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Paradoxes in a prism: Reflections on the omnipotent passivity and omniscient oblivion of schizophrenia

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ABSTRACT

I reflect on what may be termed 'omnipotent passivity and omniscient oblivion' which are some of the key paradoxes within schizophrenia. I discuss various aspects of insight and self-awareness as components of clinical recovery and argue that the minds affected by schizophrenia can in fact be very insightful, albeit a different kind of insight entirely. I argue that the nature of schizophrenia means that one's experience of the illness may be conceptualized as a nonevent or non-experience due to the detachment from subjectivity and replacement/withdrawal of will. I draw parallels between the (again, paradoxical) experience of such nonevents with psychological annihilation and physical death, as well as with some intensely reflexive states of mind in philosophical pursuits. I also put forward an argument for the importance of investigating the kinds of nothingness, solitude and nihilism intrinsic to schizophrenia and how these might be studied or perhaps even understood from the angle of paradoxicality, which I consider to be the core psychopathology of schizophrenia and which may aid differential diagnosis with higher specificity. Lastly, I urge clinicians and researchers to redirect their passion away from "solving" the puzzle of schizophrenia and toward realizing the humanity in their patients.

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1. Introduction: A prismatic awareness

It is a widely accepted notion amongst clinicians, researchers and even some lay people that there is no singular symptom that defines what we call "schizophrenia". Delusions and hallucinations are far from pathognomonic, even certain first-rank symptoms that used to carry diagnostic significance have been brought into doubt (e.g., Peralta & Cuesta, 2020). More recently, works in phenomenological psychopathology have argued that self-disorders are the missing clinical core of schizophrenia and there is ample research evidence supporting their role in the pathogenesis and maintenance of schizophrenic symptoms, with three systematic reviews and/or

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meta-analyses published in the past year (Raballo et al., 2021; Henriksen et al., 2021; Burgin, Reniers & Humpston, 2022). However, there is also emerging evidence arguing against the specificity of self-disorders in schizophrenia, which also provides support for their role in panic disorder and dissociative disorders, for example, (Sass et al., 2018), and that is only one school of thought with regard to disorders of self and levels of selfhood (see, Kaminski et al., 2019; Mishara et al., 2014) as the very notion of self-disorder is contested and conceptually diverse.

In addition to the contention and controversy surrounding the nature of schizophrenia, which are as complex as the illness itself, there is such heterogeneity in the presentation of symptoms that two people can in theory have the same diagnosis with nothing in common. But there has to be some overlap in symptoms across individuals, otherwise clinicians and researchers might as well abandon the concept of schizophrenia altogether (in fact, this is exactly some individuals call for – the total abolishment of the "medical model" of schizophrenia – which is outside the scope of the current paper). Perhaps an alternative is to look beyond diagnostic criteria (i.e., *what* the symptoms are) and focus on *how* symptoms are presented and experienced. In this sense, the most common symptom of schizophrenia, at least according to the World Health Organization's International Pilot Study on Schizophrenia conducted thirty years ago (Jablensky et al., 1992), is a lack of insight. The Pilot Study found that approximately 98% of patients diagnosed with schizophrenia displayed a pervasive unawareness or active denial of their illness and its consequences, which in turn led to clinically undesirable outcomes such as refusal of treatment and risk to self or others (Buckley et al., 2007). Therefore, restoring insight seems rightfully the first step toward therapeutic engagement and treatment adherence. Nevertheless, this emphasis on clinical recovery often comes at a cost that is unknown to many clinicians, if not also to their patients: it is now increasingly apparent that delusions and hallucinations can have and give rise to a sense of meaning and purpose which is intertwined with the patient's self-worth, agency and identity (Ritunnano & Bortolotti, 2021; Ritunnano et al., 2021).

This conundrum faced by both clinicians and patients points toward a curious observation. Many patients are acutely aware of the bizarreness and potential harm associated with their psychotic experiences, yet they appear unable or potentially unwilling to just accept that they are the symptoms of a (medical) condition. This inability goes beyond deliberate refusal and cannot be simply disregarded as a defense mechanism hidden deep in the patient's subconsciousness. There is something unique about the kind of awareness that the patient with schizophrenia holds. This particular awareness of one's self, of other people or of the world encounters a direct threat, a threat originating from both one's own psyche and

the society in which one is situated; the very foundation of what it means to be a "normal" human being is shaken, if not damaged beyond repair. Yet the patient claims that they are the normal one, sometimes the *only* normal one, and it is the world that has gone mad. Madness as exemplified by schizophrenia is lived viscerally through a prism of contradictions, tautologies and dilemmas, all of which distil into a ray of invisible light that blinds the patient – as if the patient has been absorbed into the prism where they can only use metaphors and ciphers to describe their experiences.

2. Paradox as the core of schizophrenia

The prism through which schizophrenia is viewed and experienced by its sufferers is saturated with paradox. Such paradox is not simply related to clinical insight, for example, which has been shown to be inversely related to patients' quality of life in a recent meta-analysis (Davis, Lysaker, Salyers and Minor, 2020), but also at a far more fundamental level. The existence of schizophrenia itself is a paradox for some; Crow (2000) famously argued that one of the reasons why genes for schizophrenia have never been filtered out by natural selection is because schizophrenia is the price humans pay (or paid) for language and its lateralization. This proposition is of course not without critique; however, it may demonstrate that the mystery of schizophrenia is far from solved even conceptually. Like many accounts of this kind, Crow's also originates from the perspective of the third person. In other words, from a nonchalant observer who has obviously taken an interest in the object (the genetics of schizophrenia) that is being observed. Yet still, the very act of observation renders one no longer a detached third-party. It may sound as if by simple observation one can somehow maintain impartiality, but the truth of the matter is that humans cannot purely observe another human, object or even a concept without either presumptions or consequences arising from within oneself. Such emergent consequences may be thoughts, feelings or actions, all of which contribute to further entanglement between the observer and the observed. Even at the level of unconscious processing, the time lapse between the formation and the expression of thoughts has already distorted their original or "raw" form, often without explicit awareness. Then another question soon follows: who observes these emergent consequences within the observer? What complicates matters even more is that in schizophrenia the patient is already doing the job of the observer. Patients with schizophrenia are compelled to constantly observe everything that is happening both within and outside their self and losing the same self in the process. In a way, the patient is experiencing a paradoxical condition *from within the paradox* itself. The

mind that lives with schizophrenia also lives *within* schizophrenia, desperately clinging onto a darkening veil of perception that is constantly and relentlessly creating paradox after paradox, from both within and without.

It might be now apparent that my position regarding schizophrenia as opposed to other psychoses is somewhat unusual. Psychotic symptoms, and this covers all delusions and hallucinations, first-rank or otherwise, sometimes fail to define schizophrenia not just because of a lack of specificity but also due to their given experiential concreteness, i.e., they have well-defined boundaries as to what they mean/are. "True" schizophrenia exists before, and beyond, commonly defined psychoses. True schizophrenia is the place where the two ends of a Möbius strip join each other – if such an intersection is even conceivable – and not just residing on the inside or the outside of the strip. In a very abstract and perhaps esoteric sense, schizophrenia is primordial, irreducible to any essence yet firmly tangible in the realm of perfectly compatible paradoxes. The experience of schizophrenia is not just "the experience of", for it cannot simply be willfully "experienced" by the first or the third person. To observe schizophrenia, to live within schizophrenia, one has to let go of all modes of experience as the commonsensical world defines them. To gain a glimpse of the paradoxes, one will need to depart from one's own experiential field and become fully familiar with the structure of another consciousness. And to be able to record and potentially analyze such an "experience", one must not be confined by any presumption or consequence – which are, ironically and paradoxically, the prerequisites of being an observer.

The paradoxical core of schizophrenia is exponentially close to and infinitely far away from an "experience"; schizophrenia evades common sense, logic, corporeality, physicality and sometimes (if not often) understandability because its experience (whatever the definition of "experience" might be) is a nonevent. One cannot be *experiencing* schizophrenia and be the *experiencer* of schizophrenia. It robs a person of agency whilst sparing their selfhood only as perceived by others; it deprives a person of self-awareness whilst preserving their awareness only of everything outside their self. The patient is both self and non-self, immersed in everything and nothing, and externally going through an internal nonevent. This is the sense of omnipotent passivity – as one's active self approaches psychological annihilation, one's will is spontaneously protected from total destruction by being replaced or displaced by that of a passive spectator. This spectator then takes the seat of the sole participant in mental, and sometimes physical, events and becomes the new will at the center of the patient's universe. As if one's mind is going supernova, the universe as the patient knows it implodes into an immeasurable number of possibilities and dead ends. Detached from consensual reality and attracted to infinity by the force of a will outside the realm of voluntary control, the patient (again) paradoxically gains the

ultimate control over their fate, as if they have just been given a second chance at life. Like a phoenix rising from the ashes, the sense of omnipotent passivity grants the patient a renewed means to avoid annihilation and death of their inner life; all the while, the patient is being burnt alive by the ashes from which they are escaping. The phoenix is nothing but a hallucination, a hallucination that wears the disguise of complete freedom.

Released from the duties and shackles of commonsensical reality, a new hyper-real reality is urgently needed. Needless to say, this hyperreality in fact is no reality at all: not only is it *hypo*-real, but it is also non-existent, plain and simple (cf., also Feyaerts & Kusters, 2022; Kusters, 2020, Chapter 1). Nothing is as unreal as nothingness itself, for nothing real can exist in pure nothingness. Still, this statement would only stand true in physical terms. To the mind afflicted with schizophrenia, nothingness is very real perhaps because the mind appears to be unreal itself. Absolute nothingness is full of potential for new realities to blossom – it is the prerequisite for all realities no less – everything is born from a prior state and the schizophrenic mind is certain of this truth. Nothingness is different from emptiness or falsehood. Nothingness excludes even the observer. But if nothingness itself is a nonevent that cannot be experienced, how would one become aware or be *made* aware of such nothingness without one's pre-determined existence as an observer? Perhaps it requires an existence external to the nothingness. Perhaps it necessitates another active self unaffected by the first iteration of nothingness where the annihilation of the original self created the nothingness in the first place. Just to what extent can such nothingness expand? The infinite creation of worlds and selves will only be engulfed by an "infinity plus one" amount of nothingness. And so, the Möbius strip keeps its shape intact and the circle continues indefinitely. Self is destroyed and reborn in a new world, then destroyed again with that world in an endless loop of painful acceleration and unspeakable exhilaration, operating in perfect stasis.

3. Eschatological ecstasy

The patient plagued by schizophrenia is constantly lured to and challenged by the nonevent that is the experience of their own mind. The allure of psychological, and sometimes tragically physical, death is both an opportunity and an imminent threat. On the one hand, there is an absolute counterbalance to be maintained between extreme activity and passivity (Stanghellini & Monti, 1993), between an all-knowing revelation and a self-fulfilling oblivion. On the other hand, death too is a nonevent. In fact, it is *the* eventual nonevent beyond life as Wittgenstein famously put it, that there is nothing philosophical to be said about it (see, Weller, 2003). I consider the flip side of that statement also to be true: namely, one's birth is a nonevent

just like death. Who can confidently have anything to say about their own birth? There is absolutely nothing to be said about anything before or after life, for there is absolutely nothing before or after life. Everything to be said exists in-between these two nonevents. But this sentiment does not apply to the mind afflicted with schizophrenia. There is nothing to be said about their mental events – the continuously evolving nonevents stagnated in a strange homeostasis – yet there is *everything* to be said as well. One's birth becomes the death of the unconscious processes hidden underneath self-awareness, and one's death signifies the ultimate self-mastery in a highly controlled yet entirely unpredictable manner. No one's life is *complete* until they die. This eventuality both finishes and breaks the Möbius strip that is one's consciousness and reality. The person with schizophrenia is all too aware of this eventual nonevent and they would perhaps argue that there is much to be said about it or even claim that they have been there themselves, that they have experienced their own death. Such a claim can only be figurative, at least to any outsider looking into the lifeworld of the patient. Nevertheless, perhaps the patient is only using figurative language to describe and express an actual physical event, no matter how ontologically impossible it is or how off-the-rails delusional it may sound. The patient with schizophrenia has *really* been through the journey; they have both witnessed and participated in their own demise, and, together with it, the end of the world.

Of course, *the* world has not ended. *Their* world has. The fright, the delight, the bright light at the end of the tunnel as one's consciousness perishes that have puzzled the minds and attracted the interest of so many philosophers are now a reality for the patient with schizophrenia. The patient cannot die, for they are already dead. No one can kill a dead person. In this sense, solipsistic grandiosity and eschatological ecstasy are intertwined to such an extent that they are indistinguishable from each other. What purpose do they serve, if any at all? Furthermore, how could anyone even remotely regain "insight" from and into such an extreme state of mind? Using nihilistic delusions (e.g., Cotard's) as an example, David (1990, p. 804) quotes Jaspers that statements such as "I am a living corpse" cannot be explained or conceived "in terms of a lack of reason but as a failure of the primary experience of 'Being', in which case lack of insight does not apply". Granted, nihilistic delusions are more common in psychotic depression than they are in schizophrenia. However, schizophrenia is nihilistic in a different way. The nihilism in schizophrenia is *paradoxical* as well as (again, at least to the outsider observing the patient) delusional. It could even go beyond psychosis into the realm of mysticism, assuming that these two are part and parcel of the same experience: mysticism is insightful, so is the paradoxical nihilism of schizophrenia. Klar and Northoff (2021) offer an in-depth analysis of

nihilism in schizophrenia by integrating both first-personal accounts and third-personal psychopathology literature and laying out three stages of nihilism: phenomenological, epistemological and existential-ontological. The final stage, existential-ontological nihilism, clearly entails the most severe psychopathology:

> 'The state of pre-intentional blind-consciousness now constitutes the existential void of ontological nihilism. Here, neither the self nor the world remains; nothing further exists beyond this most fundamental pre-intentional layer. Pure, authentic, and throughout feelings of nothingness permeate the individual's experience. The schizophrenic individual's existential situation transforms into a meaningless void, that is, the form of existential nihilism that we target, which conceptually represents the final stage of ontological nihilism concerning Being. (p. 188)'

I would consider this state of "blind-consciousness" a morbidly fascinating endpoint of consciousness where one's intentionality (or the lack thereof) and existence come closest to physical annihilation – the eventual nonevent – and simultaneously, a self desperately reaching out to reconnect with the world, a barely bubbling Being smothered in the undercurrents of the primordial soup that is too alive to be considered *living*. Therefore, I would disagree that it is a *meaningless* void, but a void filled to the brim with energy and potential, with ecstasy and eagerness for what happens *after* the nonevent (temporally, logically and consequentially), namely the rebirth and re-synthesis of one's mind and universe, even though they might not be the same mind and universe as before. Admittedly, no one would be able to affirm with any certainty whether the newly reconstructed unity of self always lies at the other side of nihilism, as the annihilation of the original intentionality has ensured that even the blind-consciousness left behind is also destined for destruction. Perhaps such a unified self will only emerge with the glance of an observer who is unaffected by the nonevent and untouched by the autophagy of self. To possess such a pervasive existence – an existence that surpasses the limits of physiology, logic and reality – one must first be vapourised into nothingness, like the vacuum in space. The purest state of null is omnipresent: a void concealed in the patient's mind which engulfs the entire universe. This to me differs from the nihilistic delusions in psychotic depression: nihilism in schizophrenia is strangely *constructive* and not defeatist. It protects the patient from further harm because a dead person cannot be hurt or threatened, not even by the terror in their own mind. Instead, such terror is replaced by the awe of fatalism, of the only certainty that is the eventual nonevent. The patient has ascended to paradise, a paradise created by the infinite possibilities concentrated within nihilism and the mysterious power of paradox. The lack of insight really does not apply.

4. Paradisus paradoxum

If an observer who is not at all impacted by paradox can ever exist, they must do so entirely independent of, and disentangled from, the mind of a person with schizophrenia. Just what kind of existence is it? No one else is better poised to observe one's self other than the very mind afflicted by schizophrenia, a process that has already started producing layers upon layers of paradoxes even before the first glimpse of observation can take place. It must be an existence that can simply will itself in and out of the prisms of paradox and one that can switch between the ends of the Möbius strip. In a sense, it requires a God-like creature to take up the role of the perfect observer; in other words, it calls out for a gaze that is inhuman as otherwise observation would not be humanly possible (Relevant here also Wittgenstein's description of such a gaze: i.e., a point in space devoid of any human characteristics). The ascension to paradise through oblivion strips the patient with schizophrenia of their intentionality yet endows them with a shortcut to a level of awareness that can almost only be conceived from a separate physical dimension. The patient has finally arrived at the paradise of paradoxes. The patient's mind has perished in oblivion and then through a process that is as sublime as it is subversive, reaches a new mindscape where schizophrenic paradoxes coexist in parallel with the everyday mundane reality that is the human world. This place is an ideal observation tower; there is minimal risk involved in attempting to take a quick glance of what is happening "on Earth".

Still, what are the results of taking such a glance? What are the consequences of this observatory stance, what are the findings of this lifelong experiment? What does the patient see and what can be learnt from living through the eventual nonevent and emerging at the other side of the Möbius strip? These questions have fascinated and tormented madmen and philosophers alike for centuries, if not for eons. Death – psychological or physical – seems also an unfathomable source of the ultimate knowledge, the kind of knowledge stored in a place of no return. The *paradisus paradoxum* is the analogue of such a place beyond nothingness, reserved almost exclusively for the mad, the solitary, the eccentric and the outcast. I say analogue because obviously the patient is not actually dead; but in their own mind, they live through the nonevent and approaches the *paradisus* exponentially, catching a glimpse of the glistening void at its core before being engulfed by its black light (Kusters, 2020). Like the gravitational pull of a black hole, nothingness itself is formed through it as the only entity, the only something within nothing – which holds the potential to become *anything* at all, as the beginning and the end, or to put in physiological terms, like the differentiation of pluripotent stem cells. It may be that reality – or one's very ability to

perceive it – originated from such cells. After all, the differentiation of these cells will eventually lead to a fully formed central nervous system that bestows one with the gift and the curse that is human thought.

It is curious that the knowledge gained from being infinitely close to a prior state (i.e., "the beginning and the end") even only for a fraction of a moment can completely deprive a person of the ability to describe, and therefore communicate, such knowledge in human language. In this sense, Wittgenstein was correct: there is not much to be said about the eventual nonevent, not simply because it cannot be "experienced", but also because there is nothing that can be *said*. Everything gained, everything lost, and everything transmitted in-between can only be *thought* and not said. It is a realm of pure thought, leaving absolutely no traces behind, no record to be kept and no memories to be treasured. Nothing in the corporeal world is a prerequisite; yet without the physical world there will be no more pluripotent stem cells, no more brains and no more thoughts. It is almost as if the stem cells have turned apoptotic against themselves. Indeed – whether one is a philosopher, a mad person or both at the same time (of course these two roles are not mutually exclusive!), entering the realm of pure thought mandates a profound sacrifice, an absolute negation. The allure of the *paradisus* is so immense both to the madman and to the philosopher that sometimes such a sacrifice is a necessary evil, if not a welcome price to pay in exchange of the ultimate knowledge that can never be taught, expressed or communicated to another person. One could argue that whatever that knowledge is, it is meaningless because of its ineffable nature. Its pursuit is also a futile one, for if the *paradisus* is a place for one, it might as well be a place for none or no place at all. However, it is precisely because of its meaninglessness that it is full of potential; its ineffability is its value, and its futility is to be desired if not revered. All these paradoxes are essential features of the *paradisus*.

The *paradisus* is both a place for one and a place of one. In more extreme (and much rarer) cases, the madman or the philosopher can become at one with the *paradisus*, before being consumed by the paradoxes within. Perhaps this is where catatonic states occur for the madman and the philosopher goes mad. Interestingly, the whole notion of insight is never seriously evaluated in negative symptoms or indeed, catatonia. It seems to be the case that insight only applies to florid delusions and hallucinations. The paradoxes within the *paradisus* can never be concretized as delusions *or* hallucinations at least as they are currently defined in diagnostic systems, neither are they a purely deficit state unless the patient completely loses sight of the lives on Earth. However, even though the patient is not confined (literally and figuratively) in a deficit state, it does not make the *paradisus* a pleasurable place to be, at least not by conventional definitions of pleasure. It is a lonely place that only the mad person and the philosopher could

discover and potentially endure. To use a somewhat clichéd analogy, the madman and the philosopher are like two people under water, one drowning and one diving; nevertheless, the one who is drowning will gain an entirely different perspective (albeit a fatal one) through the experience of the nonevent, which is not accessible or perhaps even comprehensible to the one who is diving. Conversely, the one who is diving will finally emerge to tell everyone else their underwater adventures and heroic tales, whilst the other lies motionlessly at the bottom of the sea, unable to utter a single word. Which of the two is truly in the *paradisus*?

5. Beyond solitude

Schizophrenia is a very lonely illness and the *paradisus* is not some sort of wonderland that those romanticizing the condition might portray it to be. Admittedly, by calling it *paradisus*, it is somewhat misleading – as if it was a pleasurable or divine ascension into a higher form of consciousness. Even if it was, the price one must pay renders the whole process unbearable. In one of the earlier accounts comparing mysticism and schizophrenia, Wapnick (1969) cited William James and his two types of mysticism, one linked with the divine and the other with the insane ("diabolical mysticism"). The God-like observatory stance in the *paradisus* is in fact a painfully isolating position in which the patient is perpetually trapped, unable to emerge victorious or admit defeat altogether. If it really was God-like, then it must be a self-destructive, death-obsessed God. Indeed, the humanity in patients with schizophrenia is often overlooked if not deliberately ignored by theorists and practitioners alike. When faced with the seemingly incomprehensible yet desperate attempts by the patient to communicate anything at all, those who are supposed to take care of the patient tend to either dismiss the patient's utterances as senseless word salad or take an unhealthy interest in "curing" the patient and imposing "clinical insight", as if treatment success was a personal mission to rescue the patient from their undeniable yet intangible suffering. The patient is stuck in a no-win situation: whichever way it goes, they have to pay a hefty price to either relinquish their solitary pursuit or to retreat and become even more entangled with the Möbius strip, the latter of which will most definitely invoke even more morbid interest in their psychopathology from those in charge of patient care and lead to more treatment attempts. I am by no means claiming that no one cares; at least some clinicians and researchers really do care, they are convinced that they have the patient's best interests in mind. However, the God-like twilight state beyond everyday humanity is often ignored, even by those benevolent humanist researchers and clinicians who emphasize the meaningfulness of delusions and psychosis, as if such a meaning would straightforwardly anchor the patient in a *sensus*

communis, or even in a private one. The paradoxes I lay bare here significantly complicate this hermeneutic stance. What the outsiders looking in do not always realize is that there has never been a choice for the patient. It sounds very obvious perhaps – the patient did not will themselves into schizophrenia and they cannot will themselves out of it. Therefore, some kind of third-personal intervention is clearly needed, if not only to reestablish the patient's own will and agency.

The real issue emerges when the patient is resistant to the interventions forced upon or recommended to them, not by any deliberative decision-making process as others know it, but by the sheer affinity schizophrenia holds over the patient's structure of consciousness. If psychiatry, or indeed philosophy, can be a vocation and an identity, the grip of madness can also transform itself into the shadows by one's feet, the mirror image one sees everywhere and the air one breathes in every moment one is alive. Furthermore, madness provides the other mind the individual *needs* in their excruciating solitude, whether through adding to their own identity or through taking away undesirable parts from the said identity and absorbing them into a human replica. Sadly, madness is not a solution to anything. It is not a willful choice, a last-minute defense mechanism or a self-fulfilling prophecy. Although delusions (for example) can be meaningful if not even beneficial in some cases, for many others meaningfulness appears only at the end of the meaning-searching and meaning-making process so desperately sought for by the patient; by that point, it may have already lost its true meaning and purpose. The Möbius strip is constantly folding onto itself, isolating the patient further and further into the solitude that madness is supposed to resolve, until the patient transcends thought and perception and goes *beyond* solitude – into the omnipotent passivity and the omniscient oblivion.

By going beyond solitude, such a radical change in one's existential position protects one from disintegration and further isolation. Solitude itself has been implicated in schizophrenia as a risk factor for suicide, especially when combined with inferiority feelings and as a result of disorders of self-awareness and self-presence rather than those of a purely social or interpersonal origin (Skodlar & Parnas, 2010; Skodlar et al., 2008). Nevertheless, solitude has also been conceptualized as a beneficial coping mechanism to escape from sensory overload, for example, (Seeman, 2017). It would seem that the very definition of solitude varies between studies and authors; the kind of solitude to which I refer is neither solely the product of diminished self-presence nor an active attempt at escaping from the social world. Rather, it is the crystallized end point of paradoxicality, of the most fundamental forms of otherworldly otherness within oneself and relentless othering by others, and of the painful struggle both for and against one's own self. It is an unbearable, unsustainable and unstable state of mind that

urges the same mind to either completely withdraw into nihilism or fall into solipsistic grandiosity, without offering any opportunity of real choice. This kind of solitude is certainly not something anyone would actively choose as a coping mechanism; indeed, most would not wish such a mental state on their worst enemies and the very idea of "coping mechanism" seems irrelevant to capture this state of mind. When some people, even some patients with schizophrenia, speak as if they enjoy solitude, it is not the type of solitude that has to be endured by those who suffer the most (in fact, I have previously argued for a narrowing of the schizophrenia diagnostic concept; see, Humpston, 2022). This solitude goes beyond words, language and description; it eats away at one's core from the inside out, whilst outsiders looking in wonder how the patient is still functioning (or, if the patient is not functioning, how to make them *functional* again in the interpersonal and social world). Ensnared by the maddening solitude and the solitary madness, the patient with schizophrenia participates in one final act of passivity – to observe their own demise, which is enshrouded in paradox, and merge with the human replica they previously dreaded. The Möbius strip is complete once more.

6. Conclusion: An enigmatic nothingness

I would understand entirely if someone pointed out to me that this whole endeavor of reflection paints a very pessimistic, if not even defeatist, picture of the lives affected by schizophrenia, as if there is no hope for recovery and no escape at all from the deadly solitude, the all-consuming paradoxes and the ever-tightening Möbius strip. This is never my intention, as a significant minority of individuals with schizophrenia do eventually meet the definition of at least "clinical recovery", whilst the majority will see an improvement to their quality of life with the right kinds of intervention. I would also like to maintain the position, however, that no one can speak for anyone else's subjective experience and reality or act on anyone else's behalf even if it is done to understand the other person's perspective. The ideas in this paper are not by any means aimed at offering a universal be-all-or-end-all account of schizophrenia, but to merely peel open the thick curtains hanging before the painful puzzle that patients with schizophrenia may feel obliged to solve by themselves even by a little bit, and to show that they are in fact *not* alone in their pursuit. Despite the best of intentions, schizophrenia (or at least aspects of it) will likely remain an enigma of human consciousness for as long as such consciousness exists. Within it lies the beckoning nothingness as well as a myriad of potentials. In this sense, my reflections are not pessimistic at all: the insights gained when reality retreats can be invaluable in their own right, no matter how obscure, esoteric or metaphoric they may appear.

Perhaps only if more people are willing to listen to such insights and not reduce them to checklist exercises or boxes to be ticked in a clinical assessment, patients too will feel more empowered to reengage with the commensensical world and be encouraged to become valuable, and not simply functional, members within that world.

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Notes on contributor

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