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FROM FRAGMENTATION TO VOCATION: THE MISSION OF THE FRANCO THEORY AS RECONSTRUCTION OF THE SELF – INCORPORATING THE "SCHOOL" AND THE "HISTORY" INTO PSYCHIATRIC CLINICAL ANAMNESIS

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ABSTRACT

The FRANCO Theory proposes a clinical approach centered on the dignification of the individual's life trajectory through two foundational pillars: the "School" (what one lives and transmits) and the "History" (what one becomes as a result of lived experience). This methodology transforms clinical anamnesis into a formative act, reconnecting the patient with their existential mission and promoting a psychiatry oriented toward meaning rather than mere symptom suppression. Clinical listening is reconfigured as both a therapeutic and ethical tool, allowing for the reconstruction of the subject as an agent of transformation. This proposal presents clinical, social, and educational applications and seeks to expand the humanistic horizon of contemporary psychiatric practice.

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INTRODUCTION

Classical psychiatric practice is typically structured around symptoms, diagnostic protocols, and pharmacological responses. While effective in many respects, this approach fails by reducing the individual to that which manifests as disorder, neglecting the subjective history that underlies their experience of pain. This limitation compromises not only the integral understanding of the patient but also their capacity to reframe pain as a morally and existentially formative element. The FRANCO Theory emerges in this context, proposing a reorientation of the psychiatric clinical act. It is a model based on two pillars: the "School" and the "History" of the individual. The School represents the major events in the subject's life—losses, failures, achievements, traumas—and what they are capable of teaching others based on those experiences. History refers to how the individual interprets these experiences and transforms them into concrete actions, relationships, and life choices. This approach goes beyond diagnosis and aims at dignifying the lived experience. This proposal aligns with what Souza and Pereira (2022) call "therapeutic re-signification," a process in which pain ceases to be merely a symptom and becomes the raw material for moral transformation. Similarly, Martins, Rocha, and Barreto (2021) argue that personal narrative, when valued in clinical settings, can yield an impact equivalent to pharmacological interventions in certain cases of mild to moderate psychological suffering. This valuation of life's meaning also echoes the principles proposed by Frankl (2006), who sees suffering as an opportunity to reconnect with higher purposes. Active and spiritualized listening has gained attention in the scientific literature. Puchalski *et al*. (2009) emphasize that the spiritual dimension of care must be an integral part of contemporary medicine. Koenig (2012) reinforces that the integration of spirituality and mental health is associated with improved clinical outcomes and greater treatment adherence. These findings suggest that practices centered on the patient's lived experience and faith can enhance both diagnostic understanding and the reinforcement of hope and purpose. The model proposed in the FRANCO Theory is thus aligned with this evidence. It recovers the value of Socratic introspection (Plato, Apology of Socrates) and the Christian ethic of testimony (Benedict XVI, 2009), promoting a reconnection of the patient with themselves—not as a case to be resolved, but as a formative being. When called to narrate their School and reflect on their History, the individual is returned to themselves not merely as a sufferer but as someone capable of teaching, not only resisting but transforming.

Clinical Methodology of the FRANCO Theory: The methodology proposed by the FRANCO Theory is structured around two pillars: identifying the patient's "School" and reconstructing their "History."

This structure transforms anamnesis into a therapeutic experience that transcends data collection and becomes a tool for existential realignment.

Recognizing the "School": The first step in the consultation involves oriented listening through the core question: "What has been the most defining moment of your life?" This invitation aims to map emotionally significant events: the death of a parent, the end of a marriage, the birth of a child, the overcoming of a serious illness. Beyond the narration of events, the goal is to decode them as formative turning points. The innovation lies in understanding that each impactful experience holds pedagogical potential—even when unconscious. The School is not the trauma itself, but what it can teach. For example, a patient who lost their mother due to medical negligence and now encourages others to seek early care demonstrates an active School. Another who survived a serious accident but remains silent about the experience reveals a blocked or hidden School. The clinician's role is to mediate this revelation—helping the patient name, process, and extract hidden lessons from their pains and victories. The School, therefore, is what one has lived, but more importantly, what one shares from it. The therapist may ask: "What did that teach you?" "How do you share that with the world?" "Have you helped anyone because of what you went through?" If the answers are negative or evasive, the work of symbolic and emotional reconstruction begins.

Understanding the "History": In the second stage, the therapist asks: "Who did you become after that happened?" Here, the focus shifts from the event itself to its unfolding: did it result in positive transformation, crystallized in destructive patterns, or lead to neutrality?

Examples include

Positive transformation*:* A woman who, after experiencing domestic violence, began organizing discussion circles on autonomy and protection in public schools in underserved communities.

Negative history*:* A man abandoned in childhood becomes an emotionally distant and harsh father.

Neutral history*:* An executive who lost everything but changed nothing—no new insights, no shared experience. The therapist must assess whether the pain has been integrated as purpose or remains as imprisonment. The aim is for each patient to see their life not as a sequence of accidents but as a mission. This methodology is grounded in Christian anthropology, the ethics of care, and logotherapy. The patient is not seen as merely ill, but as a "teacher of the self" in continuous formation. The consultation becomes not confession but vocation. The therapist acts as a restorer of legacies—someone who listens not to diagnose, but to awaken the best of what was lived. This clinical practice proposes a vocational psychiatry: the goal is not only to alleviate symptoms but to uncover the mission that lies within the pain. Once this mission is revealed, the patient not only transforms themselves, but also the relationships and environments they inhabit. Suffering ceases to be an obstacle and becomes a foundation. Healing is no longer the absence of pain, but the birth of meaning.

DISCUSSION

The FRANCO Theory represents an epistemological and ethical rupture with traditional paradigms of contemporary psychiatry. In a landscape where the medicalization of life has erased the biographical uniqueness of patients, this theory proposes the clinic as a space for testimony and reinvention. Unlike approaches that focus solely on symptom control, FRANCO elevates human suffering as raw material for moral and vocational formation. This discussion does not merely present a new method but an ontological alternative: anamnesis ceases to be a classificatory instrument and becomes an act of restitution. The patient is no longer seen as a repository of symptoms, but as a bearer of a structuring narrative. This perspective aligns with Frankl's logotherapy, which asserts that humans can find meaning even in extreme suffering (Frankl, 2006), but goes further by stating that each pain holds a social pedagogical mission—the School—and every behavioral response reflects a legacy in formation—the History. This model redefines the concept of therapeutic success. In FRANCO, symptom remission is insufficient: the patient must find a meaningful place in the world based on what they have lived. This renders them not just resilient, but relevant. Pain is no longer something to eliminate, but something to be reconfigured. As Puchalski *et al*. (2009) affirm, integrating spirituality into clinical care expands therapeutic horizons and restores existential dignity. Koenig (2012), Peteet (2014), and Galanter (2005) demonstrate that spiritual and narrative practices are associated with better adherence, lower relapse rates, and greater social engagement. The FRANCO Theory joins this expanded field by offering a structured protocol that incorporates the past (School), present (self-analysis), and future (projected History). The methodology also transcends the dichotomy between diagnosis and spirituality, proposing a transdisciplinary clinic in which psychology, medicine, theology, and philosophy collaborate to return to the patient their status as master of their own pain. As Benedict XVI (2009) stated, modern humanity suffers not only from a lack of remedies but from a lack of meaning. FRANCO provides a robust therapeutic axis for this crisis.

Its originality lies in three core elements

Formative transfer*:* The lived School must be converted into shared wisdom. The patient is not only someone who suffered but someone who can teach.

Identity re-signification*:* History is the conscious rewriting of one's trajectory based on lessons learned.

Spiritualization of the clinical process*:* Suffering is not pathology per se, but a cry for mission. Once this purpose is discovered, the patient becomes a witness.

Rather than treating trauma as an isolated event, FRANCO sees it as the origin of a legacy. The consultation becomes not just a data collection space, but a call to biographical responsibility. The therapist, in turn, becomes an "archaeologist of meaning," revealing, among the ruins of pain, the foundations of vocation. The clinic is no longer the place of endings but of beginnings. Suffering is not merely treated—it is translated. The patient is not merely heard—they are called to teach. And psychiatry becomes not a science of symptoms, but a science of human reconstruction.

Philosophical-Moral Foundations: The FRANCO Theory rests on a philosophical tripod rooted in Western tradition, applied clinically with renewed depth. This foundation is structural, not ornamental: it underpins how we understand the patient, pain, suffering, and the possibility of healing as moral transformation. It integrates Socratic introspection, the dignity of the human person as a gift, and the Christian ethic of testimony.

Socratic introspection: "An unexamined life is not worth living," proclaimed Socrates in Plato's *Apology*. In FRANCO, the psychiatric consultation is not merely clinical inquiry but a summons to self-awareness. The patient is challenged to see not just what they suffered, but what suffering taught them. Self-examination is not an end but a portal to meaning. The therapist acts as a midwife of inner truth.

Human dignity as gift: FRANCO rejects all biological or functional reductionism. The human being is understood as an image of the sacred, endowed with transcendent vocation. This means each person carries formative capital—a unique wisdom forged by their pain, victories, and choices. Anamnesis becomes reverence. The patient is seen as a living school—someone who, consciously or not, has something to teach. This is inspired by Christian anthropology and the principle of inalienable human dignity (Benedict XVI, 2009).

Christian ethic of testimony: Pain only finds its fullness when it becomes offering. FRANCO proposes that every wound can be reconfigured as mission, every story turned into legacy. The patient is called not just to be healed, but to become a sign to others. This transcends conventional therapy: it is not about eliminating pain, but elevating it. Just as the cross is, in Christian theology, a place of redemption, so too in the clinic can the wound become a source of healing for others. This tripod repositions the clinic as sacred ground—where listening is spiritual, and healing is the awakening of existential mission. FRANCO does not offer shortcuts, but paths. It invites the patient to transform their wound into a chair of wisdom, their trauma into insight, and their symptom into a call to fullness.

Therapeutic and Social Applications: The FRANCO Theory offers not merely a revision of clinical listening—it proposes an ethical revolution in the way human pain is interpreted, valued, and transformed into action. Its therapeutic power lies in allowing individuals not merely to survive suffering but to be forged by it—becoming bearers of meaning in the world. In clinical settings—especially in cases of resistant depression, prolonged grief, identity disorders, and existential collapse—FRANCO offers what no medication alone can: a reconnection with the mission of existing. When patients realize their pain can become legacy, a new kind of adherence emerges—not from obligation, but from transcendence. As shown by Seligman (2011) and Frankl (2006), it is meaning, not the absence of pain, that ultimately heals. In the social sphere, FRANCO transforms communities by transforming individuals. Patients who recognize their School and rewrite their History become living witnesses: informal counselors, spontaneous caregivers, moral leaders, mirrors for those who have yet to discover the strength in their own wounds. When this culture of listening takes root in institutions—schools, faith communities, workplaces—it generates healing environments. Pain no longer excludes but includes; no longer silences but summons. Imagine a community clinic where medical records document not only symptoms but also legacies. A school where teachers are trained not only to assess student performance, but to perceive the stories that shape their behavior and potential. A therapeutic community where every patient serves as mentor to another. FRANCO points toward this horizon: a psychiatry of mission, not just maintenance; of meaning, not just control. Ultimately, FRANCO's greatest therapeutic fruit is to return to each human being the vocation to be a light in the darkness they endured. The patient who enters the consultation bearing a burden may leave carrying a beacon. And that is what defines true healing.

CONCLUSION

FRANCO Theory rescues psychiatry from technical survival and guides it toward existential rebirth. In an age of hurried diagnoses, meaningless prescriptions, and anesthetized listening, this proposal restores the clinic's noblest vocation: to reconnect with the human being as mystery, mission, and living school. What is proposed here is not just a method, but a vision. The consultation becomes an altar of memory, where the patient is called to reorganize their pain into legacy and their history into testimony. Each experience ceases to be a fragment and becomes a foundation. Each trauma is reframed as a beginning. Every question becomes a summons to inner greatness. The School teaches us that what we lived has value—especially when shared. History shows us that who we become after suffering is what truly heals.

By articulating these axes with methodological rigor and spiritual sensitivity, FRANCO founds a new way of caring: more ethical, more human, more beautiful. By adopting this theory, therapists cease to be merely specialists in symptoms. They become gardeners of destiny, restorers of meaning, healers of sleeping vocations. And patients cease to be victims of their story—they become authors of a legacy born of pain, yet destined for light.

REFERENCES

Baumeister RF, Vohs KD, Aaker JL, Garbinsky EN. Some key differences between a happy life and a meaningful life. The Journal of Positive Psychology. 2003;8(6):505–516.

Benedict XVI. Caritas in Veritate. Libreria Editrice Vaticana; 2009.

Braghetta R. Resiliência: Construindo o conceito a partir da prática. Psicologia em Estudo. 2006;11(1):37–45.

Cloninger CR. Feeling good: The science of well-being. Oxford University Press; 2004.

Diener E, Suh EM, Lucas RE, Smith HL. Subjective well-being: Three decades of progress. Psychological Bulletin. 1999;125(2):276–302.

Frankl VE. Man's Search for Meaning. Beacon Press; 2006.

Galanter M. Spirituality and recovery in 12-step programs: An empirical model. *Journal of Substance Abuse Treatment.* 2005; 28(4):335–341.

Ironson G, Stuetzle R, Fletcher MA. An increase in religiousness/spirituality occurs after HIV diagnosis and predicts slower disease progression over 4 years. *J Gen Intern Med.* 2002;17(11):850–858.

Koenig HG. Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry.* 2012; 2012:278730.

Lucchetti G, Lucchetti ALG, Puchalski CM. Spirituality in medical education: Global reality?. *J Relig Health.* 2011;51:3–19.

Martins RA, Rocha LM, Barreto AP. Autoanálise e ressignificação na prática clínica: contribuições para uma psiquiatria narrativa. *Rev Bras Psiquiatria Integr.* 2021;13(2):55–68.

Moreira-Almeida A, Koenig HG. Retaining the meaning of religiousness and spirituality: Commentary on the WHOQOL SRPB instrument. *Soc Sci Med.* 2006;63(4):843–845.

Peteet JR. Approaching spiritual problems in psychotherapy: A conceptual framework. *J Psychother Integr.* 2014;24(3):208.

Plato. Apology of Socrates.

Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the quality of spiritual care as a dimension of palliative care. *J Palliat Med.* 2009;12(10):885–904.

Seligman MEP. Flourish: A visionary new understanding of happiness and well-being. *Simon & Schuster;* 2011.

Souza DH, Pereira MC. Intervenções baseadas em sentido de vida e espiritualidade em pacientes com sofrimento psíquico grave: uma revisão integrativa. *Arq Saúde Ment.* 2022;14(1):10–21.

Taylor EJ. Spiritual needs of patients with cancer and family caregivers. *Cancer Nurs.* 2003;26(4):260–266.

Zinnbauer BJ, Pargament KI. Religiousness and spirituality. In: Paloutzian RF, Park CL, eds. Handbook of the Psychology of Religion and Spirituality. *Guilford Press;* 2005:21–42.

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