intersubjective encounter centred on the profound experience, meticulously unfolded, can be a decisive moment for schizophrenics, who often experience themselves as being misunderstood. It is undoubtedly to Freud and

psychoanalysis that we owe this discursive dimension of psychotherapy, which, following Freud, is often referred to as the "talking cure". These therapeutic dimensions call upon the narrative self and contribute to the reconstruction of experience through the mediation of language. The aim of this aspect of therapy is to *understand* the subject and, in their company, to enable them to unfold the world in which they are expressing themselves: once unfolded, the world becomes more liveable. It is reasonable to think that if they are better understood, and if this understanding is the result of a complicity with the therapist, the schizophrenic subject will experience the anomaly of their experiences in a less troubled way: understanding existence makes it possible to exist better, and the hallmark of the clinical encounter is that this gain is acquired through a co-constructed relational act and a discourse delivered in several voices.

But it seems that the reflection on the territorial self that we are proposing makes it possible to offer an additional dimension, making the therapeutic experience with the schizophrenic patient more sophisticated (and no doubt closer to what is actually practised in therapeutic institutions).[3] For, if we take seriously the hypothesis of hyper-reflexivity as a cardinal symptom of schizophrenia (which seems to me to be correct), then we must observe that it is paradoxical to find that the first-person narrative perspective consists in eliciting an introspection that overlaps with it. Obviously, the fact that this activity takes place in the context of a relationship with the therapist makes this experience clearly different in nature from the hyper-reflexive act which is characterized by its solipsistic dimension. However, it is disturbing to note that the main therapeutic solution—i.e. discourse about pre-reflexive phenomena—is superimposable on the cardinal symptom of schizophrenic disorder—which is precisely the tendency to question implicit and normally tacit phenomena in a reflexive mode.

The very nature of schizophrenic experience seems to suggest that a complementary therapeutic approach, for patients who question life rather than live it, is to help them participate *less in* the technical knowledge of experience and to join them at the pre-reflective level. The idea would be to offer them sequences that would enable them to rediscover the carefree nature of life, the naivety of a first-person experience that manages to stop the questioning.

[3] I shall not go into it here, but in my view this applies to all forms of psychotherapeutic encounter, whether with schizophrenic patients or not.

Invoking the territorial self in the clinical treatment of schizophrenia is in fact a matter of course for many—if not all—therapists. Therapists know that, before any form of dialogue, the essence of therapy is to build an interaction, an ability to share a common meaning, to survey a shared territory. Encountering the pre-reflective, without the mediation of language, is undoubtedly a key act in therapy. This encounter occurs naturally through the body, and summons the territorial self. The particularity of these acts is that, although they are intrinsically therapeutic, they are paradoxically produced without a stated therapeutic objective. This is the paradoxical condition of a therapeutic address to the territorial self and to the relational and carefree dimension of self-experience. In these cases, the clinician does not know why they are doing what they are doing. And when they do not know why they are saying or doing something, when they are not applying a technique or complying with the standards of a protocol, they manage to enter into a relationship with the mysterious being in front of them. With their patient, they live life, rather than thinking about life.

Faced with the sometimes highly prescriptive proposals of psychotherapeutic programmes for schizophrenics, based on the application of protocols and guidelines to inform decision-making, it is undoubtedly also essential to move away from a strictly reflective attitude in order to highlight the anecdotal, pointless, original, laughable and sometimes folkloric practices of clinicians. This personalization of care, being incalculable and unpredictable, considers each clinician as a singular being and assumes that each therapist will meet a patient in their own way, and therefore in a way that will not be the same from one person to the next.

These pre-reflective mediations include artistic practices—dance (Sheets-Johnston, 2012; Xia & Grant, 2009), theatre, bodily expression (Martin et al., 2016)—the use of humour, therapies that use animals as mediators (Servais, 2016), but also the many informal moments between therapist and patient—those moments when the therapist might give the impression that they are not doing their job, when in fact they may be at the very heart of it, in their most subtle ethical commitment. I would like to take a few moments to look at therapies that involve animals because they seem to me to be particularly relevant to this subject. We know that the use of animals in clinical sequences (whether horses, pets, chickens, dolphins or even goldfish) has absolutely amazing therapeutic effects (whether for serious pathologies such as schizophrenia or for milder disorders), but why does it “work”? Without having a complete answer to this insoluble question, it seems to me that it is precisely because the animal does

not play the role of therapist and does not seek to occupy this role. Its therapeutic stroke of genius is precisely that it does not seek to be a therapist, thereby offering the luxury of a genuine intersubjective encounter devoid of techniques and standardized protocols. A therapist without knowing it (in the two senses suggested by this proposition: a therapist that manages to disregard its knowledge, but also a therapist that does not know it is one).

Of course, it is not a question of abandoning all forms of narrativity and abandoning all forms of therapeutic techniques, but of being able to "nihilate" oneself (as a Sartre-influenced therapeutic attitude would suggest) and to experience and tolerate one's own uselessness, which is perhaps, as Heidegger suggests, "the most difficult undertaking for contemporary man" (1963, p. 159). I suggest that this might be one of the essential aims of therapeutic experience with people with schizophrenia (and certainly beyond). This attitude is in line with the recommendations of Irvin Yalom (2002, pp. 63-64), the famous US existentialist therapist:

> In essence, the course of therapy should be spontaneous, flowing immutably along unexpected valleys: it is grotesquely distorted when it is reduced to a formula that allows inexperienced, imperfectly trained therapists (or even computers) to practice a uniform mode of therapy. One of the real abominations […] is the ever-increasing dependence on protocol therapy.

Perhaps, rather than using protocol-based techniques, we should rely on the intuitions and spontaneous behaviour of the patient and the therapist. In fact, these are the many unavoidable informal moments between these protagonists. Moments during which the therapist might give the impression that they are not doing their job, and which are perhaps those when they are most deeply engaged in it, most subtly committed ethically. It is important to "program chance" (as Jean Oury suggested),[4] to seek out the spontaneity and carefree nature of the experience:

> Jean-François enters a room where there are several members of staff with a superb basket of fruit that he has just bought. He says "*I don't want this fruit any more. It's angry with me … The fruit is saying bad things about me*'. A colleague shouts at him: "*Jean-François, stop it with your rants*". The clinician present, without really knowing why he was doing it, took the basket from Jean-François. He picks up a banana and says, "*Listen to me carefully, it's all over now, you are going to stop bothering Jean-François*". He picks up a plum and says, "*It's over for you too, and the same for all the others… I'm only going to tell you this once, leave Jean-François alone*". He turns to Jean-François: "*There you go Jean-*

[4] "Program chance so that there is a possibility of encounter. But for this possibility to exist, you need […] a place where you are left in peace, otherwise you don't meet anything at all. A real encounter is always by chance, a surprise" (Oury, 2014, p. 7).

> *François, I think you'll be fine*". Jean-François looks at him: "*Ahh… under these conditions… thank you!*" and Jean-François leaves. (Example taken from my clinical practice).

Here, the clinician's priority is to interact with the patient. He does not apply any protocol. Instead, he creates the right conditions for the patient to rediscover spontaneous experience. Let's start by noting what Bari, a schizophrenic patient, says when asked about hyper-reflexivity in the context of an EASE interview:

> I ask myself things like… a word for example, how do you compose a word, why do you make words like that, why are they those words and not others. (…). Sometimes it's as if I'm caught up in the questions, I no longer hear other people (…) Then I walk down the street, I'm walking, and I'm caught up in the questions. *I miss that. Just walking around without worrying about anything*. (Example given by Bari, taken from Englebert & Valentiny (2017)).

What if Bari has given us the key to what could help him? Let's finish with an even more specific proposal from Jean-François, who seems to have the same expectations as Bari. Jean-François is in my office… He has asked me to go for a walk with him. He says this incredible thing to me: "Since I've been here, I've lost the right to get lost". And deep down he is right, it is an unexpected condition of psychiatric confinement: all too often, we have lost all spontaneity, all carefreeness, even the right to get lost. My final suggestion is to follow Jean-François's advice and, in addition to Freud's "talking cure", to practise Jean-François's "walking cure". It is an invitation to take a walk as a therapeutic procedure, and to get lost (in the primary sense of these terms) by walking along the paths that are the street, the lane or the corridor of the institution. As Deleuze and Guattari put it in *Anti-Œdipe*: "The walk […] is a better model than the neurotic lying on the couch. A bit of fresh air, a relationship with the outside world" (Deleuze & Guattari, 1972, p. 7).

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