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**Disorders of Schizophrenic Embodiment:  
A Phenomenological Investigation**

A Dissertation Presented

By

**Krisztina Sajber**

To

The Graduate School

in Partial Fulfillment of the

Requirements

for the Degree of

Doctor of Philosophy

in

Philosophy

**Stony Brook University**

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## **Abstract of the Dissertation**

Disorders of Schizophrenic Embodiment: A Phenomenological Investigation

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The bodily manifestations of schizophrenia are not commonly in the forefront of scientific research. An investigation of the disorders of schizophrenic embodiment is nevertheless instructive not only for psychotherapeutic advances in the treatment of the schizophrenic condition, but because it offers unusual access to the pre-reflective experience of the body, a topic of great significance in contemporary phenomenology. This dissertation proposes a methodological framework for the systematic analysis of the various disorders of embodiment in schizophrenia, such as the schizophrenic modality of bodily self-alienation, the distortions of the body image experienced by schizophrenics, the processes that drive the conceptualization of the body as a material entity, and the disorders of pre-reflective selfhood to which these phenomena testify. This investigation is presented alongside an ethical inquiry interrogating the nature and the scope of ethical obligations owed to schizophrenic individuals in view of this novel understanding of the subjective experiences of schizophrenia.

This dissertation is dedicated to the memory of

Karen Isabel Burke

who in her usual spirit of generosity was the first  
among my colleagues to offer thoughts and  
encouragement for this project.

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# Introduction

Is it possible that the truth production of madness might be carried out in forms that are not those of the knowledge relation? A fictitious problem, it will be said, a question that has its place only in utopia. In actual fact, it is posed concretely every day in connection with the role of the doctor – or of the official subject of knowledge – in the depsychiatrization movement.

/Michel Foucault: Psychiatric Power/

I have never known anyone with a diagnosis of schizophrenia except through cursory experiences. I have been friends with many unusual characters, some of whom verifiably belonged in one or another psychiatric designation, but they never fitted with my concept of what, before knowing too much about it, I considered “madness.” The “madness” I hoped to discover in someone somewhere was an extreme condition, characterized by unreason, unpredictability and impenetrability. At first, I conjured myself staking it out as if it were the ultimate challenge of a philosopher, the limit at which my compulsive reliance on reason faces its negation. At this moment, what seems especially naïve about these original inspirations is their timidity: the various mental preparations I made for securing myself from becoming too close to it. As if the collision of sanity and madness could only occur in a death-match for the possession of the straying mind, I thought it was possible to more or less pass over to the other side, but to come back from it unchanged.

The arrangements I have made for accomplishing this project therefore focused on writing about madness from the perspective of an outsider. I vowed to remain a white-coated academic who keeps her distance, not only in order to maintain the requisite academic standards, but because I thought that this way I would not have to write about myself. Of course, I could not have been writing about myself in a more dedicated way than

by formulating this dissertation topic. This dawned on me only gradually, and only upon coming to a full realization of this was I able to engage in the task in earnest. The truth is that we all have our own romantic way of formulating a concept of madness, and the more clouded this concept is, the more it serves as the definite marker in between a self we embrace and some frightful zone of self-annihilation. But these markers that delineated me from the other were laid down by me: they belonged to my *I* and were factored into the fundamental ways in which I constituted my own sense of a self.

I think I was able to perceive fairly early on that there was something deceptive in this mythical and epic characterization of the significance of madness, though the idea that it may have been possible to pass over to the other side from the comfort of my own rather stable and sane rationality appeared even more dishonest. Because madness does in fact lie at a very important limit of our potential for knowledge, it is not like any of the more conventional forms of transcending our limits in pursuit of an ever-expanding horizon. It is not like immigrating to another country, adopting a faith, or changing one's sex. One does not become mad at will. When it comes to knowing madness, we must engage in that most difficult form of knowledge that can ever be demanded of an academic: to bear witness to the knowledge of another. One may only know the experience of madness through knowing the experience of another, and one may only know the experience of the other if one is adequately prepared for a task that is both intellectual and ethical in nature. While these concerns appear only on the fringes of our more traditional theories of ethics, if at all, the problem of the relationship of self and other is front and center of any in-depth examination of madness.

## **Normativity and Madness**

That the problem of knowing schizophrenia – not the diagnosis or its organic causes, but the person undergoing this circumstance and the nature of his or her being – is fraught with normative judgments has been the subject matter of all too many essays and books. There are at least three different levels at which the concept of madness carries normative connotations: these are important to distinguish, because they identify different forces behind the inherent normativity of the claims of psychiatry, as well as different responses to avoid these biases. I classify them here in accordance with whether they find the question of schizophrenia of normative significance due to the societal, political, or the intersubjective constitution of the psychotic person about whom the judgments and claims of psychiatric knowledge are made.

### **i. Anti-Psychiatry and the Social Critique**

The first of these concerns the status of the “mad” and his otherness as socially constituted. This is the type of criticism typical of Goffman (1961), as well as the anti-psychiatry movement represented, in its US version by Szasz (1976) and in its European form by Laing (1967).

The argument shared in common by this intellectual tradition is that the dichotomies of sane vs. insane, healthy vs. ill, and normal vs. abnormal are socially constituted, marking the other not simply as different, but as fundamentally and essentially unlike those who have never been tainted with insanity. The abnormality of otherness, these authors note, is merely a by-product of a sociological setting in which society itself tends to reinforce its own boundaries and maintain its collective identity via the exclusion

of otherness. The determination of otherness is therefore made on the basis of violations of the norms of behavior that are binding for full members of society, even though these violations are reflections on the norm of the community.

Whereas those who do not comply with such norms are studied with keen interest in what may cause them to deviate from the norm, the societal practice of systematically noting the otherness of those who fail to comply is primarily a means of perpetuating the myth that there are patterns of behavior which a great majority of society observe and from which only a few deviate. This type of criticism typically culminates in a non-conformist reversal of labels (e.g. Laing's slogan that "It is mad to be normal"), or in the demand to replace the clear-cut division between sane and insane by a continuum, "with the well-adjusted citizen at one end and the full-fledged psychotic at the other" (Goffman: 1961).

## **ii. The Post-Structuralist Claim of Social Constitution**

The second way of identifying the normative dimensions of the concept of madness is obtained through an examination of the status of the "mad" as constituted in the knowledge production of persons who approach others through the categories of the normal. This type of concern resurfaces over and over though in different formulations in the works of Michel Foucault, and is focused on the relationships of domination characteristic of the institutional setup in which madness is studied.

According to Foucault (1974), the power relationship inherent in the knowledge produced in the psychiatric setting is reproduced in the constitution of the psychotic other,

who is known as a being who is lesser in rights, or in his or her capacity for autonomy (as well as in making valid scientific claims) than persons who do not suffer from madness.

Once it becomes the grounding assumption for constituting what is recognized as madness, this “absolute right of nonmadness over madness” is also used for legitimating the essential inequality of madness and normality. For example, madness, when known through the expertise of non-madness, is a circumstance that lacks insight into its own condition, which gives rise to the sole privilege of the non-mad perspective to formulate the knowledge claims of psychiatry. Subsequently, the privileged perspective of normality is reproduced as a power relation in which the expert non-mad’s access to “reality” and common sense are justly used to correct the errors of the non-mad, and to dismiss his or her delusions not only as mistaken, but as unworthy of analysis.

Finally, the superiority of the non-mad’s perspective also reasserts itself in determining the overall goal at which psychiatric practice must be directed. Imposing order on disorder or correcting what are deviations and disturbances of an ideal normality, the student of madness acts on behalf of a social hierarchy to prevent the dissolution that would be the consequence of recognizing the perspective of madness as an equally valid perspective. These type of relationships between madness and its questioner therefore result not only in inequality, but in subservience: the madman’s otherness is exploited because it is a prerequisite of the non-mad’s ability to maintain the validity of psychiatry’s knowledge claims.

### **iii. The Phenomenological Approach to Madness**

Thirdly, we must speak of the normative connotations inherent in our own everyday experience of otherness. This ethical problem is not limited to the experience of madness by the non-mad, but is experienced in any encounter with another subjectivity. Unlike objects, other persons announce their presence by their spontaneity. At one moment or another, regardless of our similarities and no matter how reliable any of my expectations regarding their behavior might be, they are going to announce themselves as their own person, as an other whose behavior originates from their own desires or goals. In these moments, what is understood is the strangeness of the other and his or her irreducibility to an I: an extreme version of which would be what Levinas (1961) calls the absolutely Other.

Such an other could not become the object of my experiencing if I did not always as a matter of course hold certain expectations for the objects and for the persons I encounter. Often these expectations are abstract in nature when it comes to other persons, positing various ideal standards, such as the use of reason or the mutual participation in a back-and-forth of communications using body language. I expect the other's compliance with these expectations because only in this way can I be assured of the predictability of my own surroundings. It is the only way I can trust myself to my past experiences and the only reason why these past experiences serve me once they are solidified into my own habitual ways of mastering my environment. The less frequently I have to question these expectations during the course of an intersubjective encounter, the more rigid I tend to become in demanding these features from whoever I meet. What is more, the less frequently I have to question these expectations during the course of an intersubjective



encounter, the more intensely I experience the otherness of my counterpart when he or she does in fact fail to meet my expectations.

I rarely, for example, expect another person to scream on a subway platform because of his perceived persecution by his voices: such an experience shakes me up not simply because of my concern for this person's well-being, but because it puts into question expectations I tacitly held for the situation that is to ensue once I enter a subway station. Of course I do notice that there is nothing normal about what is taking place in this scenario, and it would be thoroughly dishonest not to report that I had an experience of something unusual and exceptional, and something which disturbed, or at least puzzled, me emotionally precisely because the experience of the person I see and hear is so incomprehensible to me.

The homeless person on the subway forces me to understand my inability to share in the experience he is undergoing. There is no denial that there are normative expectations in producing this experience, although these are not posited for the other, they are merely revealed to me as my tacit assumptions and ignorance of experiences of which others are capable but in front of which I must stop in wonder. The normative expectation, in such a case, has little to do with how others *should* behave. Rather, it is a matter of how I adjust myself to the unusual circumstance that I encounter. Even more importantly, what is at stake at this level of constituting the other is not simply a judgment (e.g. that this person is schizophrenic), but a measure of just how much I must extend myself in the future in order to accommodate these experiences – no longer as otherness, but as familiar features of the lifeworld.

#### **iv. Statement of Methodology**

My dissertation is prepared to speak first and foremost to this way of formulating the normative problem inherent in studying madness or schizophrenia. Just like Laing, I recognize the equality of the schizophrenic perspective, and just like Foucault, I am sensitive to the relationship of domination by which psychiatric claims may erase the requisite respect for the difference of the other. I do not consider the chapters that follow as constituting an other by a methodology exposed for its problems in Foucault's works, but as a study of the several ways in which otherness announces itself to me and to others.

It is simply not possible to give specific content to the ethical obligation we owe to the otherness that forces itself upon us in this way without laying down methodological constraints about the scope of our knowledge claims regarding this type of otherness. In the abstract, the obligation in question is to become an other to ourselves, by relaxing our expectations of normality and integrating alterity into our own experiences, yet without becoming the same person as the schizophrenic other. We would be unable to clarify for ourselves not only what is possible to know about the specific other we encounter under these circumstances, but also the capacity of ourselves and of theirs to interact with one another, if we were to aim at becoming the other we seek to know. It is for this reason that I decided, instead of focusing on the social and the ethical dimensions of the interactions sustained between schizophrenic and non-schizophrenic individuals, to dedicate an entire dissertation to describing the schizophrenic condition as it is presented in its alterity.

This was a conscious choice based on methodological considerations in spite of the apparent circularity of the approach. A certain definition of schizophrenia, produced by non-schizophrenic individuals evidently must guide my identification of my material as

belonging in the clinical picture of schizophrenia. Here, I am in fact walking a tight rope between being too selective about my definition of what schizophrenia is (the objection could be raised that there are important features of the schizophrenic condition, such as their manner of delusional system formation or the schizophrenic speech patterns, that do not form part of these selections) and relying too much on a preconceived notion of schizophrenia – borrowed from a discipline subject to both the anti-psychiatrist and the Foucauldian concerns. It is unlikely that I am guilty of both, but I do not consider myself completely innocent of either. Only in view of the chapters that follow can we judge whether these normative concerns return at the conclusion of this work as greater or lesser sources of skepticism regarding the possibility of providing a description immune to the above objections.

### **Explanation and Understanding**

In his definitive phenomenological analysis of psychopathological conditions, Karl Jaspers (1911) distinguishes between two “ultimate sources of knowledge” directed at the psychotic person. The former of these, *understanding*, is a way of knowing “from within” the psychic events experienced by another person. But, as Jaspers notes, “any systematic study or clear-sighted research in psychopathology depends on grasping the fact that” another, similarly important mode of consciousness is required for knowing this condition. Jaspers calls this latter approach to the psychotic other *explanation*. In contrast with the knowledge “from within” that emerges through understanding, he states that explanation produces knowledge claims about the other “from without.” Theories regarding objective causal connections are made by resorting to explanation. Parts of the whole, and the

syntheses of complex unities constituted from these parts, are grasped by explanation. Unities cannot be *understood* except when the phenomena in question are grasped as emerging from one another, as determined by their inner logic, in a way that is typical of one's own experience.

Jaspers himself uses this way of phrasing the distinction between understanding and explanation at a pivotal point of his book, in the introduction, where he states that the uniqueness of his phenomenological method consists in ascribing the proper source of knowledge to each psychopathological phenomenon as situated in one of these two categories. In the same passage, he instructs all of those who might find the contrast of "from within" and "from without" without requisite explanatory power to patience: he assures us that "[t]hese two different expressions denote something very specific which will become clearer as the number of examples increases." As another one of his remarks clarifies, the distinction between understanding and explanation cannot be reduced to the difference between the patient's immediate experience grasped indirectly under observation on the one hand, and objective connections that may be demonstrated in the external world on the other. Nor is it to be confused with the problem of access, i.e., with whether the phenomena in question are observed through introspection or by the observation of another.

Jasper's bifurcation of our philosophical and psychiatric knowledge about psychopathological phenomena is directed instead at the problem of whether one can expropriate another's experience: it is about whether and to what extent one may rely on the analysis of one's own experiences in the analysis of another's. Ultimately, the question to be determined is whether one can embody schizophrenic consciousness so as to

experience the inner logic of its symptoms, or whether the connections that illuminate the wholeness and the unity of this consciousness are provided by means that make the schizophrenic person comprehensible merely as an other, one whose experiences cannot fully be shared.

### **Empathy and The Phenomenological Method**

Jaspers' famous claim is that, so long as it is not our own experience, one cannot make claims of understanding schizophrenia as a specific unity of subjective experience. As a unique condition, or a specific way of being, schizophrenia is un-understandable. He is frequently criticized for this often misunderstood claim, primarily because of its presumed ethical implication that one cannot approach schizophrenic persons solely through empathy. The ethical stance of his approach becomes much more nuanced when we consider Jaspers' reasons for adopting phenomenology as the method of his empirical investigations.

For Jaspers, phenomenology was first and foremost a method of description, valuable because it provided an opportunity to prioritize evidence that one was able to solicit regarding the psychopathologies of individuals who could give voice to their inner experience. Though the *General Psychopathology* is a "phenomenology," it is not aimed at "pure description," the ultimate task of Husserlian phenomenology. Nevertheless, it deserves the name, especially in view of its emphasis on the subjective experience of psychopathological conditions. Throughout its chapters, Jaspers is more than anything interested in the details of these subjective experiences, and especially in details that were able to expose polar opposites subsumed within his own explanatory categories. These did

facilitate grasping some kind of an inner logic behind his choice of designations, though only by analysis and without any claims to their offering understanding “from within.”

Though Jaspers is often criticized for this methodological choice, his pronouncement that certain schizophrenic states are un-understandable issued from his commitment to employ a nuanced set of terminology in phenomenological description, especially in view of the fact that his phenomenological project concerned experiences that many are unable to experience from a first-person perspective. Of course the understanding/explanation distinction was widely in use by the time Jaspers appropriated it, and had a central role in the *Methodenstreit* that served as the intellectual background of his university training.<sup>1</sup> The assessment survives to this day that, no matter what Jaspers’ intentions may have been, the methodology of the *General Psychopathology* eventually falls back upon an impersonal and objectifying scientific approach to the psychoses. A justification often cited for these types of appraisals is that Jaspers considered certain states of consciousness un-understandable.

But Jaspers fought as much against overstating the potential of the emphatic approach as he did against the habit of the natural sciences to substitute claims of explanation for knowledge obtainable through understanding, whenever such knowledge was indeed a possibility. Why the former was suspicious to him is easier to explain: he found access to the other solely through understanding suspicious because it relied too much on the “intuitions” of the psychiatrist, and because it transformed the goal of

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<sup>1</sup> In the philosophy of Dilthey understanding, the act of grasping the meaning of another person became the cornerstone of a hermeneutic understanding of the inner meaning of cultures and societies, while for Weber, who may have been the most influential social philosopher on the earlier views of Jaspers, the distinction allowed for a sociological method that broke both with Hegelian idealism and the positivism of the Austrian school.

treatment into an attempt on the doctor's part to discover himself in the experiences of the patient. As such, Jaspers stood opposed to the psychologization of the psychopathological experience. This threatened to privilege the connections imposed on mental phenomena from the perspective of the psychiatrist and thereby to forestall the search for the emergence of the inner connections experienced by the person in treatment.

But Jaspers was equally opposed to any theory that relied too heavily on physiological explanations. These approaches betrayed the overall purport of his research because they investigated organic causes rather than the manifestations of disordered consciousness. As such, he in fact had very little interest in the somatic underpinnings of the psychopathologies (and in the schizophrenic body as such), since focus on these almost invariably led to biological reductions. Rather, the goal of Jaspers' methodology was to settle for explanation only in the face of the un-understandable, as he often put it: to strive for an understanding of the other but to be just as truthful about what one accessed through understanding as about the limits of this precarious means of access to another's experiences.

### **The Ethics of Not Understanding**

Jaspers' choice of a methodology – his insistence on distinguishing understanding and explaining as two different means of access to the experience of the individual undergoing a psychopathological state – was not only a methodology, but a statement of professional ethics. He insisted that the knowledge we gain through the arduous labor of familiarizing ourselves with the details of the psychopathological condition can only lead to an explanation – and not an understanding – of schizophrenic states.

What appears to me to be the most common source of overlooking the fact that his methodological commitment is infused with ethical concern is an interpretation that demands of Jaspers a fulfillment of objectives that he did not and could not have entertained. Jaspers did not write a textbook on psychopathology, and it would be anachronistic to mistake his work for the kind of textbooks on which today's psychiatric training rely. Most importantly, one does not learn how to diagnose individual conditions from the *General Psychopathology*. Jaspers wanted to trace the emergence of the individual existing in his or her "psychopathological" variety, and by doing so to grasp the psychopathologies as open-ended, indeterminate *possibilities*. Over and over again, he discusses the epistemic difficulties stemming from the fact that the variety of subjective states is endless, citing it as the most likely reason why the frustrated natural scientist might jump to unacceptable reductions and generalizations.

The groupings Jaspers imposes on his material are designed instead to allow for grasping the emergence of the psychopathological condition at each of the various levels of psychic differentiation that may be subject to disorganization. Remarkably from the point of view of a reader accustomed to today's psychiatric textbooks, Jaspers presents his material topically, citing examples from any variety of diagnoses, constantly remaining with the characterization of the psychopathologies in *general* – and without showing much care for sorting out "symptoms" by diagnostic labels. For this reason, Jaspers does not even comment on a type of causal explanation which has sadly become the reality of contemporary psychiatric treatment: the treatment of patients for what are assumed to be the consequences of belonging to abstract nosological entities, and the attendant disregard



of this type of approach for the unique life history and mode of experiencing from which the particular difficulties of the individual originate.

To approach the condition of the psychiatric patient without prejudices and presuppositions was an avowed principle for the *General Psychopathology*, one which was important for qualifying its approach as “phenomenological.” As soon as diagnostic labels are attached to the unusual phenomena observed in the doctor’s office – and as soon as the medical personnel mistakes what is known about these diagnoses for knowledge about the individual patient’s condition – psychiatry ceases to be free of prejudices but renders itself incapable of studying the actual experience of the individual’s condition. As Jaspers put it, theoretical knowledge is always ripe with the danger of leading to pseudo-insight through the terminology it settles upon for description. Beyond epistemological objections, however, thinking of the patient’s condition as made up of individual symptoms – rather than as issuing from changes to the more global or all-encompassing unity of a supposedly universal mode of existence – objectifies the patient and denies him or her a “personality”: that is, something which, if Jaspers is correct, is primary among the meaningful connections of his or her individual experiences.

Very little may be comprehended about this ethical and epistemological problem until fairly late into the *General Psychopathology*. The varieties of the more fundamental dimensions of subjective experience do not require the type of methodological clarifications I have been focusing on, since these do not involve understanding their overall connectedness in the individual’s experience. The issue of understanding simply does not arise for individual psychic phenomena, such as feelings and affective states, the experience of space and time, awareness of the self, self-reflection and the replacement of

an awareness of reality by delusional constructs. Jaspers needed to determine the limits of psychological understanding only in connection with the meaningful psychic connections discoverable in the content, the expressions and the experienced phenomena of psychopathology (1911: 310-313). After proposing that these limits may be extended hermeneutically, and that any gains of understanding must be made by encountering “un-understandable phenomena,” however, Jaspers still remains skeptical about the proper scope of understanding as a method for coming to know the other. “It is not the method which makes mankind accessible as individuals nor as a whole,” he writes (1911: 313). The issue of un-understandability, to be sure, is not limited to delusional schizophrenic states, but to the overall understanding of specific individuals, or to what Jaspers calls the “personality” of the other.

Jaspers, however, also dedicates a lengthy section to challenges faced in the psychological understanding of schizophrenia, challenges faced beyond the generic limits of understanding other people. These remarks occur in sections of the *General Psychopathology* when he does engage in diagnostic differentiation (§2-3 in the chapter on nosology – Chapter XII – and especially throughout pp. 587-594), and where, quite interestingly and uniquely, Jaspers method of differential diagnosis proceeds on the basis of the understandability of the various nosological entities. Again, these passages are not to be interpreted as his unintended falling back into a strictly biological or hereditary explanation. This would contradict principles he had already laid down in his introduction to this division of his systematic treatment of the psychopathologies – namely, that not everything un-understandable is impossible to grasp through empathy because it is extra-conscious. “Existence,” or a source of spontaneous freedom in Existence (Jaspers: 1911,

311), may itself posit a limit for the understanding of others. Jaspers thinks of “Existence” as a condition of possibility for the development of some of the psychopathologies, and especially of schizophrenia. His overall claim is that, while characterization may be given to individual psychic phenomena, the schizophrenic Other cannot be grasped as Existence by empathic understanding.

In sum, Jaspers thinks that he has moved beyond the methodological mistakes of the psychologization of the psychotic condition that claims to understand too much, and of the explanations of the natural sciences that fail to understand enough. He does so by making it a systematic concern for his investigations to distinguish phenomena fitted for understanding from those which are impenetrable by empathy. With Jaspers, I also find it important to continually delineate these two possible forms of knowing the experience of the other. Only in this way could the person suffering from the experience of a psychopathological condition be known alternately as an Other at best explained in his or her otherness, or as an other understood – depending on the detail or the level of grouping of the symptoms under discussion. Each of these ways of accessing the other’s experience is useful in its own way. After all, it is not the admission of our limits that threatens the enterprise of providing a phenomenology of the other, but rather the moments when, by confounding these two types of ways of knowing the other, we fail to recognize our own limitations in knowing or understanding.

### **The Schizophrenic Body: An Introduction**

Jaspers’ methodology remains influential down to the present day among phenomenological psychiatrists, with the exception of the unique modality of embodiment

characteristic of schizophrenic individuals. Many contemporary works on the embodiment of schizophrenia simply assume that any phenomenological analysis – or any analysis that relies on concepts adopted from traditional phenomenology – automatically yields an understanding of the body of schizophrenia, and especially of the pre-reflective body of schizophrenia. Naturally, the argument for this tacit assumption cannot simply be that mutual participation in a shared world already presupposes some form of intersubjective understanding – since what is often at stake when interacting with schizophrenic persons is our mutual participation and sharing of one and the same world. What is more, the reliance on claims to understand the schizophrenic body is even more curious in view of the fact that in many of these contemporary studies, the phenomenological method is often relaxed in favor of pursuing a naturalized phenomenology, which makes it possible to incorporate into one’s conclusions evidence drawn from neurobiological research. In this way, the fact that the other’s bodily experience is “intersubjectively constituted” suffices as a guarantee in and of itself that an empathic understanding of another’s body is reached. The problem of whether embodied subjectivity comes to be known as a radical Other, or as an other no longer experienced in his or her foreignness and difference, hardly if ever factors into the conclusions made in these analyses.

In this text, I use the term “schizophrenic body” as if it were a shorter form of the lengthier but more precise phrase, the embodiment of schizophrenic consciousness, or of the pre-reflective and embodied dimension undergirding the disorders experienced by schizophrenic persons. Unlike most phenomenological approaches to the body, therefore, I do not consider myself to provide claims of understanding this schizophrenic body. What I am about to describe is a body alien to my experience. It is a body that I came to notice (as

did often the schizophrenic persons who almost compulsively put to examination this previously unknown modality of embodiment) as a body alien to my experience. In the course of writing about this body, there were moments when I momentarily thought to have occupied this body. Having become so familiar with the myriad different ways in which this body is unlike mine, however, if there is one thing of which I am convinced it is that I could not make this body mine no matter how hard I tried. In fact, the most fundamental difficulty in the experience of schizophrenic persons is to articulate the experience of their body as their own, and to rely on a sustained bodily experience for a continued sense of ipseity. If for no other reason than because of this contingent fact, one may only bear witness to the experience of the schizophrenic body by renouncing any claims of understanding it, both for ethical reasons and for the sake of truthfulness.

The following dissertation therefore at best may only offer an explanation of the schizophrenic body (in the technical sense in which Jaspers uses this term), and not an understanding of the schizophrenic condition and its embodiment. For the reasons above, the schizophrenic body I pursue in the following pages must necessarily remain the body of an other. To be sure, occasionally I am able to engage in a description that comes close to what might appear to be an understanding of various moments and other limited segments of the schizophrenic body's experience. What is more, throughout the text I offer claims of understanding regarding my own body, as it comes to be known in view of what is learnt in the encounter with the fundamentally different potentialities for experience that are inherent in the schizophrenic body.

In the conclusion of this project, I am going to return to a specific intersubjective setting in which an understanding of schizophrenia is achieved in a temporary and

unstable form. This understanding emerges in the transference relationship of the analytic setting, under exceptional circumstances that distort the nature of what comes to be known and understood. What is more, it is a situation that offers an understanding not of the schizophrenic body, but of a self of schizophrenia (and a fundamentally different self-construct from the self of non-schizophrenics). I shall take up these ethical themes at that point, when in view of our knowledge about the schizophrenic body, we are much better equipped to revisit the relationship of self and other in the interactions of schizophrenic and non-schizophrenic individuals.

# Chapter 1

## The Schizophrenic Body: The Conceptual Framework

A point of common agreement among those in the field of philosophical psychiatry holds that the anomalous experiences characteristic of schizophrenia must be addressed as various types of disordered self-experience, and especially as disordered self-experience at the pre-reflective level. Summarizing this point, Josef Parnas writes that alterations of self-experience, and especially alterations present before the full onset of the symptoms of the psychotic stage, reflect

the primary alterations of the very basic, prepersonal and prereflective sense of self (*ipseity*). These may be, and usually are, followed by the changes in the reflective *I* awareness and in the social self, thus resulting in the profound disturbances of identity, clinically manifest on all three levels of selfhood (Parnas: 2003).

The pre-reflective consciousness that undergoes alterations in schizophrenia is a condition of possibility for self-consciousness proper. It is a specific dimension of experience, a non-fluctuating and non-varying aspect of phenomenal consciousness by virtue of which objects are always presented to *me*, and experiences are rendered *for an experiencing subject*, as *my* experiences, because of their unmistakable way of being *for me* in a particular way (though in a manner that does not easily give itself to verbalization). Unless I suffer from schizophrenia, I recognize this dimension of my experiences – their *for-me-ness* – as a subjective dimension inextricable from my self-experience. The reliable “coloring” which in this way attaches itself to self-experience is often called the first-person perspective of

experiencing. Dorothee Legrand (2007) distinguishes it from the kind of self targeted in empirical research as the “self as subject,” in order to point out a crucial difference between research required to access the disorders of pre-reflective selfhood, such as those characteristic of schizophrenia, from the self-disorders that current cognitive neuroscience purports to detect (in which the self serves as an intentional object of consciousness).

This pre-reflective self is no doubt an elusive entity of study. It introduces into our considerations a duality in selfhood: an actual difference, present both in everyday experience and in its psychopathological variations, between reflective selfhood and its constituting basis in the pre-reflective and automatic (or involuntary) syntheses of consciousness. Another duality, that of the human body, is often used to illustrate the distinction. In particular, the connection between the anomalies of pre-reflective self-experience and the undue objectification of the body’s lived experience are emphasized as typical of schizophrenic patients. It is not only reasonable to posit that pre-reflective and reflective levels of selfhood are structured along lines parallel to the interplay between the lived and the physical body; it is in fact the promise that the schizophrenic body holds for us that this connection may be established with concreteness universally – holding under schizophrenic as well as non-schizophrenic circumstances.

In other words, the duality inherent in the body lends itself as a model for conceiving (or reconceiving) the relationship between pre-reflectivity and reflectivity. This duality is especially illuminating in the case of the schizophrenic body. Reflectivity, in the framework yielded by the analysis of the schizophrenic body, is not a form of “higher-order” thinking in which, superimposed upon cognitive processes already at work, we find one form of reflective activity taking another as its object. Self-consciousness oscillates on a



continuum on which implicit and explicit, tacit and intentional, active and passive, pre-reflective and reflective, etc. are merely relative terms. One might say that in each case the former is folded within the latter – to avoid positing it, as cognitive science might do, as an ecstatic higher-order form of its more “primitive” origins. In order to understand the changes that the experience of the human body can undergo in schizophrenic states, we must employ the stark dichotomies that resurface in various modes of disordered subjective experience, while being prepared to apply them to unusual experiences in ways that are new and that, without the challenges of the schizophrenia, were previously unthinkable.

Before we can fully pursue this thesis, I would like to reexamine the analogy between self and body that is so pervasively operative in the investigations undertaken in the field of philosophical psychiatry. The underlying assumption in this field is that the disturbances of the body of schizophrenic experience proceed along lines that are parallel to disturbances of ipseity and pre-reflective awareness. This might be true if our investigations were limited to everyday forms of self-consciousness. Beyond these familiar bounds, however, this analogy need not hold. In fact, I am going to argue that basing ourselves on this tacit assumption is not warranted in the case of disturbances of self-consciousness experienced in certain schizophrenic states.

While there can be no doubt that the commonalities between schizophrenic and non-schizophrenic bodily experiences provide for an analogy that is reliable to a certain extent, thus far there has been very little theoretical effort expended on examining just how far the commonalities extend. In fact, studies of schizophrenic bodily experience have broken off precisely at the limits of this analogy. While the schizophrenic anomalies of

bodily self-awareness can serve as illustrations for the disordering of selfhood characteristic of schizophrenia, we need to restore the schizophrenic body to its proper significance in the analysis of embodied subjectivity. This body is not simply an indicator of the variety of alterations both in self-experience and in the body's experience: it is an entity that holds crucial clues to a deeper analysis of the relationship of self and body in many other "pathological" states.

Once the similarities run out between implicit and explicit ways of experiencing self and body, we need to find a theoretical framework for discussing the divergence between disorders of embodiment and the disorders of selfhood. The first step toward a framework inclusive of the co-extensive changes in the pre-reflective and the reflective realms can be found in Louis Sass' writings, and in particular in his exposition of the idea that not one, but in fact two core disturbances are "equiprimordial" in the anomalies of schizophrenic self-experience. As he writes,

Schizophrenia nearly always involves two mutually interdependent mutations of the act of consciousness .... hyperreflexivity and diminished self-affection are the two aspects of self- or ipseity-disturbance that are at the heart of schizophrenia. ... these two facets of the self- or ipseity-disturbance are equally important, playing an equally primordial pathogenetic role (Sass: 2003).

According to Sass, a focal and explicit awareness of what are otherwise tacit and implicit features of self-experience casts the world of the schizophrenic as strange and bizarre – to the point that the experience has an effect of alienation on the patient, only amplifying his already existing proneness for withdrawal. Due to reasons that have not yet been determined with finality (Sass himself indicates his wavering between calling it a compensatory process, though not one to be conceived as causally related), this alienating

type of self-awareness is associated in particular with the disturbance of self-affection - both in the body's and the ego's affectivity. I follow Sass with regard to his suggested bifurcation of the core disturbance of schizophrenia, but I show that his theory remains contradictory. Introducing the problem of the schizophrenic body in this way, in the chapters following we are going to have to retain the paradoxical features of schizophrenic embodiment, while nevertheless making headway toward understanding its unusual phenomena.

### **1.1: The Disturbance: The First Person Perspective and Ipseity**

One might summarize the core disturbance I am trying to identify in this chapter as targeting the pre-reflective first-person perspective of experience. What is altered, in summary, is the aspect of self-experience which provides for the *ipseity* of self-awareness (the Latin term connotes self-coinciding) – a sense that sustains an automatic attribution of our emotions, thoughts and experiences to an “I” or self.<sup>2</sup> However, the phrases “attribution of,” or “identification with” are misleading in this context, because any linkage of the “I” and its mental states or acts occurs without recourse to reflection. In fact, the very idea of a linkage between self and the products of its thinking, feeling, and experiencing is the core of the confusion here.

An intentional act connects what may be distinguished, analytically, as its subject and object pole. The perception of an object and the conceptualization of thought cannot

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<sup>2</sup> The difference is that between schizophrenia and, for example, old-age dementia, or Alzheimer's disease – in the latter, the reflective is affected, while in schizophrenia, the pre-reflective regions of selfhood are impacted. Therefore, patients suffering from old-age dementia find it difficult to characterize themselves from the third-person perspective: they might forget their age, occupation, or nationality. They have no problem distinguishing, however, between here and there, I and others, now and before (Zahavi: 2002).

take place without a subject who perceives or conceptualizes; and, similarly, our tacit experiencing also attributes intentional acts to an “I” as its condition of possibility. I might be sitting at my window, lost in thought, but nevertheless subject to the indistinct sounds of the city underneath my window. I do not hear a car going by on the street, a city crew breaking concrete with their machine on the next corner, or the kids walking their brand new puppy in their typically noisy way. I do not hear a distinct something, there is no object to my hearing; I am lost in thought. Yet I am aware of the city noise to which I am being subjected, I can recollect it if anyone asks me about it, I can even give a lengthy description of it. At no point do I have to identify myself as the subject of the above implicit mode of experiencing: there was never any question of integrating my subjectivity with the objects of my perception. My experiences were given to me as ‘mine,’ not in reflection, but pre-reflectively. They came with a certain coloring or layering, including a dimension of mineness that is inextricable from my experiencing as a subject. Not having this sense of mineness is unthinkable. I do not connect my experiences to me as an afterthought, because they are already given to me inextricable from the ipseity dimension of my experience; if I do connect them in afterthought, I impose on them a structure that presupposes reflectivity, mistaking categories of analysis that are of dubious standing from the phenomenological perspective for the phenomenal experience I in fact undergo. This same testimony of my experiences as involving a pre-reflective “I” is what becomes altered in the schizophrenic experience.

If my emphasis falls a little too unevenly on the first-person givenness of self-experience in pre-reflective selfhood, this is because characteristically it is this aspect of self-experience that is easiest to recognize as altered in schizophrenic self-experience. In

*Being and Nothingness*, Sartre places considerable emphasis on the temporality of the pre-reflective cogito: that is, on its unceasing productive power to “preside over” what Husserl would call the active and passive syntheses of the ego’s activity and to subtend them by means of this inextricable and qualitatively unvaried feature. For him, a pre-reflective cogito is a “theme” which presides over “a whole series of syntheses of unifications and recognitions” and is “present to itself, not as a thing but as an operative intention” (Sartre: 1943). The fact that it is invariably and continually a quality of my phenomenal consciousness helps me to recognize it upon reflection as mine, or rely on it while it remains tacitly operative in my self-consciousness.

What is at stake for schizophrenic patients is the “self-coinciding” that is taken for granted in Sartre’s exposition, which extends both to the habitual and primordial coordinates of my experience and its sense of mineness, and to the co-temporaneous production of a self-as-subject and a self-as-object – not in an attempt to compose a higher-order entity, but as two extremes for introducing heterogeneity into the unity of selfhood. The duality of the body – its tendency to be featured in self-experience both as the pre-reflective body (or what we might identify as a body-as-subject) and as the body-as-object (with attributes of the self-coinciding of the body which can be determined from a third-person perspective) compose the same kind of duality. Due to this analogy, explorations of the self-disorders experienced in schizophrenia can fall back upon a dual presentation of

what in the end is not only a unified object, but also ultimately only one object:<sup>3</sup> the lived body.

It is perhaps Michael Polanyi who contributed the most relevant conceptual pair of terms for taking stock of the significance of the lived body for our everyday experience. For Polanyi, our perception continually oscillates between a “distal” and a “proximal” pole (Polanyi: 1967). When it comes to our awareness of our body, and to its role in rendering for us an experience of the world through its affectivity, we might find ourselves anywhere between an explicit and thematic awareness of the body as a focal object of our perception (in the first extreme, at the “distal” pole), and an implicit form of bodiliness (at the “proximal” pole). The former is a visible, tangible, measurable and analyzable object. What the body becomes in the latter extreme is difficult to say: at the “proximal” pole the same body is experienced implicitly, in a pre-reflective manner, which amounts to saying that it is preverbal. One might think of the lived body on this approximation as one’s unmediated sensorimotor grasp on the world, the bodiliness which itself is a capacity to open up a world to us and which functions with such smoothness that it continually escapes notice. With this mode of casting the duality of the human body, we come closest to pointing out the contributions of the body schema to embodied consciousness, rather than merely those of the lived body or *Leib*.

The body as subject and the body as object are therefore two poles of a duality inherent in the experience of my own body. It is for this reason that investigations related to the pre-reflective self continually fall back onto examining the pre-reflective body. In

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<sup>3</sup> Though one might consider a unified object to be ipso facto one object, in the case of the schizophrenic lived body, we are going to have to distinguish between processes that disorganize the body’s unity and processes which also disturb its singularity.

keeping with this dyadic structure, we no longer need to construe a hierarchical relationship between self as subject and the self as object, in which the pre-reflective self, or the self as subject, is taken to be the object of reflection for the reflective self. The reflectivity in question is not the relationship that obtains between the subject and the object of reflection: the self-reflectivity that these investigations aim to grasp is not the product of a dialectic by virtue of which pure reflection alone emerges as self-reflective. Instead, their target is a notion of “self-reflectivity” which characterizes both the unmediated and immanent forms of self-awareness and their mediation through reflection.

This notion no doubt requires pre-reflective awareness as its medium. There is a certain meaning to selfhood that is inherent in and inextricable from self-experience, but which becomes thematized only in considering the kind of self-reference under discussion here. When I take my “self” as the object of my conscious and explicit reflections, the fact that I am engaged in self-reflection is contingent upon my choice of an object: when I reflect upon myself the subject and the object of my reflecting coincide. Immanent in self-reflectivity is a certain pre-reflective self-referentiality. As Zahavi writes, the self-reference available from the first-person perspective is different from an “accidental” or “external” case of referring to myself: “not only is it impossible to refer to anybody and anything apart from oneself in the first-person way, but it also belongs to the proper use of ‘I’ that one knows that one is referring to oneself. That is, apart from being internal and necessary, the self-reference in question is also of a thematic nature” (Zahavi: 2002). It is thematic in nature in that there can be no mistake about it: on this model, the idea of a subject and an object “falling apart” or “not coinciding” pre-reflectively is unthinkable.

But such a self-division is in fact pre-reflectively experienced by schizophrenic individuals; and it is due to disturbances in the pre-reflective regions of bodily awareness that this becomes an experiential possibility. In the schizophrenic person's reflection on his or her own bodily experience, the spontaneous unification of such experience is lost, and the implicit and tacit feel of their proximal body is transformed into an experience of an objectified body.

The most striking tendency of a schizophrenic person's experience of his or her body is that the body is experienced predominantly *as an object* (Parnas: 2003). Curiously, it is the lived body that is *alienated*, or lost to experience in this way. Such terminology is no doubt misleading: what takes place is a disturbance in the above characterized duality of the body, since there is no doubt a lived experience of the body even in the states of alienation that schizophrenics persons undergo due to their hyper-reflexivity. That the body is experienced in an unusual form is, however, no doubt true. It becomes turned inside out, so to say: what are otherwise introspective processes find themselves posited, as if they were attached to the spatially extended physical body. There is no reason to doubt the presence of one's body's unique experience, even though such a sense is considerably diminished - overshadowed, so to say, by an objectified body. The anomalous, disorganized body of the schizophrenic person is explicit precisely where one expects it to be tacit; in this way it becomes subject to reflectivity precisely in its pre-reflective aspects.

## **1.2: The Analogy: Pre-Reflective Self and Pre-Reflective Body**

The pre-reflective body is constitutive of self-experience in two aspects: as affectivity and as a spatial object. Not only do these two aspects of the body find themselves



regularly in a state of (productive) tension, but their duality also helps to elucidate the sense in which pre-reflective and reflective selfhood also form an analogous duality. To trace the analogies of the body to self in this manner, I am going to present the three most essential moments in the structure of the body's duality. Starting from the dual role they play as conditions of possibility for subjectivity, or for one's being-in-the-world, I am going to proceed to characterizing the pairing of these terms in operative intentionality.

First and foremost, let us begin by noting that, using Husserl's terminology, the body is the bearer of localized sensations. In so far that it is a surface for the objectification of sensations, it is a condition of possibility for units of hyletic data to come into prominence. It is by virtue of this embodied subjectivity that we experience two dimensions of a sensation – the sensing and the sensed – which coincide contingently in the body's sensings (*Empfindnisse*) of itself, in the same manner in which the proper use of I is self-referential in the coinciding of the self's experiences with the experiencing self.

Secondly, but just as importantly, the body is a condition of possibility for the perception of objects in its role as a "body subject," i.e. as an extended and material entity. Every spatial object, including my own body, is given to me in perspectival appearances, and as such its perception presupposes an embodied subjectivity located in space. Husserl uses the term "null-point of orientation" for the body's ability to disclose a perceptual field, but it is not in relation to a point, but in relation to my spatially extended body that the objects of the world can be engaged as physical objects. The only privileged entity among the objects of the world is my own body: constitution of the body's own spatiality presupposes my spatial extension, but it also requires my body's participation as the sensing subject of my own sensed extendedness.

For this reason, one need not be concerned with the otherwise important observation that the body-as-subject is a condition of possibility for the constitution of one's own body (including its auto-affectivity), while the body-as-object is a condition of possibility of object-intentionality (or hetero-affectivity). Sensing *something* and *being* sensed are not two independently existing components of a lived experience, but co-dependent dimensions of the same primordial unity, and for this reason we are also well-advised not to sever the two. If we were to align these two aspects of the body with the analogous terminology of a self as subject and self as object (and disregarding Husserl's suggestions via the terminology he chose for this distinction), we might say that the body, in so far as it is a condition of possibility for bodily self-awareness is the body as subject (analogously to the pre-reflective self), while the body presenting as an object of intentional acts and serving as a condition of possibility for the constitution of objects in space is the body as object.

There are other dualities I may discover in my body. For example, the physical body (*Körper*), a spatially extended and material object that is subject to the laws of nature, stands opposed to the lived body (*Leib*); the interiority of the body (*Innerleiblichkeit*), the introceptively apprehended "volitional structure" and "dimension of sensing" may be contrasted with the externally appearing exterior body (*Aussenleiblichkeit*), while the body given in the first-person perspective must be distinguished from a body that is mine but belongs to me as a third-person perspectival givenness. It is not the multiple ways in which we might characterize the body's essential duality that concerns us, however, but the curious relationship that unites them as appearances of what is essentially one and the same unified body.

Husserl insists that these two aspects of the body must be conceived in mutual reciprocity: self-affection is always penetrated by affection stemming from the world. Yet the working of this mutual reciprocity is considerably more complex when it comes to the pairing of the pre-reflective body and its objectification as a third-person givenness. Characteristically, the pre-reflective body – the body’s own spontaneous sense – recedes into the background of self-awareness. Michael Polanyi distinguished between the tacit and explicit, or the focal and proximal dimensions, of experience. Using his terminology, any intentional act must be directed from a set of clues and information (what one might call the gestalt or background of the act) to something thematized “to,” the object of the intentional act. An object emerges as an object because clues and information that provide the contrast against which its unity stands out prominently recede into the background and become operative in my perception. I can only be pre-reflectively aware of this tacit dimension of my perceptual acts. Another way of putting this is to say that the tacit dimensions of my body are self-effacing: my body reveals objects to me only in so far that it has succeeded in receding from reflective experience to pre-reflective awareness.

The balancing between the ecstatic and the recessive modalities of bodily self-awareness is predictably a problematic arrangement (I borrow the terms ecstatic and recessive from Leder: 1990). The body’s duality captured by this complementary pairing of terms is precisely what schizophrenic consciousness fails to master or regulate. The distinction between “objectivity,” the kind of objecthood that is inclusive of one’s own body taken as an object of intentional acts, and “worldly objecthood,” objectivity which is the characteristic of the world on “the outside,” might be useful to illustrate this disturbance. In its ecstatic modality, the body can emerge as an object of perception, unified as an object,

yet nevertheless not in the manner in which any other object is an object for self-consciousness. This body is neither exclusively in the *Innenwelt* (the world “within,” or the world internal to subjectivity), nor in the *Aussenwelt* (the outside world). As Merleau-Ponty (1945) put it, it is an unmediated mediacy connecting these two realms, or, stated differently, it is the middle of a spectrum uniting an interior to the exterior as two extremes that were never to be interpreted as a dichotomy or separated as if they stood opposed to one another. But even when the body emerges in its ecstatic modality, it presents itself objectified in comparison to its recessive modalities. While it may become an object for perception, it does not become a worldly object, an object entirely external to the subject: neither in the sense that this body may be situated at a place other than where the self is situated, nor in the sense that it might undergo changes independently of the self.

Yet this is precisely what takes place in the case of the person whose clinical description allows us an unusual opportunity to engage in a schizophrenic person’s peculiar ways of listening to his radio – and returning from this external object to an inner listening of his own body, now perceived as a worldly object:

listening to music on his stereo [he had] an impression that the musical tune somehow lacked its natural fullness; ‘as if something was wrong with the sound itself,’ and he tried to regulate the sound parameters on his stereo to no avail and only to finally realize that he was somehow ‘internally watching’ his own receptivity to music, his own receiving or registering of musical tunes. He so to speak witnessed his own sensory processes rather than living them. It applied to most of his experiences that, instead of living them, he experienced his own experiencing (Parnas 2000).

Robert here tells the story of an unlikely mode of listening. What he describes is not an act of hearing music, but a process of becoming the hearer of an annoyingly strange sound as well as a process of coming to realize his own inner receptivity to music. There is an arc

connecting these two events: resolved to fix the sound he originally hears by trying to modulate it to its optimal “fullness,” he discovers through the changing sounds coming from the stereo a corresponding inner modulation, a “receptivity to music” he could “internally watch.” In other words, Robert short-circuits his perceptual effort to transcend himself through a perceptual act. He reaches his object but, unable to recognize it as such, the object of his intentional act reverts back to himself: it is found within himself rather than on the outside. Through an act directed to his outside, he realizes not an other, but his own capacity to modulate the music as it is thus transmitted to him. But, rather than being quarantined into a passive mode of inert subjectivity, as the melancholic person does, Robert actively works his way into a transformation by means of self-referentiality. His perplexity concerning his own body’s ability to become an object of his self-awareness prevents it from receding into the background upon his perceptual approach to the music. In the dynamic unfolding of its dual performance as constituting and constituted, the schizophrenic person’s body fails to maintain the dyad of body-as-subject and body-object. The most immediate consequence of this is the confounding of this body’s own objective aspects with the objectivity of objects situated in the world, at a distance from the self.

In the bodily experiences with which most of us are familiar, there is an automatic coordination of two motivated series corresponding to the above-described dyadic structure of the body. When we see the profile of an object, for example, the horizon against which we perceive it is automatically aligned with the kinaesthetic and visual horizon of our body. Similarly, the profiles of the object form a system of actualized and non-actualized appearances that also co-ordinate closely with my own body’s system of potential movements. This system of appearances by which I fold my own body’s

kinaesthetic horizons into an objective unity disclosed to me by my body extends both to the movements I perform and to those that I could perform. I move my eyes continually before I determine that a continuum of perceptual appearances constitutes an objective unity; but I am also aware of the possibilities that my body leaves unexplored – the missing profiles and absent sides.

In order to constitute a unified object as my own body, I must master not only the coordination of the series of kinaesthetic sensations in my body with the series of perceptual appearances disclosed through my movements, but also the self-coinciding of my body as the constituting subject of itself and the self-same constituted object. In these pairings, my body can feature itself as an object, the content of a series of perceptual appearances. In contrast, it is always and necessarily the subject of the complementary series consisting of the body's interoceptive and proprioceptive sensations. Once we recast the body's duality as a motivated series that ranges between focal and tacit aspects, we also come to appreciate the complex unity holding together its multiple dimensions. No longer something opposed to multiplicity, bodily unity thus becomes a kind of unity thoroughly penetrated by its many references to a multiplicity.

Once again, the realm of schizophrenic experience refutes any notion that the above model holds true for all experiences of the body. The falling apart of the body as constitutive and constituted is at the core of what Louis Sass describes as the diminished self-affection of schizophrenia. While Sass does not contest that "the diverse signs and symptoms of this illness may all be rooted in certain fundamental alterations in the acts of consciousness that constitute both self and world," nevertheless schizophrenia "can best be

understood as a two-faceted disturbance of self-experience”: diminished self-affection on the one hand and hyper-reflexivity on the other (Sass: 2003).

### **1.3: The Paradox: Diminished Self-Affection and Hyper-Reflexivity**

Sass’ notion that a diminished self-affection in schizophrenia marks a schizophrenic vulnerability to disorganized self-experience must be understood with the proviso that what he calls diminished self-affection pertains primarily to the body’s affectivity, and only indirectly to the egoic affectivity constitutive of self-consciousness. In understanding the use of this term, as is the case with most concepts coined and employed in the intersecting fields of philosophy and psychiatry, what is important is that one grasps the type of alterations a concept denotes, since most of these are not familiar from everyday experience. Sass and his collaborators often explain the term “diminished self-affection” by reference to the theories of Josef Berze, who was the first among psychiatrists to note that “consciousness,” considered as a “luminosity” of sorts, figures into his schizophrenic patients’ experience in a reduced form (Berze: 1914). The following clinical vignette contains concrete examples of this luminosity’s reduction – or, in other words, of the diminishing of the body’s pre-reflective awareness – in a case of prodromal (or incipient) schizophrenia:

Maria, a 22 years old woman currently working in a municipal training project for young unemployed ... was never able to be fully spontaneous and immerse herself in the world because an invisible barrier prevented her full presence. She feels sometimes as if she was *“living like in a fog”*. It is as if her awareness were not entirely clear or fully articulated (*“I am only 70% conscious”*). ... She feels that she is not properly alive, is not *“quite human”*, *“not from this planet”* as if she were a thing, a physical object, rather than a subject (Cermolacce,

Naudin and Parnas: 2007; the italicized are original communications of the patient).

Yet, even at such an early stage of schizophrenic self-disturbance, the patient is also subject to an incipient form of hyper-reflexivity. Filling the void of the patient's "natural," or "spontaneous" presence in the world are experiences foisted upon her from the outside – experiences which she disowns. For example,

[s]he often experiences thought pressure – rapidly racing meaningless, unconnected thoughts giving her an impression of a "*network of busy freeways*". This pressure may occur simultaneously, in parallel, with a normal train of thinking. Certain thoughts interfere disturbingly with her main subject matter of thinking, arising suddenly, as if "*from nowhere*", somehow strange, "as if" they were not her own thoughts (Cermolacce, Naudin and Parnas: 2007).

Maria disowns these thoughts: she is not their source. She does not disown them, however, as the first-person subject they befall.

Here we observe the entire range of phenomena brought together by the unifying label of "schizophrenic self-disturbances." There is, first of all, the diminished presence, a "reduction" to one's first-person experiencing. Mixed with testimonies of this reduction are complaints of lacking explicit awareness of the tacit dimensions of self-consciousness (even though it is the very nature of these dimensions to recede into background). But while Maria explicitly questions the pre-reflective sense of mineness attending her experiences and thoughts, at the reflective level she describes them exactly in the same manner one might wonder about the mysterious ways in which thoughts just "occur" to a thinker. In other words, the thoughts that occur to Maria are "strange" precisely because, one might suppose, their spontaneous occurrence is so ordinary. In the meantime, Maria is also keen to consider her subjectivity as receptive to the products of others' awareness. On the one



hand, she is seen to disown her thoughts, but she also generously agrees to adopt others'. Maria's example thus allows us to survey the full range of abnormalities stemming from the schizophrenic state of disembodiment – from diminished self-affectivity to thought insertion. Her example suggests that the disturbance from which schizophrenic persons suffer impacts the regulation of subjectivity's dual role in experiencing: a disturbance of just when and what functions of pre-reflectivity may be relied on as passive or receptive as opposed to active and objectifying.<sup>4</sup>

Although the notion of diminished self-affectation already opens up a considerable amount of territory to be investigated in chapters that follow this preliminary exposition of the problems inherent in the schizophrenic's bodily alienation, we must retain our focus on the significance of Sass' notion of diminished self-affectation. This term made its entry into the chapter because, according to Sass, the root of anomalous schizophrenic self-experience is twofold: affectivity, on the one hand, is reduced, and reflectivity, on the other hand, is exaggerated.

Turning our attention now to the latter of these "interdependent" alterations, let us note that the basis for introducing "hyperreflectivity" into the vocabulary of

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<sup>4</sup> Maria's case – as most case studies capturing the initial stages of schizophrenia – is fascinating in other respects as well. I must add that she is also puzzling because she deliberately does not disown her thoughts. According to her treating staff, she knows that the inserted thoughts are ultimately and in some mysterious way the product of her own mind. What she nevertheless insists on is that her inserted thoughts are different because they feel neither "personal" nor "voluntary" (is she saying that they do not feel personal *because* they do not feel voluntary?). She thus complains about a distance separating herself from her thoughts. This appears to be an adequate explanation of her problem: since she cannot rely on an implicit sense of ownership of her thoughts, her post facto, reflective thought attribution is bound to lead her astray. I am going to take up these interesting issues in due course: Chapter 6 is going to address the problem of the dis/ownership that follows from the self-disturbance which here I can only describe in a preliminary manner. Already in Chapter 5, however, I am going to present the reversibility between under- and overstating important distinctions that are constitutive of subjective experience in schizophrenic states. In that chapter, my primary focus will be the dichotomies that are regulative in the constitution of the body's spatiality, such as its substantial attributes (being extended vs. being incorporeal).

phenomenological psychiatry was Sass's observation that schizophrenics "often adopt a particularistic, overintellectualized, and deliberate" cognitive style, "relying on piecemeal, decontextualized analysis rather than intuitive, spontaneous, or global modes of response" (Sass: 1992). Rather than a deficient mode of thinking, however, Sass found that the schizophrenic focus on the abstract as well as their almost compulsive avoidance of objects of thought corresponding to particular things is due to their overly keen employment of reflectivity. Sass uses the term "hyper-reflexivity" for this "constant, compulsive need to exercise [their] own consciousness" (Sass: 1994) and for the "exaggerated, reflexive awareness of aspects of experience that are normally tacit or presupposed" (Sass and Parnas: 2001). He also defines it as an "exaggerated self-consciousness, that is, the tendency to direct focal, objectifying attention toward processes and phenomena that would normally be 'inhabited' or experienced as part of oneself" (Sass and Parnas: 2007). On some of his accounts, hyper-reflexivity and diminished self-affection are compensatory processes; in virtually every instance, he holds them to be equiprimordial and interdependent.

An object is approached via hyper-reflexivity by a schizophrenic person describing his perceptual experience:

"[w]hen I watch something, I would like to see it better. While watching, say, a tree, I can but *scan* with my eye its profile and count its sides. My voices tell me to visually analyze an object and sort it out in innumerable parts. Everything in the world can be described in mathematical terms. For instance, a dog is seven parts; that tree up there has five sides. I called this *counting*, because for me everything in this way is reducible to a certain number according to its sides. It started as a sort of game, then it is turned into a kind of obsession – I must do it. It is *not entirely under my control*. I *become aware* of my eye watching an object. I must admit it is a bit *mechanical*" (Stanghellini: 2004 – italics in original).

This person is led by his hyper-reflexive tendencies to continually and compulsively maintain a grip on his experience; he tries to do so by engaging in explicit thematizations of his experience, including aspects of bodiliness one normally takes for granted – precisely because they are implicit in our body’s mediation of the world. What this patient succeeded in rendering explicit, by making it into an object of focal attention, is performed with an automatic spontaneity in ordinary experience, and serves as the background region of self-experience pre-reflectively attending one’s grasp of an object.

Sass’ concept of hyper-reflexivity served as a catalyst for interdisciplinary collaboration among philosophers, psychologists and psychiatrists. Its impact on the field was influential enough not only to spur extensive research into the ipseity-disturbances of schizophrenia but also to invite additional reflection regarding the complexity (and variety) of the phenomena originally subsumed under this theoretical designation. In a more recent article, Sass and Parnas (2007) themselves pointed out that their term, written as *hyper-reflexivity* since its coining by Sass, includes both a hyper-reflective, volitional (or quasi-volitional) intellectual achievement of self-consciousness, and an operative hyper-reflexivity which occurs in an automatic manner. It is this operative hyper-reflexivity – and not the hyper-reflectivity into which proneness to hyper-reflexivity may become sedimented – that is responsible for the disruptions of the pre-reflective self-awareness of schizophrenic individuals. Phenomena or processes that would otherwise remain in the background of self-awareness “pop out,” as it were, from their medium of implicit self-affection due to the impact of this automated intensifying of experience on what Husserl would call the “fundamental receptivity” of consciousness (Sass and Parnas: 2007).

Disrupting self-awareness and action, hyper-reflexivity in this way leads to experiencing processes of self-awareness as alienated or objectified.

Hyper-reflexivity there for is a reflective or reflexive stance which, when substituted for processes that must of necessity remain implicit, becomes a self-defeating feat: accessing these regions through reflexivity does not only fail to replace the lacking dimensions of self-experience, it disturbs the constitution of the tree as an object. It appears then that the implicit/explicit poles do not simply form a complementary pair operative in self-consciousness. Their disturbance, as we are now beginning to see, reverberates throughout the regulative structures of subjectivity by which we make sense of the world. As the above example of a person counting the parts of a dog and the sides of a tree suggests, when those elements that normally recede into the background of consciousness come forward suddenly, the result is the breakdown of perceptual experience.

Wolfgang Blankenburg calls this source of perceptual breakdown in schizophrenia “the loss of natural self-evidence.” He considers schizophrenia a disorder of a common sense in which, due to a “pathological explication of the implicit,” the passive syntheses of self-experience are altered and consciousness itself is disordered in a systematic, global sense (Blankenburg: 1971). Blankenburg gestures toward putting the same point in terms of active and passive egoic activity. In schizophrenia, sensations that would otherwise emerge by passive synthesis that are tacitly regulative of self-consciousness are now provided by active, objectifying syntheses, syntheses that are normally only at work in object-intentionality.

The arc I am to complete in the space of the next three chapters is directed at progressing step-by-step to the analysis Blankenburg might provide of the altered self-experiences that these bodily states reveal. To undertake such an analysis, however, we must become better acquainted with the dynamic processes by which the disorganizations of the body's experience are produced in schizophrenia – in other words, with clinical descriptions of the body as experienced in schizophrenic states – yet remain focused on the problem that we seek to understand by performing this analysis. In the concluding section of this chapter, I would like to provide a brief prognostic view of the two motivations that shape this division of the dissertation.

#### **1.4: Beyond Bodily Subjectivity: Examination the Divergence of Pre-Reflective Self and Pre-Reflective Body**

Sass' casting of a double "trouble generateur" of schizophrenia is a reminder that, in the realm of psychopathology, alterations never proceed in only one direction. There is hardly a "movement" to be captured from the normal to the abnormal: like a pendulum, the "abnormal" takes off from the "normal" in two different directions, stretching it as if it were a piece of textile which ceases to be a homogeneous fabric by virtue of its transformation into the "pathological," and reveals the threads that compose normalcy and the interstices of its composition.

It is of no use, therefore, to refer to schizophrenic phenomena as "abnormalities," implicitly assuming that the route they take is a degeneration of the normal into the "pathological." Approaching two extremes and exhibiting two alterations all at once, we find the conditions of possibility of embodied subjective existence magnified in the

muddled compositions of the bodily self-experiencing of schizophrenic persons. The two extremes in question are hardly if at all distinct in normal experience. Furthermore, the specific pairing of these extreme states is unified without reconciliation: they operate in unison even though they appear to pull the schizophrenic person into irreconcilably different directions.

Sass makes a convincing case that the same core disturbance produces hyper-reflexivity, which indicates disturbances in egoic activity (namely, its “undue” exaggeration, when compared to what normal subjects experience) and which stands in stark contrast with regions of egoic passivity comprising self-affectivity (which is diminished in comparison to the normal). Differently put: in schizophrenic self-experiences, disturbances of the pre-reflective body are co-indicative of disturbances of reflective consciousness. This is perplexing not only because it calls for an analysis of contradictory tendencies that nevertheless appear to have reached their smooth reconciliation in the schizophrenic experience. Perhaps the greatest source of our inability to comprehend the schizophrenic state as thus described is that the pairing of hyper-reflexivity and diminished self-affection defies our conviction that body and self form the kind of unity in which pre-reflective alterations in one would indicate corresponding pre-reflective alterations in the other. It is difficult to admit as an experiential possibility that a reduction in pre-reflective bodily affectivity, instead of being mirrored by similar alterations in the tacit dimensions of self-consciousness, presents itself alongside an exaggerated and compulsive tendency to bring tacit dimensions of self-experience to reflective consciousness.

In what follows, I do not propose to resolve the contradictions of this bifurcated experiential state – to the contrary, my aim is to maintain them as intact as possible. In particular, I shall insist on treating the problem of the body’s experience and that of the schizophrenic self separately. My chapters on the body’s experience in schizophrenic states are designed to set up a consecutive analysis of the specific patterns of disorganization we might identify in the schizophrenic self – precisely because, in the realm of schizophrenic experiences, the two problems cannot be assumed to stand in a relationship of mutual implication.

One possible objection to the above would point out that a similar kind of reification, or distancing alienation, is characteristic of a schizophrenic person’s relationship with his or her body. I examine this claim in the next chapter, and show that it is precisely because it demands that the schizophrenic person’s body and self follow similar patterns of analysis that it is misleading. It certainly suffices as a succinct characterization, but the more we probe into it, the more difficult it becomes to maintain. Conceiving of the body as the embodied equivalent of the hyper-reflexive schizophrenic self, one is tempted to interpret the peculiar ways in which schizophrenics describe their bodies as products of undue objectification: as deanimated, machine-like entities. I show that this description does not take into consideration the different types of alienation experienced in clinical depression and in schizophrenia. The depressive person’s alienation from his or her body may be understood within the framework of this analogy, but I contend that the body as experienced by a schizophrenic person requires moving beyond this experiential range. If we fail to do so, unbeknownst to ourselves we become motivated by our own preference to distance ourselves from these “bizarre” experiences – which drives a wedge between the

experiencing subject and the interpreter of his or her experiences. Such an approach fails to forward our attempts to understand the schizophrenic experience.<sup>5</sup> I thus conclude the next chapter by pointing out the different paradoxes produced in the bodily states characteristic of clinical depression and schizophrenia, suggesting that the latter states must not be understood as comparable to those of the body of the melancholic, person but as another order of complexity that is built upon the paradoxes of the depressive person's bodily experiences.

In Chapter 3, I further develop this thesis by engaging the variety of body image distortions experienced by schizophrenic individuals, discussing them as produced by one of four different type of modifications. It would be mistaken to describe these four processes by the generic term "alienation": instead, I describe four different dynamics for dissolving the normal person's monolithic body/self construct. Here again, I avoid interpreting these disordered images of one's own body as indicative of analogous self-disorders. I treat the bodily image constructs of schizophrenic persons as disturbances of an explicit (and reflectively maintained) unity of the body which signal disorders in the body schema and in the body's implicit self-experience.

Finally, it is in search of the disorders of the body-schema underlying the disordered body-images as discussed in chapter 3 that I set out on an examination of schizophrenic passivity experiences in Chapter 4. What is at stake in these phenomena is not simply one's sense of ownership, but an explicit sense of ownership of oneself as the source of power in

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<sup>5</sup> Such an understanding, as it is probably already apparent, is not an emphatic understanding, or, to be precise, is an understanding that does not exclusively stem from empathy. It combines an analytic of the schizophrenic body tasked with building up the categories through which such an experience may be understood with the approach of empathy required for understanding bodies not merely as bodies, but as embodied subjects.



accomplishing acts, i.e. one's sense of agency. This final chapter of the division of the dissertation directly engaged with the body of schizophrenia describes the interpenetration of the body-as-subject and the body-as-object (or, viewed from the "sense of agency": the interpenetration of the body-as-agent and the body-acted-upon). Specifically, I am going to rely on testimonies from schizophrenic individuals about disturbances to tacit regions of bodily experience in order to gain access to the peculiar ways in which the body schema of schizophrenic persons remains an implicit source of orientation for the schizophrenic self while also qualifying as an "anomaly" in so far that it is grasped in reflective and hyper-reflexive consciousness.

## Chapter 2

### The Alienation of The Schizophrenic Body

The previous chapter examined the self-disorders characteristic of schizophrenia and determined that schizophrenia's impact is first and foremost in the pre-reflective regions of selfhood. The alterations of self-experience that we only began to grasp in the first chapter manifest primarily in alterations to the schizophrenic person's sense of mineness. This alienation extends to the body's sensation as well – surely an aspect of mineness -- and the resulting state is often described as a state of “disembodiment” (Stanghellini: 2004) or as the dispossession of the self of its body (Sass: 2004). Such terminology certainly succeeds in conveying the severity of the distancing that might take place between the subject and the object poles of self-awareness, yet adopting these terms without further commentary also poses its own dangers.

One of these is that the emphasis on a “self” severed from its “body” returns us to the Cartesian duality of mind and matter, of *res cogito* existing distinctly and independently of a *res extensa*, of the physical body and its objectivity conceived in opposition to the cognitive and spiritual dimensions of selfhood. Instead of being truthful to the sensations schizophrenic patients report of their bodies, following the dualism implicitly embraced by the use of such terminology would return us to the dualist thought experiment of professional philosophers. No doubt the states of alienation experienced by schizophrenic persons merit our attention, since they are actual states of experiencing, but unwarranted

emphasis on the supposed severing of mind and body might obstruct rather than facilitate grasping their significance.

Secondly, while the terms “alienation” or “disembodiment” do signal a pathological quality to the schizophrenic experience, a certain measure of alienation from our body’s most immediate experience is part and parcel of our familiar experience. Words like “alienation” or “disembodiment” are therefore empty of content *unless* we are able to establish that an essential difference exists between schizophrenic and non-schizophrenic subjectivity, or between schizophrenic and non-schizophrenic embodiment. The clue to determining the commonalities and the differences of psychotic and non-psychotic modes of embodied subjectivity, however, cannot be settled without a comparative study of the states of alienation possible under each of these conditions – which, in this way, return us to the need to differentiate the meaning of the word “alienation” as applied to the schizophrenic, as well as to the non-schizophrenic, condition.

In this chapter, I would like to develop this distinction by what might at first sight appear to be a surprising detour: by appeal to the difference between the alienation characteristic of melancholia and of schizophrenia. Why the inclusion of the melancholic body was necessary in this chapter will become apparent by the end of the chapter. Though I will rely on examples and theories of authors who have already pointed out that these states are instructive to compare, especially because the kind of alienation characteristically experienced in each of these conditions have their origins in the lived experience of the body, I see my account as a necessary complement offered from the philosophical perspective to the diagnostic and therapeutic concerns already addressed in the literature. As I personally do not have the clinical experience of working with

melancholic or schizophrenic individuals, I incorporate especially the examples and the case studies that these psychiatrists discuss. Yet, while I sought to keep my discussion rich with illustration, the philosophical conclusions I draw from these examples are my own.

## **2.1: To Have and/or To Be**

Philosophers describe the changes experienced in our body's sense by recourse to a distinction between two different approaches to one's own body. The difference in question between these two bodies, the lived and the objectified body, could be easily explained by imagining yourself paying a visit to your doctor. You are seeking treatment for an intensely piercing pain in your stomach – an appendicitis, as you are soon to learn – when the doctor shows you a diagram of your digestive system to explain the surgery he is about to perform. Once you are confronted with a visual experience of your inner organs on the diagram, it is as if the pain impacted your body in a completely different way. The bearing and sensation of your own body immediately comes into alignment with the body you see, and before long you relate your body's inner experience to the drawing of an anonymous (and dissected) man.

The diagram allowed you to slip into another body: into the system of organs you find laid bare for you on the anatomical sketch. It is no wonder that the apperception of your body also changes as a result of relating your pain to this *objectified* rendering of your body. The piercing pain in your stomach bothers you in your flesh, while the doctor now literally locates it for you in anatomically precise regions of your body normally invisible. It is already an ominous sign when one's appendix is about to be handled as merely a mass of tissue: visible to your surgeon, literally available to his grasp before it is extracted from

your body. But your sense of alienation from your objectified body is not due merely to the fact that your appendix is about to be taken out and away from you. You are also robbed of a flesh-and-bone *sensed* pain, a bodily sensation at first private and incommunicable. In the first instance, the doctor leads you to approach your body as *Körper*, or objectified body, and what this objectified body finds itself contrasted with in this encounter was *Leib*, your lived body.

In this way, you experience a rare moment of your body's duality in the doctor's office. This is a duality we all carry in our bodies. The German words *Leib* and *Körper* are convenient ways of summarizing these various aspects of the lived and own body, on the one hand; and, on the other, of the material entity divorced from a specific subjectivity – a body that belongs to no one in particular yet to everyone in so far that it approaches a scientific ideal of objective impersonality. The German words by which we refer to these presentations of the body are also useful for marking their distinction, because, in German, one “is” a *Leib* (the term “lived body” is used with the phrase *Leibsein*, “being a body”), while *Körper* is something one might have (*haben*) as one's property.

Following these linguistic clues, we must be certain not to mistake the body's felt duality for the idea that there might be two bodies to speak of, coexisting as it were, within one's own. *Körper* is my body in so far as my body naturally gives itself to objectification. I can move “it,” perceive “it” and present “it” to others: in various moments and for various reasons I come to relate to my body as to an entity separate from me. *Körper*, then, is a body I “have” because I am capable of divorcing, in the abstract, a form of bodiliness from my identity. One's relationship with *Leib* is similarly complex, though for different reasons. I “am” a body (and “live” this body) because none of what I do as an embodied subject is

done without a “luminosity” or bodily “tonus” – both of which are terms Berze (1914) favored to describe the self-affective dimension of the pre-reflective body’s sense – accompanying it. In fact, for the most part, I do not move my body as an “it.” It would take extraordinary circumstances for one to be aware of the entire procedure entailed in lifting a foot while composing one’s “walking.” What is more, unless I am specifically interested in making my body an object of my inquiry, the body with which I am one is strikingly resistant to objectification. Visually, for example, I am always limited to a perspectival view of the peripheries of my body; introspectively, I never have a sense of my whole body, but only of various “regions” standing out against the background of a more general sense of bodiliness. The distinction between *Leib* and *Körper*, therefore, is my means to account for a dual possibility inherent in my embodiment. I allow for the possibility of maintaining distance from it as *Körper*, and, when using the term *Leib*, I deny a dichotomy between my material and spiritual manifestations and choose to embrace them as a continuum upon which my embodied being and its phenomenal experience is revealed to me as my experience, my self-consciousness and my being.

Inherent in the duality of the German terminology we choose to follow, therefore, is a specific type of alienation characteristic of *Körper*, as well as a certain extent of immanence in the experience of *Leib*. Under specific types of psychic stress, these might be experienced in the extreme. Especially under acute psychosis, we might not only distance ourselves from our body to the point of merely only “having” it; indeed, we might go as far as disowning it altogether. Under similarly extreme conditions, the lived body and its experience, already inexplicable to a considerable extent, could be denounced so severely that being a bodily self may become inaccessible to experience. First, I would like to devote

attention to this latter “disorder” in the body’s experience: to one’s loss of access to the lived experience of the body, a mechanism more typical of the affective psychoses (such as depression and bipolar personality disorder). In later sections, I am going to contrast this disturbance of one’s bodily awareness with an entirely different type, one that is typical of schizophrenia, but one which, as will probably become more evident below, is much more difficult to relate to or to describe.

## **2.2: The Foreclosure of Lived Experience in States of Clinical Depression**

Melancholic individuals (in accordance with European psychiatric nosology, I use “melancholia” interchangeably with the term “endogenous depression,” though the states here described are also characteristic of the depressive phase of a bipolar psychosis) typically lose interest in interacting with others, in moving about, and in being affected by the qualities of their surroundings. Those suffering from a neurological cause affecting their mobility (such as Parkinson’s disease, for example) are anguished because they cannot easily traverse the distances that separate them from other objects. Melancholic individuals experience a similar sense of immobility, though this is not due to organic damage: they seem to have no motivation to engage their body in activity because they tend to conceptualize the body as an entity that serves merely as a physical confine. A specifically melancholic type of alienation descends on them, therefore, due to the limitations inherent in the concept they form of their bodies; it imposes on their attempts to interact with the world and as a result they find themselves relegated to an ever-shrinking sphere of activity. As a melancholic patient put it, addressing perhaps not only

other persons, but the world as the counterpart for the activity of the self, “[t]he other is separated by an abyss and cannot be reached any more” (Fuchs: 2005a).

The bodily alienation typical of the melancholic condition is characterized by the kind of objectification that, in the end, permeates a sense of lifelessness. Persons suffering from melancholia express their sense of bodiliness as, for example, a vest of armor pressing down on them, as a tire wrapped around their chest, a lump choking them at the throat, heavy pressure plugging up movement in their body or, when the same feeling is present with lesser sensitivity, as a “feeling of not feeling” (Fuchs: 2005a). Already in these statements they stress not only the material aspects of their body (it has weight, it requires kinetic energy to be moved, etc.) but the most oppressive aspects of being a body (its weight is a burden, or at the very least it is numbing). This sensation also colors their outlook on the world surrounding them. They become increasingly cut off from the world, but, quite notably, the world from which they are now separated by the self-encirclement of their body is an environment that encroaches upon the bodily confines of the self. The space of the individual appears to gradually narrow down, until the “body” is felt as encircling the “self” to such an extent that the individual claims to be choked or pressed into lifelessness – or to a merely material existence lacking in psychic vitality.

In his memoir *Darkness Invisible*, William Styron describes the hopelessness felt during his clinical depression precisely in these terms, as the hopelessness deriving from no longer being able to imagine shifts and movements away from where one is and how one feels:

The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come – not in a day, an hour, a month, or a minute. If there is mild relief, one knows that it is only temporary; more pain will follow. It is hopelessness even more than



pain that crushes the soul. So the decision-making of daily life involves not, as in normal affairs, shifting from one annoying situation to another less annoying – or from discomfort to relative comfort, or from boredom to activity – but moving from pain to pain. One does not abandon, even briefly, one’s bed of nails, but is attached to it wherever one goes (Styron: 1990).

But this intolerably narrow sphere into which the self becomes “imprisoned” encircles it with vicious intensity:

... mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression ... is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room.

This collapsing of the world upon the self – and more particularly upon the body – is the result of being incapable to see the ego in contrast with other objects, and of the inability to contrast the momentary state of the self with other, past states. While Styron notably describes his *self* imprisoned in an overheated room (though continually making references to bodily pain), melancholic persons often progress in their reports of sensing not only their psyche, but their body’s suffocation from lacking the vital space of a surrounding.

Insensitivity to the environment in these states can become so severe that patients might become unable to smell a meal or feel the difference between hot and cold. Melancholic individuals also conceptualize obstacles surrounding them, which prevent reaching out beyond their increasingly threatening isolation. It is an impassable limitation that is noted in an example drawn from one of Thomas Fuchs’s melancholic patients, who said that “[t]he other is separated by an abyss and cannot be reached any more” (Fuchs: 2005a). “The person affected by melancholia collapses into the spatial boundaries of her

own solid, material body,” is how Fuchs summarizes the matter, referring to the result as “affective depersonalization.” What Binswanger describes of the manic state also holds true of those inflicted with lengthier bouts of depression, who experience a peculiar kind of flattening to the world as experienced. A nexus of innumerable possible gestalts loses its thickness for them; the world’s design narrows down; it gradually comes to be organized alongside just a few increasingly self-referential themes.

Fuchs (2005a) characterizes the melancholic condition in terms of the body’s loss of transparency. Drawing on Maurice Merleau-Ponty’s theory of the lived body, Fuchs claims that in melancholia, the body becomes an opacity prohibiting, rather than enabling, the body’s mediation between self and the world.<sup>6</sup> Instead of connecting it to a domain of affordances for experience, the lived body of a clinically depressed person becomes “corporealized” in the sense of restricting rather than opening up its surrounding environment – thus rendering the world further and further distanced from the body and the self entombed within. Fuchs sums up his clinical observations in the following way:

[i]n melancholia, the body loses its lightness, fluidity, and mobility of medium and turns into a heavy, solid body that puts up resistance to the subject’s intentions and impulses. Its materiality, density and weight, otherwise suspended in everyday performance, now come to the fore and are felt painfully. ... [A] loss of vitality in many systems of the organism occurs, which further restricts the space of the lived body. The exchange with the environment is inhibited, excretions cease; processes of slowing down, shrinking, and drying up prevail. All this literally means a *corporealization*, in the sense of resembling a corpse, a dead body. Hence, depressed people are preoccupied with bodily malfunctions or possible diseases; hypochondrical delusions mostly relate to a restriction, constipation, or shrinking of the body,

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<sup>6</sup> Maurice Merleau-Ponty’s theory of the lived body on which the majority of the authors mentioned in this chapter rely is going to be the point of origin in the next chapter dedicated to a theoretical account of the phenomena under discussion here.

which is experienced as decaying from within or even dying (Fuchs: 2005a).

Fuchs' use of the term "corporealization" returns us to the distinction between *Leib* and *Körper*. *Körper* is often described as the "inanimate" body, a material object stripped of its vitality, and Fuchs appeals to exactly this connotation of the word in his use of this specific terminology. The melancholic patient abandons his lived body; likening himself to a corpse, a body stripped of life, he or she is more and more settled on being – and not simply having – an objectified body.

But why should the narrowing of the range of emotions experienced lead, through these types of felt restrictions in what is considered to be the body's 'proper' sphere, to such a 'flattening', 'narrowing' and 'constricting' of the world? The body plays a fundamental role in the constitution of the object-world, yet this notion can be given too much emphasis in an explanatory framework, especially if a "bodily self" is confounded with the notion of "self," which itself is only an umbrella term. In the case of the melancholic body (and perhaps in the affective psychoses in general), when the above question is raised not only with regard to the issue of self and body, or psyche and soma, the issue at hand is clearer. In what follows below, I would also like to extend the skepticism stemming from this way of putting the question to the notion of identity as well. Before subjecting the schizophrenic body to the same analysis to which I submitted the melancholic body in this section, and before I can formulate with greater precision the significance of the melancholic body for the problems we face in discussing the bodily alienation characteristic of schizophrenic conditions, I would like to discuss in more detail

why I think it crucial not to treat bodies, selves and identities analogously – a point which is going to turn out to be central for understanding schizophrenic states.

### **2.3: Bodies, Selves and Identities**

Drew Leder, whose work *The Absent Body* (1990) explores the phenomenological significance of the body's dual potentiality I described above, casts *Körper* and *Leib* as “a complementary series of focal and background disappearance” in the human experience. Leder shows that *Körper* and *Leib* come to be paired together in such a way that the disappearance of one of them is directly connected to the focal appearance of the other. The lived body and its objectification as *Körper* are therefore found in specific pairings, emerging and disappearing in different yet complementary degrees. In this way, it is possible to think of a series of experiences in which the body's objectification is felt to an increasing degree, building up toward the extreme case of the melancholic condition. To remain with Fuch's terminology, in the melancholic body's “corporealized” experience, the objectified body (*Körper*) becomes the dominant aspect of this pairing. It is this assessment that I would like to refine in what follows.

My identity is constituted in equal part by my lived experience and by the gaze (and glance) of others and, since others can experience me directly as *Körper* but only indirectly as *Leib*, this means that my identity is intricately linked with my body's visual representation to others. Normally, the lived body serves as an origin, or nullpoint, of the body's orientation: it centralizes space by virtue of letting everything spatially perceived by my body appear as surrounding me. Yet this experientially-based body of mine is not the only source of the ideas I come to entertain of my body. My lived experience is often

supplemented with the experience of a body I appropriate for myself with the help of an identity assigned to me by virtue of the fact that others also hold notions about me as a person perceptually available to them in the form of a body. Some of these notions are constituted by reflection on my societal roles and participation, while some of them are formed in more personal interactions with my peers. Accordingly, at the same time that it might seem, from my own first-person perspective, that everything around me is related to me through my body's mediation, I might also feel that I am cornered into this centrality by the objectifying gaze of the other. For example, my "I" or a "self" is established at the level of an abstract individual when I think of myself as just one of a community of many similar individuals – this social identity of mine, however, is also based on my body's experience of this community, for example in terms of the bodily negotiations of the space I collectively share with others. My bodily experiences also feed into my personal identity as mediated by the experiences others have of me (and through any feedback I might receive, or believe to have received, from others in this respect).

In this way, what we might call the "body," just like the "self," is made up of a variety of experiential regions. I am recognized as the person I am for others through my body's image, and yet this image of my body that I see formulated in the eyes of others may become "misaligned" with my own lived experience.

In his seminal essay on the unification of the body image at the mirror stage, Lacan (1949) notes that our body's external appearance, as an image for others, is produced by alienation from our lived body: the lived body's experience undergoes a "symbolic reduction" as the pre-specular self of the infant is transformed into a social I by virtue of its identification with its own body in the form of a body image. It is in exchange for foregoing

the hope of being able to be known as the embodied beings we are by way of our lived bodies that we acquire the recognition that we exist for others. Beyond the mirror stage, we must resign ourselves to being recognized as a self symbolized by our body's visual appearance: we must accept that others sum us up as an image of our body, and that the full depth of our body's experience will remain ignored in the constitution of the personhood that we come to acquire in this social dialectic.

Our identification with our *Körper* – the body which is to some extent the product of alienation, but which, because it is universally available, nevertheless remains a symbolic representation of us – therefore plays a role entirely different in the constitution of a social persona than in the constitution of a bodily or prereflective self. This is especially important to note in order to understand the melancholic person's undue identification with his or her "corporealized" – inanimate, immobile and increasingly empty – body. While our *Leib* connects us to our most intimate experiences, it is our *Körper* that forges a way to the world of other persons.

Accordingly, we often traverse the continuum between lived and objectified body, and we do so without difficulty. We continually fluctuate between occupying a central position in the world and taking ourselves as an object of our observations. This Helmut Plessner (1928) calls excentric positionality (*Exzentrische Positionalität*). Plessner emphasizes that, since humans take a reflexive position on their experiences, the centrality of the body's positioning within the world ("*das lebendige Ding, das in die Mitte seiner Existenz gestellt ist*") is automatically complemented by also living outside of (*hinaus*) this egocentric position. Being situated excentrically, humans are therefore capable of experiencing their body as *Leib*, but also of transcending the here and now of their

experience. In this way, they oscillate between being a body that discloses the world around them and looking upon themselves from a point of view situated in the surrounding space of the world, from a reflective distance. The same body apprehended as *Leib* in the egocentric position becomes a *Körperding*, just one material thing among others forming the outer world, as seen from the excentric pole of human self-consciousness (since Plessner holds that humans are distinguished from plants and animals by virtue of their capacity for this excentric positionality).

Anthropological studies characterize melancholia-prone individuals as persons who, before falling ill, excelled in social roles. A series of studies – notably in the German philosophical anthropology tradition, represented by Kretschmer (1922), Tellenbach (1961) and Kraus (1982) – point out that they function exceptionally well as employees, parents, citizens, etc. because they find it easy, and in some sense reassuring, to fit themselves with categories already well-established in the social sphere. They do not seek to be exceptional or unique, but they do feel accomplished when they can approximate a role that garners respect: for example, the ardent patriot, the self-sacrificing mother, or the dutiful son. This is due, in large part, to their preference for clarity: for rules and directives that are unambiguous and conducive to positing an appearance of order around them. They are intolerant of ambiguity or complexity, but they make up for this by their diligence in social adaptability, and by their hypersensitivity to the expectations of others and to being in compliance with norms.

The *typus melancholicus* therefore forges his or her identity by deriving it from well-established social categories. In capturing it as a personality type, the German philosophical anthropology tradition (whose thoughts I follow here) aims precisely at

capturing the social identity of psychotic persons – at what is in effect a differential diagnosis of the psychoses through the social identities these persons prefer to construct for themselves. At the same time, however, persons afflicted by severe depression are also anxiety-ridden about the looming prospect of being found inadequate to the social role they choose to emulate. This is due, above all else, to their awareness that distinct features of their selfhood are in disagreement with these social roles. It is not unusual to see these poorly fitting aspects of their social personality also dominate their characterization of their lived experience, and to trace a certain type of dread emerging in relation to the body's experience as a result – an attitude which eventually coalesces into a dominant state of bodily alienation.

What terrifies the melancholic personality even more than being attuned to their bodily experience or to rendering their implicit experiences as a bodily self understandable to others is that, if they do so, they might be “found out”: that, as a result, others would come to see their inability to embody the ideal through which they derive their social identity. The constitution of a social identity and the preference given to the body's visual presentation in the bodily self-awareness appear to be different manifestations of the same tendency.

Lacan is correct to point out that one is required to undergo a certain “process” of alienation in order to construct a social identity at all. But more importantly than alienation, what is crucial in the melancholic preference for an identity viewable from the outside is the ability to objectify one's *bodily self*. The self from which we are distanced by the primordial alienation indexed in Lacan's theory must be distinguished from the social identity (later, we are going to refer to the former as the pre-reflective self – for now, the



term “bodily self” will suffice). The notion of “being” a lived body and “having” an objectified body once again becomes useful for describing this alienation that is a prerequisite for constructing an identity originating in our body’s lived experience. The objectification in question makes it possible for us to conceptualize our state of being ourselves as a body in the form of its “corporealized” counterpart: as having ourselves in the form of a determinate body. What, before, was a body in which we experienced ourselves and our surroundings in an indeterminate way can also present itself as an object, something which we can take possession of, by virtue of our ability to occupy an excentric position with regards to ourselves. But while being a materially present object insofar as my body is perceived by another, in the context of excentric position-taking, is a fleeting and partial experience, the pathological version of materiality that melancholic persons substitute for it bears considerable resemblance to something sheerly material. Conceptualizing the melancholic body more and more explicitly, the subject’s experience of his or her body approximates that of an inanimate object, as the melancholic person comes to feel hollow, dense, resistant, dried out, rotting, shrinking, immobile and decaying.

Just as their body is no longer something here and now situating them in relation to a larger domain of action, the vitality of melancholic people’s self-experience also comes to be restrained as they gradually come to bear a body severely corporealized and serving as an obstacle barricading them from the outside. All in all, the corporealization of the melancholic body, in the realm of the self’s disorder, is a state of “over-identification.” What Fuchs calls the corporealization of the body in the melancholic condition is produced by favoring the excentric pole in this normal oscillation over the egocentric moment of the body’s experience. The result of this process is not a *Körper*, the objectified body, but the

patient's inability to freely oscillate between the body's egocentric and excentric positionalities: to embody social ideals while remaining her own person, a locus of unique experiences.

Why does the narrowing of the range of emotions experienced by melancholic (or perhaps also of manic) individuals lead to a "flattening," "narrowing" and "constricting" of the world – and why do these distortions in the world around the self present themselves in the form of the body's sensed limitation (in feeling choked, clamped down, and surrounded)? It is impossible not to admit at this point that, when it comes to the melancholic body, this question takes the form of an inquiry into what leads one to construct one's social identity increasingly through the exclusion of the body's lived sense. In other words, further explorations into the melancholic body must of necessity center on these persons' exclusive identification with the corporeal or objectified aspect of their bodies. It is this standpoint – what might be called excentricity in a pathological measure – that allows them to collapse the richness and depth of the social world by recourse to a realm of abstraction. It is due to this perspective that the flesh-and-blood individuals as well as the complex and contradictory dilemmas of the body's lived experience are reduced to trivial categorization, as it happens to be the case with the melancholic body.

#### **2.4: Schizophrenic Bodies, Schizophrenic Identity**

It is important to spell out the alienation constitutive of the melancholic body in detail, if only because schizophrenic bodily states tend to center around an alienation of a completely different kind. Setting up the distinction between what are fundamentally different ways in which psychotic patients diminish the lived dimension of their self-

experience, Fuchs refers to the melancholic condition as the lived body's "corporealization" or "reification," as opposed to the "disembodiment" of schizophrenia. The melancholic body, he writes, tends to approach a "pure materiality," while the schizophrenic body "becomes detached from the mediating processes that it normally embodies" (Fuchs: 2005a).

In contrast to the melancholic corporealization ... the schizophrenic person suffers from what may be called a *disembodiment* of the self. She does not "inhabit" her body any more, in the sense of using as taken for granted its implicit structure, its habits or automatic performances, as a medium of relating to the world. ... The tacit self-awareness or self-referentiality present in everyday experience is weakened or lost, and an alienation of perception and action results. The result may be described as a fragmentation of the intentional arcs of perceiving, feeling, thinking, and acting (Fuchs: 2005a).

But since a forceful distancing of oneself from one's body is part and parcel of both the melancholic and the schizophrenic experience, and because alienation appears to feature prominently in both of these two processes, it is not at all obvious what might prevent what Fuchs calls the body's "corporealization" from serving simultaneously as the distancing that "disembodies" the self.

The distinction on which Fuchs insists seems to focus on the idea that, in the melancholic condition, the lived experience of the body comes to be lost. Schizophrenic persons, on the other hand, maintain a greater distance from a selfhood rooted in materiality and corporeality. Famously, schizophrenics often liken themselves to machines that receive or capture sense-information about the world, describing their bodies as if they were scanners, plotters, cameras or radios – or, earlier in the 20<sup>th</sup> century, as puppets,

instruments or automatons.<sup>7</sup> Their body undergoes mechanization especially in relation to tasks that demand non-reflective reliance on the affectivity of the body: describing such acts, schizophrenics often speak of themselves as sensing, feeling and even thinking machines.

Interestingly, while we might interpret these self-reports as one's denouncement of his or her own humanity, the schizophrenic persons who serve as the sources of these self-descriptions could equally well be interpreted as forging a new kind of identity for themselves. The problem of identity, which we had to examine for understanding the melancholic condition, returns here once again, and not simply in the form of whether this embracing a machine-like identity, which is so eagerly done by schizophrenics, is not already a normative *judgment* we bring upon schizophrenic individuals on the basis of values specific to non-schizophrenics.

Machines possess unfailing predictability, while the manifestations of human identity require the tracking of commonalities across a bewildering variety. Thus, one of the most prominent problems for a schizophrenic person's participation in a world

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<sup>7</sup> The complex changes of schizophrenic delusional content depending historical and cultural context has yet to receive the attention it deserves in theories of delusion-formation. Delusions, of course, matter not in terms of their content, but in so far that they demonstrate a transformation of subjective experience; nevertheless a history of the changing symptoms of schizophrenia, as well as the ever-shifting prominent themes would support a lengthy treatment on their own. Machine-delusions, however, seem to be an exception to this rule. They were reported as early as 1914: Josef Berze noted then the tendency among his schizophrenic patients to describe themselves as "automatons or instruments" – in the context of a hardly industrialized country and before the First World War (Berze: 1914). In Vienna, machine-delusions were so widespread that Viktor Tausk dedicated a psychoanalytic study to the so-called "influencing-machine delusions", challenging Freud specifically on the strength of the machine-imagery and pursuing the first specifically body-oriented treatment of delusional thinking, which, at points, explicitly directed against some of Freud's findings in the Schreber case (Tausk: 1919). In the 21<sup>st</sup> century, psychiatrists continue to report machine-like delusions, contemporary patients however have incorporated the imagery of digital technology, with scanners, plotters and cameras taking precedence over the more mechanical constructions favored by earlier schizophrenic individuals. For detailed discussions of machine-like experiencing, see for example Stranghellini (2004) and Fuchs (2005a). For a reading of Doctor Schreber's "metric nerve-language" that utilizes machine-language from digital technology to explore the speech pathologies of Schreber's *Memoirs*, see Langan (2003).

populated by others is a heteronomic vulnerability (Stanghellini: 2004). They are extraordinarily cautious about becoming attuned with the identity construct of those who surround them. As the following accounts from schizophrenic persons indicate, they tend to distance themselves from understanding the feelings and thoughts of others as much as they distance themselves from their own:

Diving into my mother's head scares me, because I'm afraid I'll get lost.

Interpersonal mental bonds are total death for me.

I'm afraid to get trapped in their way of thinking. (Stanghellini: 2004)

Experiencing others as overwhelming, and continually threatening with the possibility of reaching them through their influence, schizophrenic persons are known for their antagonomia: their striving against or aversion to rules. In contrast to melancholic individuals, they consider common beliefs and acquiescing to the expectations of others as a threat to their autonomy. The following are quotes from schizophrenic persons that should form a representative sample of their attitude to what is respectable in society or has the seal of approval of an overlapping consensus:

I reject my tendency towards identifying myself with what others say.

Interpersonal bonds have no reason to exist.

What I detest more than anything else is being persuaded by others.

My aversion to common sense is stronger than my instinct to survive.

These quotes were again taken from Giovanni Stanghellini's collection of his patient's testimonies (Stanghellini: 2004).

The above, however, is only one side of the schizophrenic person's ability to observe commonly recognized rules of the intersubjective sphere. Perhaps their aversion to social

rules stems from the fact that it is extraordinarily difficult for schizophrenic individuals to attune themselves to others. This becomes especially apparent in the case of implicit “rules” of sociality – such as our automatic reactions to bodily gestures, or the hard-to-articulate rules of courteousness. The following are statements indicating the almost compulsive search performed by schizophrenic persons for supposedly abstract rules by which these human interactions are governed and from which they think themselves excluded:

As a little girl I used to watch my cousins to see when was the right moment to laugh, or to see how they were able to act without having to think it all through first.

The others know the rules; I have to study them.

I lack the backbone of rules of social life. I’ve spent whole afternoons at parks observing how others interact with each other.

I’d like to graft a file of discourses onto my memory which I could pull up at the right time.

Reality is too complex, I can’t find the key rules.

I feel inadequate and it’s such a pain – I have come up with algorithms to go and talk with some guy. ...

People have a system; I’m trying to understand it. But then I end up not understanding anything. (Stanghellini: 2004).

Incapable of engaging with the autonomy signified by another person’s lived body, schizophrenic persons find it especially difficult to take their cues automatically from the bodily comportment of others. The search for the abstract rules so evident in the above statements is to make up for this bodily ability to interact with others. The schizophrenic person’s tendency is to exhibit an overarching concern for “cracking the code,” to render non-propositional forms of knowledge explicit and to posit universal laws of behavior even

when the clue to reacting to others is situation-based. In view of the fact that they are left as outsiders – spectators, preferably, or panicked participants, if put on the spot – to the unfolding of a social interaction, it is no wonder that they identify themselves with machines that record manifestations of human spontaneity as something alien and foreign.

What is determined in the terms above is the social self of schizophrenic persons. We must keep in mind, however, that such a concept is extraordinarily problematic to apply to schizophrenic individuals. “I feel cool and I feel like a nothing at the same time, because I don’t have any rules, and so I don’t hang on to them,” a schizophrenic person says about his aversion to social norms. The antagonomia of this person is not an expression of one’s identity emerging in defiance of the norms that apply to the masses; to the contrary, this person protests rules because he himself is incapable of recognizing them. The person in the quote does not live by rules because he does not have any – and he points at a bodily feeling of “being nothing” while in the company of others as the cause of this failing. In turn, his lack of identity – the emptiness that takes up the place of his social identity, the sense of “being nothing” – he connects to being cool and disinterested, presumably toward others.

In the therapeutic setting, it is well known how difficult it is to lead a schizophrenic person out of this state of emotional withdrawal. Once a therapist establishes personal contact with a schizophrenic patient, however, the personal bond is often stronger than expected. What turns out to be the case is that schizophrenic persons are in fact overly prone to identification with others (what analysts typically designate as a difficulty of self-object differentiation). The “identity” that the schizophrenic patient identifies with, however, is hardly the flesh-and-blood other, but an early object relation projected upon

the therapist (and felt with intensity much than the transference experienced by melancholic individuals).

Above, I characterized the melancholic person as intolerant of ambiguity or complexity, for which he or she makes up by an enormous finesse in social adaptability. The situation is the reverse for schizophrenic persons: they are hyper-tolerant of semantic complexity and of ambiguity, though only at the cost of being unable to identify bare structures or ordering principles to which they adjust (bodily as well as socially) while interacting with others. This means that the schizophrenic person is averse to an identity derived from social categories – while being fully capable of alienating an objectified “self” from himself or herself that is recognized in the eyes of others. Once again, what is going to be most crucial for understanding the peculiarly schizophrenic way of finding distance from immanent self-experience is their attitude toward the unavoidable alienation that is part and parcel of every person’s identity formation.

Schizophrenic persons have an almost cavalier attitude toward what has been lost through this process of becoming an other to themselves: as we are going to see in later chapters, their body-image tends to be fluid and discontinuous, continually subject to change and open to incorporating others. The reason behind this is that they do not make a final break with the alienated features of their self-experience. They do not sever these alienated parts from the whole of experience, and as such they do not have to retreat to an ever-narrowing territory symbolizing both the self and the body. For melancholic persons, the experience of alienation becomes a catalyst for the progressive shrinking of their bodily and personal sphere – because their alienation, as we can easily imagine, is experienced as a “loss.” The schizophrenic tendency, on the other hand, is more likely to strike one as



counter-intuitive: to avoid the emotional turmoil of the experiences appropriated by the other person's hold on their own experience altogether.

Though reactions of these kind are frequently noted, the schizophrenic reaction is often misunderstood because it is not accessible by empathy in the same way that the melancholic person's alienation is. The schizophrenic modality of alienation, instead of culminating in despair over the loss, is seized upon instead as an opportunity for psychic reorganization. Instead of undergoing the emotional process of parting from a loss of what used to be "mine" in a deeply personal way – after all, what is at stake is the alienation of experiential dimensions of the self – the schizophrenic person's strategy is to "distribute" the loss: to devise and demarcate subcomponents to the self, and to rely on these for reassembling various momentary self-constructs. Though it is true that this distribution also results in the splitting of the self, what is more important is that the fact of the loss can also disappear in the crevices thereby created. The strategy is certain to result in shifts of "personality" – especially in the eyes of others. As a coping mechanism, however, it is deemed preferable to the melancholic mechanism for experiencing a sense of deprivation issuing from the body's alienated experience.

For this reason, the schizophrenic person does not appear to be concerned with forging a consistent relationship between an objectified self-experience and the immanent experience of the body, or between a "self that I am" and a "self I present for others." In his or her interactions with others, there is little if any concern shown for presenting these two facets of one's personal identity as unified. Melancholic persons are extremely mindful of hiding this inner duality from view. Perfection, they believe, is demonstrated by offering to others a crystallized self that does not offer an opportunity to be confounded by

ambivalence or ambiguity. As such, it is typical for melancholic persons to engage in considerable effort to hide from view seams that might betray the precariousness of the transcendence by which one's identity is constructed. In contrast, schizophrenic individuals are usually oblivious to appearing not only "imperfect" in the above sense, but outright bewildering to others. They would much rather shroud their "true" self in mystery: it is as if the more mysterious they appear to others, the more satisfied they are with the interpersonal experience. Why they prefer this mode of presenting themselves to others is not a mystery, however. As Laing managed to show (1959), the "true self" of schizophrenics is hidden even from their own view, so the mysterious personality they prefer to emulate is by no means a dishonest performance: it is in fact an effort to present to others what the schizophrenic person considers to be his or her authentic self.

It would be fair to say that, unlike melancholic persons, schizophrenic individuals do not think of their identity as a symbol that represents an "I" for others, but rather as a country might think of its colony or a company of its affiliate. Their selves can reorganize themselves: with the help of these "subdivisions," they can withstand the losses which would otherwise prove debilitating to a whole incapable of such inner differentiation. Thus the duality of indifference and extreme concern in relation to this construct: on the one hand, they cannot experience a debilitating loss to "themselves" (except when this alienated property comes under the ownership of another, i.e. when they experience an interference with their independence). Behind these contrary tendencies is the schizophrenic person's unique ability to divorce essential aspects of himself – including the lived experience of his body, in which this chapter is interested first and foremost – and yet to maintain thinking about his reified thoughts, his objectified body, and his identity. It is

for this reason that they can both engage with a lived experience of their body and yet do so as a disembodied self; it is due to these propensities that they can treat these constructs as easily alienable yet capable of submitting to reflection.

Thus, while we might understand or present for ourselves these phenomena as a loss – “loss of affectivity,” “loss of a stable identity,” or “loss of natural self-evidence,” to quote only a few of the terms commonly used to describe the schizophrenic experience – the schizophrenic person experiences different psychic events in relation to his or her sense of alienation. This is important to keep in mind when characterizing their experience as a state of “corporealization,” to use Fuchs’ term, or as a state produced by the self-reflective explication of the implicit dimensions of the lived body. Wolfgang Blankenburg, who coined the term “loss of natural self-evidence” for the core disturbance in schizophrenia, was able to demonstrate alterations in the passive syntheses of self-experience and prove a systematic, global disordering of self-consciousness due to the “pathological explication of the implicit” characteristic of the schizophrenic state (Blankenburg: 1971). Yet again, in making communicable for others what for most persons is an intimate experience, the schizophrenic person casts his or her lived experience at a distance uncharacteristically wide in the constitution of the non-schizophrenic body’s experience. Without worrying about the loss, the schizophrenic person takes a reflective stance to it in a way that he or she is able to objectify it without ever ceasing to remain inextricably connected to its experience.

## **2.5: The Schizophrenic Body**

The schizophrenic state of disembodiment, the alienation from the smoothly functioning pre-reflective body, and the objectification of the body's lived experience do not have to be a sign of an identity foregone or denied from oneself therefore. To the contrary, all this might be a paradoxical way of relating self and world without reliance on a stable notion of identity. Both psychoanalytic theories and definitions of schizophrenia that stress the disordering of pre-reflective selfhood undergone by those suffering from this illness would concur on this point. What remains to be seen are the essential characteristics of embodiment as a schizophrenic subjectivity. Of these, I will mention three, relying on the contrast with the melancholic body, which, as we can now see, stops short of the kind of disordering we witness in the schizophrenic body.

First, while both the melancholic body's "corporealization" and the schizophrenic self's "disembodiment" refer to the objectification of one's own bodily experience, the melancholic person makes his or her body an object for others, while the schizophrenic person objectifies it as a property of his or her own. The melancholic person's objectification of his lived experiences is offset by the goal he seeks to attain for his identity construct vis-à-vis others. In contrast, the schizophrenic person's disembodiment is due to the relatively low significance, from the schizophrenic perspective at least, of forging an identity for others. The schizophrenic body undergoes objectification and is presented in imaginary forms not for others, but because such fantasies play a vital role in the psychic life of the schizophrenic person herself.

The paradox here, simply stated, is that a schizophrenic person undergoes his bodily experiences as a disembodied "I." A wide range of clinical features testifies to the ability of

schizophrenic patients to implicitly admit of a bodily sensation which, in the closer approximation of an explicit and reflective rendering of their self-experiences, they disown and dispossess. From derealization experiences through the depersonalization of subjective experiences all the way to the attribution of thoughts to other persons, as is characteristic for example of delusions of alien control, the list of such phenomena can be overwhelming. Studying this range of phenomena, we would be able to explore the bodily origins of even the most rigidly established delusions in the acute states of schizophrenia.

As I will remark relatively little on this possible faucet of the schizophrenic body's philosophical treatment in what follows, I will present examples of this type of evidence of disembodiment here. The disembodied condition of schizophrenia is manifest, directly, in a patient's conceptualization of his body as a wall ("[t]here is something between me and the things and persons around me, something like a wall of glass between me and everything else") and indirectly in depersonalization experiences ("[f]eelings are not felt by me, things are not seen by me, only by my eyes" - (Spitzer: 1988) ). The separation of body and experience is expressed more explicitly in a remark by one of Louis Sass' patients who noted, upon emerging from a quasi-catatonic state that "I feel like a man in a cartoon. My thoughts and actions are outside of my body, as if in a bubble" (Sass: 1992). It is not uncommon to observe a similar disowning not only of thoughts and actions, but of emotions as well, in delusional as well as non-delusional schizophrenics. Being affected is described as a mechanical process in which the body passively undergoes the active pressing and pulling of outside forces. One patient, for example,

often felt a pressure on her tear glands; she then had to cry without being aware of a motive, and it felt as if she were made sad. ... Similarly, normal sensations of sexual desire, hunger, or other visceral and muscular sensations may lose their contextual meaning and come

to be explicitly experienced as *cenesthesias*, strange, unpleasant and object-like states of tension, movement, pulling, pressure or electric flow, which more and more appear to be caused by an outside source manipulating the patient's body (Fuchs: 2005a).

Secondly, while the melancholic body was characterized by the body's becoming weighty and bearing down, as well as clamping, restricting and immobilizing a person, the schizophrenic body, while objectified, is continually vulnerable to change. For this reason, the so-called "morbid objectification" observed in schizophrenic persons should be thought of as the explication of the body's otherwise implicit experience, in contrast to the melancholic body's sense of having become inanimate, stationary and oppressive.

This overall sensation is featured saliently in the testimony of another schizophrenic person, who connects his body's lightness and emptiness to his inability to feel emotions, while he describes normality in terms of a fullness that is first and foremost a bodily weight that keeps him in touch with reality:

[a] while back, I thought I could walk through walls. That made me realize that in order to stay attached to reality, I need emotions. If you don't have emotions you can change reality in any way you like. Sometimes all this spontaneity makes me feel empty. But sometimes, when I forced myself to make reality seem normal I would feel as if things were complete. ... The problem is that the ground holding you up can't be any bigger than the feet standing on them (Stanghellini: 2004).

The specific formulation in which one's relationship to reality is expressed in this train of thought is striking. Quite contrary to psychiatric thinking about a psychotic person's break with reality, reality here is posited as a ground to which a body without emotions and a body so spontaneous that it is in effect empty of content struggle to stay attached.

Thomas Fuchs emphasizes the failure of the lived body to serve in the function of a medium to the world under both of these conditions. In the case of schizophrenia, however, the diminishment of self-affection is due to an entirely different disturbance to this important function of the lived body. The melancholic body becomes too static to serve in this capacity: it has abandoned a sense of animation that it would receive from the ability to smoothly traverse between the egocentric and the excentric poles of bodily self-awareness. The schizophrenic body fails to act in the capacity of transparency because it is too volatile or unstable to maintain the mediation between self and world – because, though it is in many respects the most ideal in-between of a corporeal yet lived entity, it is nevertheless too prone to absorb the change that it embodies as the boundary between self and world. These ideas are going to be revisited in considerable extent in the chapters that follow.

Thirdly, the melancholic body had already revealed the complex relationship between *Leib* and *Körper*. This pairing of two rather complexly related terms, however, becomes especially convoluted when applied to the schizophrenic body. As we are going to find in the final (fourth) chapter, dedicated to the examination of the schizophrenic body, we can trace felt modulations of the schizophrenic body's substance and positionality in space under the schizophrenic condition – and find an account of regions of the lived body which remain inaccessible to the lived experience of a body for which *Leib* and *Körper* remain a neatly ordered dichotomy. Neither *Körper* discovered as *Leib*, nor *Leib* submitted to analysis as *Leib*, what is discovered in this analysis is the logic of the lived body as a new kind of unity of apprehension: one entirely distinct from any object of the material world due to its unique kind of substance, spatiality, and extension.

## **2.6: The Melancholic and the Schizophrenic Orders of Bodily Alienation**

To sum up, melancholic alienation is not only a qualitatively and experientially different state of alienation from the alienation characteristic of schizophrenia. It does not simply result in different alterations of self-experience and of the experience of the world. My aim has been to demonstrate something more consequential than these conclusions. These two distinct states constitute two different orders of alienation.<sup>8</sup> Both of these states are paradoxical, but it is only upon resolving the paradox of melancholic alienation, and only if we are willing to build another paradox upon this already vexing dual impossibility, that we can resolve the paradox pertaining to the schizophrenic body.

In melancholia, given the “disordering” of the body, the same change radiated both to the outside and to the inside. The self and the world have undergone the same kind of disorganizing: there is a narrowing down to the world’s design and an implosion in the world’s space which, as it comes to confine the self more and more, encircles the self more and more oppressively. The sense of alienation is due to a “disorder” of the body. It is not a disorder in the sense of a disease or of malfunction: the body continues to function, though now with highly detrimental results, as a transparency or opening onto the world. Nevertheless there is a disorder, or disorganization to this body. Perhaps we should say that a disorganization radiates from the body’s mediating between self and the world.

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<sup>8</sup> Though I did not discuss various states of dissociation, and especially those undergone due to traumas, since discussing the melancholic person’s bodily alienation already required a lengthy detour from the schizophrenic body, one should say that the reversible dissociative states should be understood as constituting the first order of this complexity. I do not mean to suggest, however, that there is a psychogenetic link between reversible traumas, melancholia and schizophrenia. My ordering of these is merely an analytic attempt to penetrate into the complex tensions held together by those experiencing these states.



The severing that causes the bodily sense of alienation in melancholia is between self and the world. Paradoxically, it is due to the body's continued mediation between self and the world that this severing occurs. The alienation characteristic of schizophrenia builds upon this paradox, distributes its two poles even further, and takes us to a paradox of a higher order. There are several indications of this departure of the schizophrenic body from the melancholic condition. According to the clinical evidence, it is not unusual for schizophrenic persons to experience a melancholic body in the form of the immobility, the pervasive sense of being corpse-like, and being limited "within" and cut off from the "outside" of melancholic bodily alienation.<sup>9</sup> But in the schizophrenic's bodily sensations that I am about to examine in the next chapter, we must be prepared to forego the parallel between self and body upon which our analysis tacitly relied. The disorders of the body image I am about to describe in the next chapter are not to be taken as merely an indirect way of expressing the selfhood of schizophrenia. These "disorderings" bring to the fore increasingly differentiated aspects of embodiment and subjectivity that form a severed unity -- yet, paradoxically, still a unity of some sort. Tracing amplifications of the inner

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<sup>9</sup> I would stipulate that the continuity may proceed in the other direction as well. William Styron, whose haunting description of melancholia recreates for us so strikingly the bodily sensations of clinical depression – and whose symptoms steer safely clear of the schizophrenia spectrum – reports having found himself engaged in hyper-reflexivity. What is more, in its incipient stages, schizophrenia often "presents" as clinical depression.

"A phenomenon that a number of people have noted while in deep depression is the sense of being accompanied by the second self – a wraithlike observer who, not sharing the dementia of his double, is able to watch with dispassionate curiosity as his companion struggles," wrote Styron about his preparations to arrange for his own suicide (Styron: 1992). He casts his hyper-reflexive self-awareness as the duality of two observers: one caught up in "the dementia" and another watching disinterestedly (though it is more likely that his melancholic self was caught up in his own sensations of despair, while the "observing self" remained coldly disinterested because it brought an alienating reflective perspective to the overwhelming experience). The initial presentation of schizophrenia in the clinical setting is often described as the "specific nonspecificity" of incipient schizophrenia: before the onset of the psychosis, neither the patient nor the clinician is able to identify specific symptoms other than non-specific and trivial complaints (Blankenburg: 1971). On superficial observation, these generic complaints (fatigue, avoidance of the social sphere, perplexity) are easily miscategorized.

contradictions that animate our lives in this paradoxical unity, as we are to do in the next two chapters, will allow us to return in our reflections to the nature of selfhood, schizophrenic and non-schizophrenic, with novel findings.

## Chapter 3

### **Schizophrenic Body Image Disorders**

Persons diagnosed with schizophrenia think their bodies changed or distorted in ways that are intriguing yet unique to each individual. The result is a range of experiences considerably varied and almost defiant of systematic characterization, which psychiatrists often frame by organizational principles devised in a rather ad-hoc manner. My aim in the following chapter is two-fold. Firstly, I identify what I contend are the four basic types of alteration in the body image of schizophrenic persons (including patients in acute stages of a psychotic break). Secondly and in tandem with this project, I provide a methodological justification of the conceptual framework I hereby develop for these clinical phenomena. After describing each of the four basic categories, I present the first of them in greater detail to probe into the logic by which these altered body constructs are produced. One of my theoretical goals is to distinguish alterations of the body image from alterations of the body schema, and to arrive at a theoretical appraisal of convergences (as well as divergences) in the way in which these two levels of the subjective experience of one's own body function in schizophrenic experiences.

#### **3.1: The Psychiatric Literature on Schizophrenic Body Images**

Not only is the material available for understanding the way in which schizophrenic persons typically perceive and conceptualize their own bodies complex, but, perhaps more importantly, the evidence upon which such studies are based often appears to be

contradictory. The following are merely a few examples drawn to illustrate the overall problem of how such variety in the clinical phenomena complicates the task of sorting, organizing and categorizing this material.

D. H. Bennett (1956) describes as many as fourteen different types of changes in the body image of schizophrenic patients, dividing his cases solely on the basis of “where” the body image distortion takes place. His method yields categories like the “distortions of the perceived body,” “changes in feelings concerning the position of the body in space,” “a generalized change in the appearance of the world,” etc.; yet nothing specific about the processes at work in these changes. Lukianowicz (1967) names only four categories – “disturbances of shape, size, mass and spatial position” – and in this way he seems to be able to devise precisely the solution that the abundant richness of his subject matter demands. Yet the initial elegance of his system comes to be compromised as soon as he proceeds to instate sub-categories within his categories. In fact, before long, the overlaps and patterns of repetition from one category to another start to take the shape either of a matrix, or, more likely, of the very chaos that his classification set out to forestall. In both of these cases, the authors rely on specific examples to demonstrate the purported meaning of the categories; these, rather than a systematic treatment, take the place of a theoretical exposition of the phenomena in question.

Lukianowicz, however, is correct to note the need for subdivisions, especially in so far as contradictions, or divergent tendencies in the alterations reported make distinctions within categories necessary. For example, the schizophrenic person might experience his or her body parts as elongated or shrunk, or the number of body parts he or she experiences may increase or decrease in these distorted body images, etc. But if

researchers are to understand this perplexingly contradictory nature of the impact schizophrenic self-disturbances might have on one's experience of his or her body, a theoretical framework – preferably one adequately informed about the body's role in embodied consciousness – is of crucial importance. What is more, the divisions for ordering the apparent chaos inherent in the material studied must be devised systematically: choices of what distinctions must be subsumed under the same categorical heading must be made separately from choices regarding the categories that capture the alterations to which the schizophrenic body's change is susceptible in general.

From the standpoint of such a philosophically informed conceptual framework, the quantifiable changes to the anatomical body – whether it was the shape, the size, the mass or the spatial position that became the subject of unrealistic ideation, on what body parts were impacted in this way, or on whether the schizophrenic person hallucinated more or, to the contrary, fewer body parts than he actually has – are hardly the most important aspects of the changed perceptions schizophrenics report with regards to their own bodies. To remain with Lukianowicz's example, he offers no justification for prioritizing disturbances of the shape, the size, the mass, and the spatial position of the body image. All four of these categories are attributes of the scientific body – a supposedly objective body that the natural sciences commonly take for granted. As such, the emphasis on these four specific aspects of the body image remains on the objective body's physical appearance. There is an unreflective assumption here that the subjective and the third-person experiences of one's own body are interchangeable: my head has become elongated (or shrunk), a schizophrenic person might complain, which in this research framework would be taken as his or her testimony about what his or her body might appear to others. Not

only is it assumed that the subjective experience driving this change has a one-to-one correspondence to the person's assessment of his or her body's appearance to others, there is a total disregard for the significance of the schizophrenic person's subjective experience and of processes factoring into its testimony with regards to the appearance of one's own body.

These type of surveys, though they are superbly informative about the particular details of the experiences to which schizophrenic persons become vulnerable during their psychosis, nevertheless fail to illuminate the question I am pursuing here, which is about identifying the region of experience impacted by these changes and about specifying the nature of the body image "distortions" undergone by schizophrenic persons. To attain these goals, not only does one need to be theoretically-driven in one's approach and choice of categories, but – precisely because the alterations to the schizophrenic body image display such a large variety – one must aim at a categorical framework that organizes this bewildering variety under a few headings only. One cautionary tale may involve the methodology employed by McGilchrist and Cutting (1995), who, having reviewed 550 cases of psychotic body image disturbances, come up with thirty-one categories. They write that they arrived at this number by generating, independently, two lists of possible organizational categories each of the authors was able to recognize in the survey material. Forty categories were named in this way, of which thirty-one overlapped (a fact that McGilchrist and Cutting consider to be adequate to act as validating for their choices). Later McGilchrist and Cutting impose a two-fold division on their thirty-one categories, dividing them into "cognitive" (inferred) and "perceptual" delusions – which may or may not correspond to the distinction between the subjective and the objective experience, but

which at any rate contribute more toward obfuscating the analysis than to making its topic matter more meaningful.

The obvious objection to the conclusion that exactly thirty-one categories capture the alterations of the body image in schizophrenia is whether there are any guarantees that the proper number is not thirty-two, or perhaps sixty-two. In Koide and Tamaoka's research, the body image is apportioned into fifty-nine "body referring items" in a diagnostic tool designed for detecting alterations to the body image of schizophrenics who were administered daily doses of neuroleptic medication (Koide and Tamaoka: 2006). Each of these "body referring items" are self-assessed symptoms elicited from the patient during a psychiatric interview. Koide and Tamaoka then divide these fifty-nine items into "deviations" in the "functional," the "anatomical" or the "psychological" body image (these notions seem to correspond to distinctions between whether the body image distortion is experienced in the body's functioning, in its anatomical conceptualization or due to psychological reasons).<sup>10</sup> This list of fifty-nine items allowed identification of "body referring items" with regard to which schizophrenic persons tend to testify more reliably than individuals suffering from other psychotic diagnoses.

Not surprisingly, the study shows that the distortions are not the side-effects of the neuroleptic medication, but symptoms of the schizophrenic psychosis left untreated by the medication. At the same time, "the visual or the spatial component," as examined in questions about the anatomical body, is intact in patients regularly taking anti-psychotic

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<sup>10</sup> For the purposes of evaluating the effect of neuroleptic medication on these symptoms, only the "functional body image" (one's appraisal of the body in action) and the "anatomical body image" (the perceived body) are considered significant, as they only target frontal-medial dysfunction, i.e. impairment of memory, attention and executive function. Alterations of the "psychological body image" (a person's subjective appreciation or assessment of his or her body) do not show improvement in response to medication; and neither can they be designed for the purpose.

medication. The body image “deviations” Koide and Tamaoka identified as statistically significant in their research sample of 93 schizophrenic patient, compared to 177 control subjects, are dullness in movement, powerlessness, unusually strong digestive function, lifelessness and fragility. In the end, therefore, minute details are shown to be significantly altered in the schizophrenic person’s bodily experience, but these details fail to cohere into a characterization of an overall body state (if there is a body state to be composed on the basis of these items at all).

A “systematic categorization” of this material is called for by almost every one of the authors who have dedicated considerable effort to this complex problem. Arbitrary lists of categories that do not assign proper significance to those aspects of these changes that are truly worthy of prioritizing can, however, hardly serve this purpose however. From the philosophical standpoint, the most important aspect of these changed perceptions is not the quantifiable change of the anatomical body (in what measure were parts of the body impacted, or did the change bring about a “feeling” of more or less body parts, mass, etc.). In what follows, I am going to show that a theoretically informed systematic presentation of the disturbances of the body image in schizophrenia yields four types of processes that generate four distinct types of impact on the perceived body of an individual during psychotic episodes. These, rather than what immediately strikes the observer as “bizarre,” or what the patient directly emphasizes in his or her descriptions, should guide the future design of empirical studies on the schizophrenic body.



### **3.2: Categories: The Logic of Schizophrenic Body Image Distortions**

In contrast with the considerable disorganization of works surveying the variety of alterations seen in schizophrenic body images without reliance on applicable philosophical concepts, what I introduce in this chapter is a considerably simpler organizational schema: a four-fold organization of the material I introduced above. What I would like to establish in the next chapter is that all in all there are only four types of changes that the schizophrenic body image may undergo.

The first of these, the category of “fractured” bodies includes complaints of scattered, dispersed, discontinuous, partitioned and otherwise mutilated or broken body images. A manifold of self- and bodily-related sensations and experiences finds a stable unity through the body image in non-schizophrenic persons. It is the very unity of the body image that is destroyed in this way in schizophrenia. Yet, as I will show, various groupings of this manifold might emerge on the ruins of the fracturing, reappearing in forms of organization that are thoroughly unfamiliar to most of us. The second category comprises “flowing” body images. Our bodies act as a boundary between the unified self and what the medical sciences might prefer to call “external reality,” separating as well as actively bringing them together. In schizophrenic body image disorders of the flowing kind, the body of the schizophrenic person is too disorganized to perform this function. The borderline between the self and its surrounding world therefore is posited in a manner entirely arbitrary, in extreme cases disappearing altogether. In these cases, the body schema truly exhibits a continuum between the interiority and the exteriority of the psychic organism. As a result, contrary to what we find in the first category, where the body image of the schizophrenic person abandons its unity, in the second category, rather than

being dispensed with, this same sense of the body's unity is so strong that it tends to reach over into the environment surrounding the self. In the case of the third category of "proliferating" bodies, the body falls apart, but rather than losing its unity through fracturing, it posits multiple body parts for itself, or, as may be the case on rare occasions, multiple full bodies. Finally the fourth category is comprised of what I call "collapsed" bodies. These examples are noteworthy because, instead of multiplying, they are reduced: they are explicitly two-dimensional, and often they come to be lived as a mere surface or skin around the body, rather than as an entity extended in three dimensions.

I contend that there are four ways in which the body image of a person is vulnerable to disordering under a schizophrenic psychosis (or in stages leading to a schizophrenic psychosis). These four processes – the body image's shattering into pieces, its growing conjoined with others or the world, its multiplication and its disorganization along the surface-depth dichotomy – are the only four alterations that the body image may be subject to in the experience of schizophrenic individuals. Since what I am interested in is the overall alteration of the body image, not the actual variety in the specific examples, I suggest that we need to revise any impulse to expect any arbitrary "disordering" of the body image – such an attitude might be the most we might be willing to conclude facing such a chaotic collection of experiences, yet theoretically speaking, such concessions prevent scientific or humanistic understanding of the phenomena in question. Even in the greatest chaos of the most severely delusional and hallucinated cases there is a certain type of order or logic to be discerned. Thus the philosophical interest in engaging in the details of these body-image alterations: each of these four categories reveals a key process toward the changed perception of the body's external representation, and an unusual opportunity

to understand the lived experience of a bodily state which lacks unity at the level of conscious representation.

In other words, I distinguish between these four categories of schizophrenic body images not because these four body image “types” look different, or alter from the norm in certain specific ways, but because four different types of processes are to be discerned behind the distortion they “produce.” Instead of being concerned with the fracturing of the experience of one’s own body, I am more interested in what makes such a fracturing possible, and what are the regulative principles at work in this specific mode of finding one’s body construct disorganized. Ultimately, my interest is in developing a vocabulary for a kind of analysis that is instrumental for making intelligible for ourselves the specific bodily complaints of schizophrenic persons. A prerequisite of this, however, is to delineate these four types of body image disturbances that schizophrenic individuals report in the clinical literature, and to understand the coherence of the varieties brought together under each categorical heading. I am thus going to proceed first, to a general characterization of these four body image types. Following these sections, I am going to engage in the apparent “contradictions” that remain in the first of these categories, in phenomena that are different, and even contrary developments at first look, in the wide variety of body image alterations I call fractured body images.

As I already indicated above, one of the most difficult aspects of developing an analytic schema for schizophrenic body image distortions is to identify the significant differences that make up the multi-faceted character of a given material and to discern these from what are mere variations in the specific examples studied. The former of these merit our attention because they demand a proper conceptual framework, which, in turn,

might contribute to our understanding not only of the way in which the body image of schizophrenic individuals emerges from their subjective experience, but of the body image in general. The latter are also useful: they allow us to understand the major categories of the material better; in other words, they expose the processes by which these body image “distortions” are produced. In the last section of this chapter, I will engage in in-depth analysis of only one of these four categories: of the fractures body image type, the category which recurs with enough frequency and detail in the clinical literature to allow for phenomenological assessment of a particular schizophrenic bodily state.<sup>11</sup>

### **3.3: The Fractured Schizophrenic Body**

Fractured schizophrenic bodies emerge in delusions or sensations that the body has fallen apart, has become disjointed or dispersed in space. The condition is easy to typify if we only think about Lacan’s most basic understanding of the fragmented body image: a body image in which body parts do not yet cohere into a unitary form. If the idea that the psychotic body is typically fractured rings familiar, this is because of the wide-spread influence of Jacques Lacan’s theory regarding the psychoanalytic significance of the “fragmented” body (*corp morcelé*) in the psychoses. Lacan (1949) theorized a critical moment in the development of normal subjectivity: somewhere between the sixth to the

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<sup>11</sup> In this chapter, I begin engaging psychotic stages of the schizophrenic condition and developing a phenomenologically-inspired analysis for this condition as well as a methodology for doing so. The reason I am not going to make mention of prodromal experiences of alterations to the body image in this chapter is because patients in the initial stages of schizophrenia typically do not normally report experiencing these more severe alterations in their body construct. While the previous chapters discussed incipient as well as chronic stages of schizophrenia, often privileging evidence from the prodromal stage as opposed to the testimonies one takes from delusional patients, this chapter is going to focus on self-descriptions of patients in the more advanced stages of the psychosis. By doing so, however, I also cross beyond the limit of what, according to Jaspers (1911) are understandable features of schizophrenia. In other words, I am now on territory that, according to Jaspers, is beyond the reach of empathic understanding.

eighteenth months of his or her existence, the infant recognizes itself “jubilantly” in the mirror. Before this, limbs, lungs, bowels and a myriad of body pieces were felt only in so far as their organic significance propelled them temporarily into the baby’s center of attention. At the “mirror stage,” in the moment in which the infant recognizes his or her body unified through its image – through its unitary visual representation – this diffuse sensation is supplanted by an experience summarily signifiable through this image.<sup>12</sup>

It is also through this unified body representing a “me” – someone unique, singular and indivisible – that the self comes to attain spatial attributes and to differentiate between a within and a without. It is only in relation to a body image that the idea of what lies ‘within’ me (my emotions, my thoughts, my organs, my flesh, etc.) comes to make sense, and it is only by virtue of bodily experiences unified at the level of a signifier, i.e. by virtue of a body image, that I can distinguish between myself and another: the world, other subjectivities, the great mass of other things unified through their otherness from myself. According to Lacan, only with the mirror-stage unification of the body image is the infant prepared to successfully move on to further stages of psychical development.

Lacking a unified body image, delusions might come to merge with one’s perceptions, and the boundary between self and other will remain blurred. According to Lacan, these main features of psychosis can be lead back to the failure of the mirror stage: to the inability to construct a unified body image, a coherent signifier for a unified self. Lacan notes that in regressed states and in dreams one acquires access to imaginary

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<sup>12</sup> The key texts by Lacan available in English on the mirror stage and the schizophrenic body are *Seminar III: The Psychoses* (1955-56); its summary, *On a Question to Any Possible Treatment of Psychosis*, published separately in the *Ecrits*; *Seminar I: Freud’s Papers on Technique* (1953-54); a 1948 paper *Aggressiveness in Psychoanalysis* and a 1949 talk *The Mirror Stage as Formative of the I Function*. My account is also indebted to Alphonse De Waelhens’ thorough reconsideration of Lacan’s views as they apply specifically to schizophrenia (De Waelhens: 1972).

representations of the body that include “images of castration, emasculation, mutilation, dismemberment, dislocation, evisceration, devouring, and bursting open of the body” (Lacan: 1948). Lacan calls this a “fragmented body,” the form of embodiment of an ego regressed to the pre-mirror stages – in other words, the bizarre bodily delusions experienced under the psychoses.

Thus Lacan stipulated that psychotic individuals experienced what he called a fragmented body because they failed to anchor their phenomenal experience of the body in a unifying signifier.<sup>13</sup> There is no doubt that the most crucial question for analyzing the unusual body-image constructions of schizophrenic individuals is summarized in this important Lacanian tenet. The body image stands in for a multiplicity of inner sensations as their shared signifier. In his essay *The Child's Relations with Others* (1960) assessing Lacan's philosophy of the body, Maurice Merleau-Ponty describes this multiplicity as

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<sup>13</sup> Accordingly, those of Lacan's followers who did work with schizophrenics – Lacan's own experience relied more heavily on the symptoms of paranoia and the affective psychoses and were directed at analyzing hallucinated content rather than the experiential dimensions of these states – made great analytic use of the “corporeal signifier,” though in a manner somewhat unexpected on the basis of the above theoretical formulation of the same point. P. Aulagnier-Spairani in particular provided a detailed record of her analysis of a schizophrenic patient who was unable to envelop perceptions of an objectified body into sensations of a lived body – when it came to recognizing another person through this body: namely, the baby she was expecting. P. Aulagnier-Spairani interprets this as the patient's inability to construct an imaginary body for another person (for a summary of her work with schizophrenics, see Chapter 2 in De Waelhens: 1972). A typical example would be the patient's torment over her mother-in-law's insistence that she knit clothes for the baby she is expecting. The patient thought this an unfair demand, since it is not only impossible but absurd to knit clothes for a fetus. Aulagnier-Spairani points out that her patient is impossible to anticipate the body of her baby – she finds it difficult to move beyond the idea that what's growing inside of her is “a physical collection of muscles created from her substance.” On the one hand, without access to the corporeal signifier, the patient fails to insert her baby's body into the symbolic order, though Aulagnier-Spairani also points out that the baby's creation inside her body only reinforced the patient's sense of omnipotence (she believed herself to be the sole creator of the child). The patient was thus unable to invest in the child's body libidinally because she herself was unable to think of herself as a unified, bodily existing locus of personhood. Aulagnier-Spairani's work with schizophrenics is thus an interesting improvement on Lacan's theory. She seems to agree that the patient was unable to move beyond the immanent coenesthesia of a prespecular *moi*. This also prevented her from constructing an imaginary body of her own for herself, which made it impossible to relate empathically to others, i.e. to project an imaginary body for others as well. It did not prevent her, however, from using a signifier for the human body – for others as well as her own – which, lacking any basis in lived experience, represented it as a mechanical collection of tissues, muscles and bones.

comprised of at least three types of bodily sensations. The first of these, the interoceptive sensation of the child's body, is an image constructed of touch and inner sensations, including sensations related to digestion and breathing, as well as visceral perceptions and perceptions from 'within' the body. At the mirror stage, two other types of experience of the body, the proprioceptive and the exteroceptive bodies, are brought into alignment with this interoceptive image. The former is a body image acquired from perceptions attending to the movement of the body (to these belong the body's reach for objects as well as early experiences of the internalization of objects by the movement of the mouth), while the latter is acquired through the senses directed at the infant's environment, first and foremost through the visual image of the body. Not only are these three different sensations of bodiliness given through different senses, not only are they continually subject to change, and not only are they customarily overshadowed by the individual's attendance to objects of interest other than the body – things in the environment, ideas in the mind, worries about how their body is perceived by others rather than how it is perceived "from within" – but they must also come to be symbolized in exactly one construct: a bodily I, a unity in difference, a representation of selfhood for the outside.

Lacan himself vacillates between two metaphorical ways in which the task of unification is accomplished through the body image, speaking, on many occasions, firstly of the integration of previously "disjointed" body parts into a unitary body (Lacan: 1948; 1949), and, secondly, of the role of the body image as a container to a variety of bodily experiences 'contained' in the adult's reflexive experience (Lacan: 1975). That he called attention to these two types of fragmentation is perhaps already an indication that Lacan himself may have been aware that the body image of psychotic individuals is vulnerable to

not just one, but several different processes of disordering. Nevertheless, Lacan continued to describe psychotic bodies as if the entity in question was, for all purposes of analysis, a homogeneous one. This is one of the reasons why I reserve the term “fractured body” for the experience of dismemberment or dispersal in the schizophrenic body image. From now on, I shall refrain from using the term “fragmented body,” which, according to Lacan, is the generic characterization of the body of schizophrenic persons (and indeed of all psychotic individuals), and use the term “fractured bodies” for this sub-category of schizophrenic body images.

The fracturing of the body image in schizophrenia and its significance for psychotherapy are among the most frequently recognized phenomena in psychiatric practice – perhaps because it is the easiest to recognize even on the assumption that one’s bodily state is always a reflection of one’s psychic state. (If this latter is the case, it also explains the comparatively lesser known body image alterations I am about to describe below: reliance on the self/body analogy in this case puts an end to any investigation). But to remain with the examples frequently noted by the psychiatry textbooks: in his handbook for the psychiatric treatment of the schizophrenia spectrum, Arieti (1974) notes that body parts singled out by a sensation of dislocation are likely to carry psychoanalytic significance, and are even indicators of the success of therapeutic intervention:

As a rule, delusions about sexual organs and functions are accessible to psychotherapy with good results, because they lead easily to analysis of many problems. On the other hand, I have found that delusions concerning brain, face, and nose are very resistant to any type of therapy. The patient seems to have focused all of his concern on that part of the body and clings tenaciously to his belief.



The dislocation of body parts, however, is produced by a more global disorganization of the body's primordial unity. It would be overly simplistic to interpret them as referring to specific body parts, or to limit their occurrence to fractures of the body image explicitly recognized by schizophrenic patients.

Testimonies with reference to the fracturing of the body image *may* also express the self's sense of dispersal within space. In the more subtle examples, one can discern the body's fragmentation in the discontinuities, holes and gaps dividing up the body image. Sometimes holes, vacuums or missing joints among the body's parts are the only indications of the fragmentation of the body image; though it is not impossible to find testimonies of a total dispersal of all body parts in space: Mary Barnes, for example, speaks of her body as having exploded (Barnes: 1971). In a different state that nevertheless belongs in this category, a patient says of his body that it "doesn't seem to stay together" and that he feels "loose-jointed" or "falling apart": "the head and the neck do not connect" (Angyal: 1936). Another patient described sensing that "there is no connection between the upper and the lower part of the body." "The inside of the skull does not feel at all, it is like air," complains the first patient. Angyal notes that he treated several patients who complain about the perception of discontinuity in their body – often with resounding unanimity in the terminology used. The body image distortions I group together here as fractured schizophrenic bodies therefore are considerably more varied than what Lacan's notion of a fragmented body might suggest. I am to return to an analysis of this category in a later section of this chapter.

### **3.4: The Flowing Schizophrenic Body**

As if in stark opposition to the previous category, in flowing schizophrenic body image distortions we find, instead of disjointment, an extreme tendency to merge with one's surroundings; instead of discontinuities, an emphasis on continuity between self and the world; and instead of felt distinctions, sensations of steady and continuous change. The flowing schizophrenic body therefore is a body image in an ebb and flow of changes to its contour and to its volume, experienced as shrinking or becoming elongated, undergoing growth or suffering the disappearance of its part, as well as oscillating between these states.

Flowing schizophrenic bodily distortions are well-documented in psychiatric practice in the United States, because somatic delusions that involve the elongation of body parts are routinely checked for during the diagnostic interview. This type of change to the body image is in fact the only type of body-related delusion for which psychotic patients are checked during entrance interviews, at the psychiatrist's first encounter with any possibly schizophrenic patient (Kay: 1991).<sup>14</sup> Arieti, one of the most renowned practitioners in this tradition describes body image distortions in schizophrenia as if they all belonged to this category:

It is common clinical experience to treat schizophrenic patients who have distorted ideas about their own bodies. The face is the most common cause of complaint and preoccupation. [...] Some patients demand plastic surgery to change the look of their eyes, ears, nose, face, head, legs, breast and so on. They have the idea that their arms are shrunken, legs expanded, eyes dislocated (Arieti: 1974).

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<sup>14</sup> The initial diagnostic questions most commonly include: "*Has any part of your body been troubling you? (IF NO: How is your head? Your heart? Stomach? The rest of your body?)*" and "*Has your body changed in shape or size?*" (Kay: 1991). For obvious reasons, entrance interviews do not ask patients if their bodies had "exploded", "fallen apart" or "doubled".

Lukianowicz (1967), in an article attempting to classify the variety of somatic delusions experienced by psychotic patients, presents cases of zoophilic and sexual metamorphosis: patients with delusions of changing into animals or into the body of the other sex. He also details cases of bodily protrusions felt in patients who later speak of having grown additional body parts. This phenomenon can take place through doubling (patients who believe they have two heads, or two bodies, etc., either next to one another or within one another) or by visual and haptic hallucinations of additional elements to the body image. For example, a schizophrenic patient experiences a change in the size of his body: "When frustrated I sometimes feel that my body begins to grow very quickly, so that in no time I become six foot tall." Another patient's body expands by spreading to the territory of attachments to the body: "spurs growing out of my feet and ankles" (Lukianowicz: 1967).

Angyal also reports schizophrenic patients who complain that their "arms are creeping into the chest" or that their "head [is] sinking into the body" (Angyal: 1936). The same logic that applied to the growth of the body beyond its normal boundaries is at work in these examples as well. An undue insistence on the body's unity may result in the body's flowing over beyond its boundaries: in the elongation of body parts, or in the perceived distortions of the face that one notices when having "become" an animal, the body's sense of its parts belonging together is overarticulated (in stark contrast with the articulation of the *dissolution* of this unity in fractured schizophrenic bodies). Thus, in cases of feeling elongated, schizophrenics describe the expansion of the 'territory' they consider to be their own body with an almost stubborn insistence so as to mark the unity of their bodies; as if they willfully wanted to hold their bodies together, even with the help of such inexplicable

sensations. Yet they might also be able to achieve the same purpose through a different strategy. Perceiving the body as condensing - sinking into an ever denser bodily mass, which must of course imply the contraction of the body's contour – would similarly assure one of the strength of one's bodily unity. But the body's shrinking within its normal boundaries follows the same logic of flowing bodies.

The body image distortions that belong in the flowing body image category most commonly involve facial features and the extremities, which have been studied in terms of their phenomenological significance: the face as the localization of the gaze and the limbs as the quasi-localization of the non-spatial lived body (Fuchs: 2003).<sup>15</sup> Another category frequently enveloped by delusional structures are the sex organs – a fact which has lent credence to treating these delusions by psychoanalytic interpretation (Arieti: 1974). For example, a person suffering from chronic schizophrenia asserted that

... my voices often order me to do some dirty things... When I refuse, they begin to threaten me: 'Now we will punish him. We will blow his head up.' And they blow my head up, as if it were a balloon. I can feel the bones of my skull getting thinner and extending almost to the point of bursting. Then they stop ... and after a while my head begins to shrink to its normal size. This persecution leaves me with a bad headache for the rest of the day (Lukianowicz: 1967).

The close connection of these types of clinical phenomena to or possible basis in hypochondria is often noted (e.g. Szasz: 1957).

It is important to note that the flowing body image category does not need to be connected to a specific psychoanalytic interpretation (e.g. that the above patient's

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<sup>15</sup> An example would be a schizophrenic person in acute condition, who experienced hallucinations that his ears and nose were becoming very large before he was trying to fall asleep. The growth of these facial features were threatening that he "kicked himself out of sleep" several times before being able to rest. (Lukianowicz: 1967).

experiences at the genital phase are collapsed upon and symbolized as symptoms of a disorder of pre-narcissistic ego formation). From the perspective of clinical work, it is important to go beyond the general hypothesis that the body distortions indicate regression to earlier stages of ego-formation that need proper completion through psychotherapy. Rather, shrinking and elongation bring to the fore the fluidity of the contour of the body. The body image is free to expand or to withdraw into and from its surroundings; the boundary between the self contained within this bodily contour and the world that is disclosed through the body in these patients is under continued negotiation.

Perhaps even more important than the ebb and flow of the body image is a sense that the body is continually undergoing change. Accordingly, schizophrenics experiencing flowing bodies are not simply uncertain about the boundaries between self and world, they are uncertain about it because they experience it as an unstable construct, a border that may yield to further change at any moment. In extreme cases, schizophrenics may present with dysmorphophobia, i.e. the fear that the body is continually subject to change. This heightened sense of continuity over time - manifesting as if that the continuity inherent in their over-articulation of their body's unity could impact one's extension within space - often leaves the patient with ongoing terror about a future change in his or her appearance.<sup>16</sup> While it is not clear whether the fear produces distorted perceptions of the body or the distorted perceptions of the body give rise to the fear of the change, it is evident that flowing schizophrenic bodies, quite contrary to fractured schizophrenic

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<sup>16</sup> Although historically "dysmorphophobia" is used for a person's ongoing fear of being subject to inexplicable bodily changes, the term has undergone significant transformations over the decades. It has come to serve more and more frequently as a substitute for "dysmorphia" - the body or its parts perceived as misshapen - and since the inclusion of "body dysmorphic disorder" and "somatoform disorder" into the DSM - IV (1994), a diagnostic difficulty presents itself in identifying schizophrenic patients who suffer from these specific type of body image distortions (Koide and Tamaoka: 2006).

bodies, are characterized by undue emphasis, perhaps even hyperreflexivity, over the belonging together not only of body parts, but of distinct bodily states over time.

The dismemberment, fracturing or explosion of the fracturing of the body image finds a curious counter-part, if not opposite, in flowing bodies. Instead of the explicit violence to which the former testify and their deleterious impact as a fracturing or coming apart, we now observe an over-articulated continuity between various perceptions of the flowing body. These culminate in dysmorphophobic reactions: in the fear of becoming a subject of a terrifying change in one's appearance. In fractured schizophrenic bodies, what is normally continuous is perceived as distinct (the unity of the body is "carved up" into pieces), while in flowing schizophrenic bodies, what is normally distinct is posited onto a spectrum of ongoing change.

### **3.5: The Proliferating Schizophrenic Body**

The flowing body type demonstrated a schizophrenic ability to express variations in the body's sense in terms of the changing "territory" considered to be properly belonging to one's own body. This way of marking the body's unity, normally supplied by the singularity of the body image construct, was absent in the case of the fractured body: in the examples of the first category, the body's sense could not settle on any one organizational principle to locate the body as one unified object in immediate experience. In contrast, a flowing body is constituted by overstating what is missing – the unifying corporeal signifier – in the fractured body's experience. This type of "distorted" body image sometimes represents the body's unity in the form of a growing territory, though in other person's experience, the same is approximated by the body's shrinking. An over-articulated continuity (which is

likely borrowed from the temporal continuity of the experience of bodiliness) is spatialized in flowing bodies so as to present the body's image as if it were capable of adding additional realms to the body's dimensions, or as receding from the same.

In the third category of schizophrenic body image distortions, an even more inexplicable change to the perceived body comes to question not only the felt sensation of the unity, but its singularity as well. In proliferating schizophrenic bodies, one might recognize oneself in multiple bodies, or in bodies with parts attached in excess, as well as parts "grown." For bodies relegated to this category, the body's central position is no longer undermined simply by its dismemberment, or by the negotiation of the boundary that defines how far the body extends and at what point the world beyond the body begins. An even more foundational aspect of the body's central position in the world is in question in these cases: a centrality by virtue of the body's oneness, a central position which, when one perceives a multiplicity of bodies, is evidently non-operative in the body's perception.<sup>17</sup>

"I look at myself in the mirror, and it is not really me that I see. I don't have any definite image of myself, but many different ones, all of them horrible to me," reports a schizophrenic patient about her body (Arieti: 1974). The complaint that it is impossible to settle on just one image of one's body was voiced so frequently that a series of studies was devised for its examination in the 1960s. In an experiment from 1965 by De Martis and

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<sup>17</sup> It is important to note that the body's perception of itself in the form of proliferated bodies does not seem to impact its perceptual experience of the world itself. From a theoretical perspective, these cases force us to reconsider whether or in what manner the distortions of the body image in schizophrenia – and this category in particular – should be categorized as disorders of self-consciousness. Thus far, above, we accepted the suggestion found in Lacan's theory that the self that these experiences reference are not necessarily the self of self-consciousness: that the disorders we examine here are notably disorders of a psychogenetic phases of the body prior to the ascendance to subjecthood in the proper sense. There is no doubt that the fact that the proliferation only impact the body indicates that these experiences are self-referential – even if they reference not only one, but many "selves" when they proliferate in this manner.

Porta, patients were placed in front of the mirror and asked to describe themselves. Six of them did not recognize their mirror-image, while the majority saw more than three images.<sup>18</sup>

Clinical records of the multiplication of the entire body image, as featured in the following testimony, are relatively rare.

[M]any times when I was sitting and reading or watching TV I felt that my 'other self' got up, walked to the window and looked out, when my 'real self' was still sitting on the chair, like a shadow. Some other time I would feel that 'he' was the 'main me', looking through the window and seeing people and cars moving in the street. ... after a while I get so confused that I couldn't say which one of us is the 'real' me. I suppose that they both must be (Lukianowicz: 1967).

Autoscopic doubles like the one described by this patient are not mere Doppelgänger: in these cases, the presence of one or more additional body images is experienced not merely visually, but through more than one of the senses.<sup>19</sup> Both "selves" are acknowledged to be

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<sup>18</sup> Interestingly, De Martis and Porta's experiments originated in an attempt to explore what I refer to as "flowing bodies." What they obtained, instead, was more and more evidence of 'proliferating bodies'. The history of these experiments is in fact very instructive about the scientific rationale at work in reducing studies of lived bodies to an ad hoc examination of the anatomical body. In 1960, an experiment conducted by Weckowicz and Sommer found that when medical personnel placed schizophrenic patients in front of three-paneled mirrors, they underestimated the size of their various body parts, although the parts they were to underestimate could not be predicted. In 1961, however, Burton and Adkins found that, to the contrary, schizophrenic patients looking at themselves in the mirror overestimated their body parts (Burton and Adkins used a different technique in eliciting these estimations). De Martis and Porta's findings were to settle this anomaly of scientific testing. Instead, however, they were forced to settle for a supposed failure, as the questions structured for "measuring" the size of the perceived body of schizophrenics were answered by a rich compendium of their patients' comments on what they in fact saw in the mirror. Not recognizing that they happened upon groundbreaking evidence of what I call "proliferating" bodies, De Martis and Porta blamed their patients. They compensated for their own supposed failure in resolving a contradiction only they thought was crucial in the study of schizophrenic body images by postulating that perceptual and cognitive disorders must be responsible for the inconsistency of the findings, i.e. by positing cognitive weaknesses in schizophrenia as the cause behind the "misperceptions" of the body.

<sup>19</sup> A separate diagnostic category is reserved for hallucinations of one's own double, usually accompanied by the menacing threat of the preternatural vision. Persons with Capgras syndrome have a "feeling" of a well-known person's presence. These delusions however do not involve the multiplication of one's own body image, as in schizophrenia. Proliferating body image distortions have been reported however in cases of severe depression and during extraordinarily painful attacks of migraine (Lukianowicz: 1967).



the same as the “I,” and each of these selves can occupy its own specific place at a certain distance from the other’s. Besides projections of additional full body images, the multiplication of various body parts (e.g. patients complaining of having two heads, two right arms, etc.) has also been reported.<sup>20</sup>

Multiple and proliferating schizophrenic bodies suggest that the body does not simply break apart in the delusional state, but, most curiously and without a clear explanation, it actively reconstitutes itself as a collective of bodies. As Merleau-Ponty (1960) notes, such a state is by no means unfamiliar to an infant who has yet to learn to distinguish between the visual body image he or she sees in the mirror and his or her felt body. The initial identification of these two aspects of the body image at the mirror stage, Merleau-Ponty argues, requires a common basis: an equality of a specific sort between the body in the mirror and the body of the infant, one that extends to and includes the reality attributed by the infant to these two different manifestations of his or her body. In other words, the child’s identification with his or her self-image relies on an initial equivalence of the mirror image and the infant’s body, which is only possible if, prior to the integration of the visual body image with the felt body’s interoceptive representation, both bodies are invested with an attribute of quasi-reality. Only after the proper unification of the interoceptive and the exteroceptive body images does the infant have the insight that his or her body is real, while the mirror-image is merely a reflection. One might say that only after recognizing the difference of the body’s reality and the mirror image’s non-reality

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<sup>20</sup> One further variety of these cases are experiences of bodies within one’s body, or autoscopic doubles projected not into the space outside of that occupied by the body, but within. I contend that these experiences are also produced by a proliferating body image in which the unity of self, as marked by one’s unity of a body, is severely compromised. There is an additional feature of these experiences, however: the interpenetrability of one’s material body due to a disorganization of one’s representation of one’s body’s corporeality. I will take up this phenomenon in more detail in the next chapter.

(sometimes called its “virtuality”) can one view oneself excentrically, using Plessner’s terminology: by uniting an embodied central perspective of oneself to an image of the self visible to others. In proliferating schizophrenic images, we see a failure of this unity of excentricity: as long as the process of identification between body and body image is unresolved, more than one body images may come to be considered to be real - and, what is more, real in the sense of a spatially and materially existing body.

The ability to attribute reality to the central location at which the body is interoceptively felt, while withdrawing from previous investments of the body image that possess the same sense of reality takes place alongside the unification of the body image. Proliferating schizophrenic bodies thus bring to the fore the fact that the stark polarization of the physical body as real and its body-image as deficient in reality is a core function of the ego that comes into being in the course of the self’s narcissistic development. The failure of this distribution is probably one of the many functions of a unified bodily self, a function which, when disabled, may result in the perception of a manifold of body images. Proliferating schizophrenic bodies thus help us to understand the role of the narcissistic ego not only in centralizing the space around the human subject, or in guaranteeing object permanence by virtue of the correlation of the perceived unity of the ego with the perceived unity of objects in the intentional field. Maintaining an even more basic function of attributing reality to the material substratum of the self and of withdrawing the ascription of reality from objects constitutive of the ego’s dialectic of unification is also relegated to the narcissistic ego’s functions, but may be seen as disordered in the experience of schizophrenia.

### **3.6: The Collapsed Schizophrenic Body**

In order for the human body to be more than a mere physiological entity, the body's materiality must be transcended with the help of various tensions that provide implicit orientation for bodily action, including the body's positioning in space, its perceptual or proprioceptive explorations of the world and its habitual compartments. In general, the experience of collapsed bodies is lacking in the animation that such contrasts might provide. When these dichotomies, and especially dichotomies operative in the body's spatial orientation (such as up and down, left and right, etc.) are disturbed, the result is a "fractured" body. In collapsed bodies, there is a similar disturbance of a "deeper" structure of the body, specifically, of the sensation of depth and the distinction of spatially extended and therefore penetrable regions of the body from the flat surfaces that serve as the bounds of such depths. In essence, what is at issue in "collapsed" bodies is the contrast between surface and depth. The distortion of the body image thus develops alongside a misrepresentation of what is flat or paper-thin about one's body image and how the body's roundness factors into one's self-image. A sense of two-dimensionality may interfere with the body's conceptualization as an organism in which parts and organs are intricately enveloped within each other, or a sense of being edgy or delineated by discrete unities comes to replace experiences of the body's smoothness and continuity. These distinctions, just like the spatial correlates of the body, are also fundamental for the body's experience; when they collapse, they result in the failure to project the body as a material lived body.

The concrete manifestations of the collapsing of the body image vary. In general, one must be on the lookout for complaints that stress the two-dimensionality of the body. Metaphors likening oneself to thin material such as paper, cellophane or the skin give away

this type of disturbance to the body image; while in other cases, the collapse is seen by the reduction of the body's layers to its core, e.g. when a patient likens himself or herself to a stick figure or a skeleton. In the former group of cases, the surface of the body is identified as the whole body: in the latter, the inner core of the body comes to stand for the body's entirety. What is common nevertheless to all these symptoms is the disordering of depth and surface as a constitutive dichotomy for the body's three-dimensional reflective experience.

That the schizophrenic body is often identified with its surface is well-known since Freud's 1915 essay *The Unconscious* discussed schizophrenic patient unduly preoccupied with the pores of his skin condition. The skin is clearly a privileged "part" of the body for this person constantly devoted to the blackheads on his face and the "deep cavities" left behind when he got rid of them. But similar stories are frequent not only among schizophrenics but also in paranoiacs, who have been known to sense any number of creatures – worms, bugs, dirt particles, etc. – moving in the epidermis. In his essay, Freud was nevertheless more interested in delineating the transference neurosis from psychotic conditions, and as such he did not come to appreciate just how important the distinction between surface and bodily extension is for schizophrenics.

The attention schizophrenic persons pay to the surface of their body signals a favoring of the outside, of the visual perception of one's own body over a three-dimensional sense of this body. As an example, a patient in Angyal's study (1936) compares his body to a woolen suit; at other times he complains that he feels as if his body were wrapped in "cellophane or fluid glass or celluloid paper." We should wonder what he considers to be in the woolen suit – on other occasions he notes that he feels as if he were a mere skeleton for

clothes to hang on, and the metaphor of being a stick, a lamp-post or a skeleton recurs in other schizophrenic testimonies (e.g. Barnes: 1971). In other words, he can either identify his body with its surface, or, alternatively, with its skeletal structure; what is in between, a body of depth is excluded from these self-descriptions.

But Angyal's patient does not only collapses his body's surface and cancels any notion of depth to the lived body, but he also experiences the body thereby distorted as threatening, especially because it poses formidable constraints to his movement. As this patient described it, "[m]y body feels too short for me; my whole body feels like a woolen suit which was in the rain and became wet, then dried out and became short. When you move, it stretches, it binds." Being wrapped in this structure, the lived body's ability to open up an intentional field is itself limited. As we are soon to see, not only his body but the world he perceives surrounding him is going to have a particular tendency for stretching, folding and enveloping him in the same manner.

The theme of discontinuity reappears in some of these self-descriptions. However, any "gap" in the collapsed body image is not due to the fracturing of various parts or regions of the body, but to the lack of inner space between surface and core. Accordingly, the patient insists that there is "no inside of the body, but only a frame." Notably, dimensions of the lived body that are interoceptively felt are missing, while the representation of the body focuses on its exteroceptive modality. It is this focus on the visual appearance of the body – construed, most likely subsequent to a hyper-reflexive search, as three-dimensional objects that can nevertheless be represented in two-dimensions – that produce its "collapse." The patient likens his body to some kind of a wrapping – cellophane or paper – though the idea is not that his skin has anything to wrap

in it. There is “[n]othing is behind my chest,” the patient says. “I have no back. My chest touches the back of the chair” (Angyal: 1936).

Not only is the body of the patient collapsed, but, at times of fright or terror, the world surrounding his body falls flat and collapses into two-dimensionality as well. The patient describes an anxiety-provoking social situation: “[s]ometimes in the street-car it seems to me as if the people would sit on top of me, they are so near. I mean they sit at their places, but the car becomes small, is folded up like an accordion” (Angyal: 1936). To account for his sense that the presence of these people is felt as if they were sitting on top of him, the patient seems to reinterpret his felt experience of the space around him in the same way he did when he signaled his confusion about the two-dimensional feeling of his lived body. Prolonged confinement leads him to project a social space in which three-dimensional co-ordinates of his position and those of others surrounding him are mapped onto a two-dimensional plane, which is folded up so as to nullify the spatial distance among them.

Overall, the collapsed body of this person signals his inability to project his body into the world. It is important, however, not to think of this collapsing as a state of constancy – more typically, the collapsed state is an extreme. In fact, the patient himself can distinguish between various states of being more or less collapsed. “Sometimes I have a nice heavy backbone, a well filled body, but other times it feels like air,” he says for example. Being a “well-filled body,” a wholesome spatial projection of a self marks his well-being, as opposed to the kind of collapse that his metaphors of two-dimensionality (or airiness) describe. The metaphor of being an accordion seems to best codify for him what it feels to suffer the loss of the body’s dimensionality: “[t]he space between the chest and the

back is so short that you don't feel altogether human, but like an accordion" (Angyal: 1936). What should be an experience of the spatiality of the body is reduced to an experience of the continuous pressing and stretching on the bellows. Folded up, compressed and expanded to hit just exactly the right note, an accordion is like the body of this person: a body reduced to a two-dimensionality which, as a result, must be folded up, twisted and forced to take up the right position for registering spatial co-ordinates that a sufficiently projective three-dimensional body can experience without similar pain or effort.

Collapsed schizophrenic bodies are crucial to recognize, not only when designing a psychotherapy for reintegrating a schizophrenic person's sense of bodily and psychic unity, but for eliciting core distinctions animating the sense of lived bodiliness in healthy persons as well. In schizophrenia we can observe the collapse of important distinctions, distinctions that are posited so automatically in everyday experience that they go almost unnoticed. We find such core distinctions in the numerous examples of collapsed schizophrenic bodies. The collapse often impacts the distinction between bodily surface and the extensive, three-dimensional body. In the drawings of schizophrenics, we might in turn find the contrast between soft, smooth bodies and their edgy, almost too cruelly delimited representation. The perception of a flat, two-dimensional image instead of a body projected as a spatial object similarly highlights lacking dimensions of depth in the experience of the lived body. The explanations schizophrenic individuals offer about how this two-dimensional body may function in place of a non-psychotic person's three-dimensional lived body are far from "delusional": these testimonies struggle hard with the task of explicating a dimension of the lived body otherwise preverbal and inexplicable. Taken together, they open up a field of investigation of the lived body that is so implicit in experience that it may only be

accessed in its disordered modality, in examples such as the distorted body image construct in certain schizophrenics.

### **3.7: The Body Image in the Disorders of the Schizophrenic Body**

So far this chapter has focused on the differences among the fractured, the flowing, the proliferating and the collapsed body images and overlooked the important empirical fact that further varieties are subsumed under these headings. Therefore, to complete the project I am engaged in here – an initial presentation of what I consider to be the basic varieties of alterations undergone in the schizophrenic body’s experience – clarification is in order for subsuming, under the same category, further varieties of the same “altered body type.” In this section, what I offer is merely a preliminary investigation of the problem. I focus this discussion on the fractured body image category, as this altered body image type is most extensively documented in the clinical literature.

#### **3.7.1: Splitting, Fracturing and the Self**

The following patient does not simply report a fracture in his body image – his body is divided along a split that separates him into even halves that are opposite yet complementary. He “experiences himself as follows: Right side: masculine Left side: feminine Left side younger than right side. The two sides do not meet” (Laing: 1969). It is R. D. Laing who presents this patient as if rent alongside the left/right and the masculine/feminine, which signifies, as he himself puts it, that “the individual’s being is cleft in two.” One can identify a lack of unity in chronic schizophrenics, Laing thought, a



“division into what might variously be called partial ‘assemblies’, complexes, partial systems, or ‘internal objects’ ... each [of which] could be aware of objects, but a system might not be aware of the processes going on in another system which was split off from it” (Laing: 1959).

What Laing is at work in establishing here is a two-fold claim: one, that it is the body image of schizophrenic persons that is split in halves by these processes, and that this split signifies a division in the self, or in one’s “being.” This split is at the level of the “inner self,” but produces alternating “reflective systems”; it is these “partial assemblies” that do not meet, in the same way in which the two halves of the schizophrenic person’s fractured body fail to meet.

The split bodies on which Laing models his theory are ubiquitous in other studies as well (especially among Laing’s contemporaries). The left/right polarity is most frequently the basis for the division, though horizontal splits are also not uncommon (e.g. Scott: 1969). Once we focus on the bodily state of the schizophrenic person undergoing such “splitting,” however, the first thing that becomes apparent is the continuous progression of this two-fold division of the body. The body’s fracturing develops into a two-fold division, and, rather than settling into a divided mode “being,” it just as quickly moves beyond it in a further series of changes.

A laborer diagnosed with schizophrenia, who was originally from Jamaica but experienced the onset of the psychosis in the United Kingdom (from a sociological point of view, his identity being already characterized by a hybridity) described his body reaching the same division privileged in Laing’s work, but in a way that challenges Laing’s insistence on the unity of self and body during the process of becoming fractured:

[W]hen I walk my body feels divided into *two parts*. The right half is strong and has my soul; the left is weak and has no life. The right side is good, the left is no good. The right half of the head is alive and thinks, the left is empty and like a dead man's head. Sometimes it is impossible to walk, because two halves of my body do not want to hold together. The right wants to walk to the right, the left wants to go to the left. I feels torn apart, as if somebody pulled apart my arms: Sometimes the left side becomes mad: it tried to tear away from the right side. Sometimes I feels that the whole left side of the body is missing" (Lukianowicz: 1967).

The two personas in this case are also located in the left and the right halves of the body. They are well-integrated, however, until the person in the example starts to walk; it is only when movement is attempted that he discovers that his two sides "do not want to hold together," and that the former is headed in one direction while the other "wants to go" in the other. There is a sense during this exercise that the "I" feels torn apart; from what this person says, it is unclear whether it is the "I" or the "body" that feels this way, in any case, the person speaking is not keen on dissociating the two. At the same time, he comes close to attributing the agency of the pulling movement to someone other than himself: the pulling sensation bearing down on his body as a splitting force is akin to another person (or persons) pulling his two arms apart. At this point, the splitting, the same state that would fit Laing's description, is accomplished. However, there is a further progression in what he has to say about the fracturing of his body. Before long, the left side of the body comes to be missing. His body is opened up, though the gaping hole does not yet bother him as such (we are to see examples in what follows of individuals who are terrified of this sensation). At this stage, one of the halves previously divided is dispersed in space and the boundaries of the body are no longer a part of the body image on the implicated side.

Another example contradicts Laing's theory on an even more important aspect of his theory: that is, regarding his hypothesis that the splitting of the body separates the body as it were between the two irreconcilable polarities of existence. András Angyal, a psychologist whose interest in the schizophrenic body centered primarily around the body schema also describes individuals with what fit in the mold of Laing's theory, but the peculiarity of his example is that, rather than becoming divided into two separate parts, his patient's body is subject to "muddling." His patients experiences "uncertainty in the distinction between left and right. [He complains that] his 'left and right side are muddled up ... The muscles of the left side are on the right side,' and vice versa" (Angyal: 1936). Here, far from pointing out the irreconcilability of two partial assemblies or systems, their tensions are under negotiation through this back-and-forth incorporation of the left side by the right, and vice versa.

Though it is rarely manifest as much as in the above example, it is the case in general that the fracturing of the body must take place against the background of a more fundamental unity of selfhood. What the source of this unity is, and at what level of experience we might (or might not, as the case may be) experience it, is one main reason why those interested in schizophrenia are drawn to the kind of experiences I have been reporting. What is important is that something unifies the body *contrary to* the fracturing it undergoes at the level of the body image – and at the level of reflective selfhood. The psychic tensions that go into the constitution of what Laing calls the divided self split the body image: the presentation of the self to others, a view on the body from the third person perspective, and presented as an image of the schizophrenic person's bodily experience

from a third-person perspective. Is it possible to approximate a first-person experience of this fracturing?

### **3.7.2: Different Intensities of Fracturing**

One of the most interesting aspects of Laing's "split" bodies is that they are fractured along "abstract" dichotomies, such as the left or right and the up and down axis. At the intersubjective level, this mode of presenting the self to others is rather intriguing: the schizophrenic person's attempt to codify a bodily experience by appeals to the basic dichotomies accessed through the body already signal a certain degree of immersion into a communal setting, which is presupposed as the source of such precise dimensionalities.<sup>21</sup> Many examples of the fractured schizophrenic body divide it, however, along a more organic grouping of the body's components. Outside of the realm of "split" bodies, a sense of dismemberment is typical. The body is shattered into body parts; the unity of the body is dissolved exactly alongside units emerging as the most obvious elements of the body's visual experience (or, when it comes to the inner organs, on the basis of the scientific systematization of the body). The experience of fracturing may be found at different levels of intensity, however.

First and foremost, there are what one might call "ideal cases," representations of the body as a collection of body pieces strewn 'all over the place'. Such an ideal case (ideal, that is, in the sense of approximating this rarely experienced state the closest) was

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<sup>21</sup> The fact that these more integrated communications to the schizophrenic person's other feature *more* abstract descriptions make bodies split in this manner even more interesting. It is as if Laing's patients manage to *relax* into a sense of sharing a common intercorporeal background to their communications – which, however, as far as they are concerned, is a body codified in binary opposition.

described by one of the patients living in a community operated by R. D. Laing, Mary Barnes, who spoke of her body as “exploding.” She had a sensation during her regressed state as if “a leg or an arm could be [at] the other side of the room” while she was lying in bed (Barnes: 1971). It is rare to find a body so completely fallen apart, where a sense of dismemberment as well as spatial dispersal accompanies these alterations. When such cases are reported, however, the fracturing does seem to focus on the body’s organic parts. His body “flies off at different angles and [he doesn’t] seem to be in one piece” (Bennett: 1956), reported another patient, for example. A dispersal of this explicit kind, which renders the schizophrenic person’s body shattered and distributed into pieces is probably only reached in the acute stages of psychosis.

The sense of fracturing is only implicit in cases in which, instead of the dismemberment or dispersal, only a sense of “displacement” is indicated. Sensations that individual parts of the body are experienced in a place they are not usually found, or that various body parts have been switched or interchanged are reported fairly frequently by psychiatrists: for example, a patient in McGilchrist and Cutting’s study (1995) is convinced that his mouth is where his hair should be, i.e. that the oral crevices are not only an opening but the top rim surrounding the body image.

One might surmise that these displaced body parts were severed during an experience of a more proper sensation of fracturing, and are now merely “misplaced” among the body’s co-ordinates. The simplicity of this theory might make it popular with the empirical scientist, but suspicious from a philosophical standpoint, since it does not even notice nor aim to explain the overall disordering of the body image underlying these particular symptoms. Their explanation assumes that the unity of the body may remain

intact in spite of its partial fragmentation: after all, in order for body parts to switch, nothing more is required than for these parts to become severed and change places. If this were true, the human body were no different than a strange doll which one could take apart and rebuild anew into any combination of its original parts. Perhaps psychiatrists find it reassuring to explain these phenomena in this way, because on their theory this experience would imply positive progress in the patient's state, especially in comparison with the fully dispersed and dismembered fractured body image: in their explanatory framework, one may recognize in these schizophrenic testimonies a sign that the patient is now on the road to becoming "stabilized." But on a more philosophically-minded approach to the body it is imperative to recognize that the body image had been disordered in its globality even in such cases, even though the manifest change is limited to specific body parts.

One welcome consequence of any appeal that this questionable and naïve explanation may hold for psychiatrists is that this specific variation of the fractured schizophrenic body image is frequently reported in the clinical literature. What might explain why the experience of the body's fracturing is reported in such a "tampered down" version is that testimonies about one's actual sensations presuppose a high level of person-to-person cooperation between doctor and patients, and lacking such a relationship in the psychiatric setting, the patient's self-descriptions might intentionally be subject to moderation. In all likelihood, the schizophrenic person senses that not only are such "abnormal" experiences suspicious from the non-schizophrenic perspective, but, given that one's interactions at the intercorporeal level automatically structure these interactions, they might also be frightful to the person conducting the interview. If his or her self-reports

are dismissed as mere “delusions,” and when hospitalization and medication are imminent as a result of the psychiatric interview, there is every reason for the schizophrenic person to temper these self-descriptions.

Therefore, for as long as the institutional setting and the unrecognized counter-transference on the part of the psychiatrist serve as a natural selection mechanism against proper noting of a schizophrenic patient’s more complete experiences, it is impossible to ascertain what the proper significance of such “tempered” fractures are. There is no reason to exclude from among the explanations that these implicit fractures in the body were the product of a previous experience of an explicit fracture, including the total dispersal of the body, which is now stabilized in the form of a bodily unity in which certain body parts are misplaced. Other explanations are also available. Conditioning inherent in a certain observational setting may have led the patient to temper his or her descriptions of the state. It is also possible that there is a distinct “displacement sensation” which is in no way connected to the sensation described by patients who reached a state of total dispersal in space.

### **3.7.3: Fracturing as the Boundary of the Body**

In one case above, a schizophrenic person already spoke about “gaps” in his bodies. One can find similar examples of persons in whom the fracturing of the body image establishes an artificial boundary – a newly imposed limit to their bodies.

Angyal’s study (1936) includes a patient’s comments about his tendency to overeat because of his bewilderment over the discontinuities of his body. As the patient states, “[t]he food does not reach the stomach at all but when it passes the throat it disappears.”

When he eats, he says that “the food is falling into a vacuum” – it “disappears,” “evaporates just like steam,” “it is taken out” or drawn away and removed by somebody.

The patient’s eating problems are explained, however, once he undertakes a description of how his body is represented to himself in the form of a body. This patient has complaints about gaping holes within his body in general: “[b]ehind the chest is nothing, only a big hole” - specifically, “[t]he stomach and the top of the skull are open.” Thus, a gaping hole beyond the throat explains the disappearance of food from sensation – his various explanations of how the food might disappear are only secondary to this felt bodily fracturing. It is a sensation so real that the vacuum beneath his throat and the emptiness into which his food falls propel him to overeat: he compensates for the continued feeling of emptiness by eating in excess, trying again and again to “fill up the stomach.”

Swallowing does entail a sensation of having our food disappear as it passes through the throat. With the contraction of the muscles in the throat, the sensation of a foreign body in our mouth is cancelled. In turn, we can anticipate a feeling of being “filled,” along with various markers of the digestive processes taking place in our body, e.g. the sensation of feeling our stomach expanded or the sensation of sluggishness due to the rise in blood sugar.

For the patient in question, in contrast, this transition has to be signaled by a symbolic marker: by the hole he claims to feel separating his pharynx from his esophagus. He seems to insist that a foreign body, such as food, should remain traceable by sensation, highlighting the seamless integration, in most persons, of an interoceptive, felt experience of the inside of the body and the more spatially determined body of extensive qualities. Most people’s unquestioning acceptance of the mysterious disappearance of their food



beyond the pharynx is due to this smooth interchangeability between an externally perceived body, a body for which the food is an object of spatial extension placed into the mouth, and a body of interoceptive sensations in which this foreign object, once it is carefully chewed, will expectedly disappear. Angyal's patient, however, cannot accept this curious logic. Instead, his perplexity about the phenomenal experience of eating leads him to posit a fracture that marks the limit of his body.

This gaping hole beyond the throat is elevated into the body image from an abnormal feature of the schizophrenic person's pre-reflective body. A "hole" separating the mouth from the stomach is characteristic of any person's phenomenal experience – what differs in the description that this patient offers is its conceptualization as a "gap" or fracture. Relying on Wallon's work with infants (Wallon: 1949), in *The Child's Relations with Others*, Merleau-Ponty (1960) attributes the infant's capacity to experience a unitary body to the fact that his or her proprioceptive as well as exteroceptive experiences of the body are not yet distinct from what is primarily an interoceptive experience of the body. According to Merleau-Ponty, the ability to automatically co-ordinate these three aspects of self-experience comes about in three stages, and with the help of the mirror image, which helps to anchor these three modalities of the body's phenomenal experience on a unitary body image. Such a unity at the experiential level presupposes identifying the visual experience of the mirror image to the felt interoceptive sensation of the lived body – this is a pre-requisite to the psychic processes of connecting the image of the body to an "I," as Lacan suggests.

The pre-reflective body of the schizophrenic person in the above example is not integrated at this level, however. Not only is the automatic conversion from interoceptive

to exteroceptive experience lacking, but this state of not cohering together in these two aspects of phenomenal experience is subjected to reflectivity. It is for this reason that a “gap” appears in the reflective representation of the body, in the body image.

### **3.8: Disorders of The Schizophrenic Body: From Body Image to The Pre-Reflective Body**

Finally, conclusions of wider phenomenological significance are in order, in particular as regards the relationship between body image and the pre-reflective body. Both of these emerge in various forms of disordering in the schizophrenic experience. Nevertheless, the close relationship in the manner in which they are impacted points to an important aspect of their relationship that manifests itself only in schizophrenic experiences.

The above manner of categorizing the distortions of the body image in schizophrenia provide access of a unique kind to a foundational unity which is inherent not in the body image, but in the experience of the pre-reflective body. The unification of the body’s representation into body image already prohibits access to this underlying unity of the normal body’s unified experience. Accordingly, phenomenological investigation of this feature of the pre-reflective body is rendered impossible in non-schizophrenic experience, and only through the schizophrenic body’s “abnormal” example may this important relationship become subject to analysis.

In a summary interpretation of these cases I am going to argue that the distortions of the body image are made possible by the grounding provided to the schizophrenic person’s bodily self-experience by a unity of experience constituted in the passive

syntheses of the pre-reflective body. The fracturing, the flowing, the multiplying, and the collapsing of the body, though destructive of the unity of the body image do not altogether disable some level of coherence of experiencing. I would like to propose an account in favor of the theory that, at the level of pre-reflectivity, even the experience of one's own body finds a specific type of organizational unity.

To be sure, this secondary unity of the body is much weaker than the unity afforded to self-experience by the body image and, when accessed through schizophrenic states, it may be subject to alterations which might inhibit its proper functioning. This, in turn, has important implications for what we understand as the "schizophrenic pre-reflective (or minimal) self." Though one may cite examples where there appears to be a total disintegration of the schizophrenic self and the schizophrenic body image, the disordering targets specific higher-level structures of selfhood. By resorting to a reflective examination of any other sources of personal cohering or unities, these tendencies are counteracted – most importantly by embodied processes operative in experience, i.e. in implicit embodied self-experience.

In Head and Schilder's psychoanalytically inspired engagement with the body image, careful attention is paid to the role of the body schema to maintain continuity in the self's presentation as a bodily entity. As Schilder writes, incorporating Head's more neurological approach into his own statement, one of the functions of the body-schema is precisely to provide a specific type of continuity by which the self maintains itself as represented by a unified body image:

The body schema is the tri-dimensional image everybody has about himself. ... The term indicates that we are not dealing with a mere sensation of imagination. There is a self-appearance of the body. It indicates also that, although it has come through the senses, it is not

mere perception. There are mental pictures and representations involved in it, but it is not mere representation. Head writes: 'But, in addition to its function as an organ of local attention, the sensory cortex is also the storeroom of past impressions. These may rise into consciousness as images, but more often, as in the case of special impressions, remain outside of central consciousness. Here they form organized models of ourselves, which may be termed "schemata." Such schemata modify the impressions produced by incoming sensory impulses in such a way that the final sensation of position, or of locality, rises into consciousness charged with a relation to something that has happened before. ...

By means of perpetual alterations in position we are always building up a postural model of ourselves, which constantly changes. Every new posture or movement is recorded on this plastic schema, and the activity of the cortex brings every fresh group of sensations evoked by altered posture into relation with it. Immediate postural recognition follows as soon as the relation is complete (Schilder: 1935).

In this way, the body schema is a three-dimensional *image*, an image in the sense that it tends to approximate a sense of unity not yet coalesced into a singular and distinct entity, though already comprised of dynamic functions that constitute a minimal or core self. In schizophrenic sensations of the body, the unity of the body's image may be distorted, but this temporal constitution of a bodily unity is not necessarily subject to the same process of disturbance. In fact, the destruction of the body's reflective unity may rely on an implicit sense of unity in the pre-reflective body – as such, the experience of the pre-reflective body may also be disordered, but only in so far that it counteracts or stabilizes the distortion of the body construct that comes to be experienced at the level of reflectivity.

In non-schizophrenic persons, the sense of minimal unity that the pre-reflective body contributes to self-experience in and of itself, without already coinciding with the more complex unity provided to self-experience by the body image, is concealed from reflective experience. At times, the schizophrenic experience on the other hand is solely

organized by the unity inherent in the body's pre-reflectively engaged schemata. In the case of the fracturing, the flowing, the proliferating or the collapsing of the body image, the experience of the body becomes disorganized – nevertheless, as disorganized experience, it must make recourse to organizational principles. The implicit unity of the pre-reflective body does not stabilize or correct for these distortions, except in so far that it allows for its constitution. Of course there is no reason to speak here of the constitution of a fully or finally unified experience of the body, nor even of the unification of self-experience, and for this reason the organizational principles derived from the pre-reflective regions of the body's experience are not to be understood as having an organizing role in the same sense as this word is used in normal experience.

The tendency of schizophrenic persons to reflect on their body's functioning, on its appearance, boundaries and distortions is in fact a testimony to the fact that in their bodily experience they have direct access to a depository of self-experiences testifying to a continuity in their selfhood. Though this depository is mechanically patched together, it is nevertheless sought out as a compensatory mechanism against a sense of disintegration to which their experience becomes subject in their efforts to represent experiences for themselves and for others. Their turning toward any unity they might discover in their body's experience is not pathological, therefore: it is due to the fact that there is a certain form of unity available to experience even in states in which the body image fails to frame one's self-experience.

That a secondary sense of unity already results from pre-reflective acts of self-constitution is in no way contradicted by another important finding, that the pre-reflective body of schizophrenic persons itself undergoes disordering. The latter problem is most

apparent in experiments examining the kinaesthetic processes normally coordinated by the body's schemata. In his studies of the schizophrenic body image, Bennett (1956) found that patients with distorted body images also experienced "distortions of the visual perspective," which he attributed to the "perceptual deficiencies." The details of the case descriptions support a different explanation however. Since schizophrenic persons rely on their pre-reflective experience of bodiliness as a background of unity against their disorganized self-experience, and because they access these experiences via a reflective (or hyper-reflexive) examination of their bodily sense of unity, the body schema are employed as substitutes for their regular bodily unification, and, as such, they are not available to contribute to the automatic, smoothly functioning orientational functions of the body.

In fact, the patients suffering from perceptual deficiencies also suffered distortions of their environment that mapped almost precisely onto the disorganization of their body image. One of Bennett's patients with a bilateral distribution of the body image felt himself pulled to the left, for example, and "when he looked at windows or the television screen the left side of the square or rectangle appeared to be at a lower level than the right side." The patients who reported, in Bennett's word, "changes in [the] co-ordination between visual and other senses" described these as follows:

most people don't realize they've got a body; they are not concerned with where it begins and ends. It's as if they've got eyes all over them." He felt that, although he could see, he was really blind when moving about and had to touch things when walking between two objects. At times he knocked into things, usually on the left side. Another patient, when doing the washing up in the ward with dirty dishes on his right side, found that if he turned to the right "the rest of my body and my eyes would not co-ordinate to pick the dishes up." Poor coordination of the visual and postural sense was often noted when the patient was travelling in a vehicle (Bennett: 1956).

In each of these cases, automatic processes inherent in the body schema are contributed instead by reflective acts of self-consciousness. As such, they distort the world in which the schizophrenic body is to find its orientation, because they are so crucial for maintaining the bodily self's coherence despite of the disorganization of the body image.

As I showed in the detailed examination of the fracturing of the schizophrenic body, the splitting or the dispersal of the body in space is keenly observed and recognized in such detail that the intentional representation of the body as a unity becomes impossible. In such a state, however, a more primordial unity of the body comes to the fore to provide a substitute organizational framework to the body. The body split into equal halves becomes a map for representing partial assemblages of selfhood, dismembered body parts become registered at unusual locations of a newly reorganized body, and edges are drawn at the limits of the schizophrenic person's own understanding of his or her body's functioning.

To be sure, the unity that is thereby reaffirmed is not the kind of personal unity that emerges in Lacan's symbolic order. Nor is it a basis for personal identity, at least not in the way in which such a construct would otherwise emerge if the unity inherent in the body image supplied a singular representation of the body. Rather, it is a unity in a distinctly different sense. It is indicative not simply of the "pre-reflective regions of selfhood," but of pre-reflective regions of selfhood experienced independently of an experience of its reflective ordering. What is more – and for proving this claim we must resort to a fundamental experience of schizophrenic persons' interpersonal relationships – it tends to be much more porous in the case of schizophrenics than in the non-schizophrenic experience, i.e. when it is not experienced independently of the regulative impact contributed to experience by psychic defense mechanisms characteristic of "normality."

The key to understanding this permeability, as I am to show in a later chapter, is not to be found in the disorders of the body image, but in how schizophrenic persons internalize others.

Examples taken from the realm of psychopathology show that this secondary unity of experience already available to experience at the pre-reflective level is a unity frequently resistant to the fracturing that one might experience in the body image. It appears that, contrary to our expectations otherwise, in so far that the body stabilizes itself by undertaking one of the four distortions I describe above, a schizophrenic person finds for himself or herself a possibility for being embodied. As such, in the clinical setting, this sense of unity as it contributes to the schizophrenic person's self-experience appears to be an important and to this point under-utilized therapeutic direction for treating individuals experiencing the fright and horror of shattering and dispersal, as well as all of the above described distortions of the body image.



## Chapter 4

# **Interpenetration in the Schizophrenic Body's Disordered Experiences**

In the previous chapter, my investigations led me to conclude that it was on the basis of passive syntheses, which in and of themselves constitute a “weaker” sense of unity immanent in the body’s experience, that certain aspects of selfhood are regulated for schizophrenic persons. In what follows, I am going to set up the final investigation of the schizophrenic body. This will allow us to enter into a more detailed discussion of the precise manner in which this implicit self-construct might intermingle with a higher-order reflective self.

What is required for the determination of the above emerges out of the interplay of self and other, and of ipseity and alterity, in the schizophrenic person’s bodily experience. One can discern expressions of this relationship in a variety of schizophrenic symptoms, which did serve as a basis for clinical description and analysis, but only while framed in terms of their abnormality – only as symptoms indicative of a pathological condition, as disturbances of the various functions of the ego understood as the normal, non-schizophrenic self. The phenomena that fit this pattern fall into numerous groupings – delusions of control and thought insertion are among the most frequently studied among

these – but they are best captured in terms of their overarching logic as “passivity phenomena.”

Instead of engaging in the theoretical difficulties that this terminology occasions, my suggestion is to understand this class of schizophrenic disturbances as “interpenetration phenomena.”

First, I shall provide a brief survey of theories of passivity phenomena that inform my analysis, though, upon reviewing Wolfgang Blankenburg’s notion of “interpenetration,” I will turn to identifying a peculiar kind of double performance one notices in these schizophrenic symptoms in structural terms. In the section that immediately follows this theoretical exposition, I analyze four arresting examples in which interpenetration is at work and show how the various facets of interpenetration phenomena interact to produce these unusual experiences. The first three of these involve disturbances of bodily self-experiencing, while the fourth one is of a specific delusion that typically precedes either thought insertion or thought withdrawal. Having indicated the range of symptoms in which interpenetration is operative as the disturbance process, I turn to the question of what exact patterns of disordering are typical in these disordered self-experiences. Next, I discuss one of these examples, the case of a schizophrenic individual reported by András Angyal (1936) in greater detail, in order to show that the pre-reflective body of this patient, having undergone interpenetration in the various examples he reports, explicated the thing-like material body temporally constituted as the body-subject. Rather than automatically constituted in such a way that a higher-order body-object may emerge as a unified entity in self-experience, this patient can distinguish in numerous ways between two objectified bodies, which are interpenetrated within one another. In sum, I argue that a

similar interpenetration is characteristic of the disturbances of the pre-reflective self of schizophrenia.

#### **4.1: Passivity Phenomena**

Throughout the history of phenomenological psychiatry, unusual alterations to one's sense of mineness received parallel treatment (especially by those philosophically trained) as "passivity phenomena." The proper interpretation of this group of alterations to schizophrenic self-awareness has in fact divided German psychiatrists ever since the early 1910s. Some of them treated these as a mistake of self-attribution, while others thought that they demonstrated that active and passive syntheses are convoluted in complex ways in schizophrenic egoic performance.

"Passivity phenomena" is a term used to refer to a range of experiences exemplified by the following collection of self-descriptions used by schizophrenic persons:

I feel that it is not me who is thinking.

My thoughts are not thought by me. They are thought by somebody else.

Feelings are not felt by me, things are not seen by me, only by my eyes (Spitzer: 1988).

As neither "self-disturbances" nor "passivity phenomena" are terms normally used by psychiatrists in the United States, an English-language equivalent of this grouping of psychopathological phenomena is not well-established – at times, the term "loss of control" or "loss of agency" is used to connote them. Lacking a word to thematize and foreground this problem of agency in consciousness is in fact one of the reasons why psychiatric

practice in North America is quite unaware of these important dimensions of the schizophrenic condition.

Whether it is more appropriate to view these examples as ipseity disturbances or as passivity phenomena has a wide range of implications for the analysis of related symptoms, such as thought insertion or delusions of control as well. In more familiar terms, this debate concerns competing interpretations of the same phenomena. If it is a disturbed sense of ownership that produces these sensations, the phenomena can be attributed to the disordering of the ego's pre-reflective self-awareness (as already discussed in Chapter 1). There are clinical phenomena, however – which typically occur later during the progression of the disease – which suggest that an additional feature intrinsic to the phenomenal experience of an egoic act comes to be disturbed in these examples. Contemporary authors, taking their lead especially from Shaun Gallagher (e.g. 2000: 2005), prefer to think of these as alterations in the schizophrenic person's pre-reflective sense of agency (instead of "pre-reflective," Gallagher often uses the term "thin phenomenal awareness").

One of the most important tenets of this new approach to passivity phenomena is the insistence that one's sense of agency (one's experience as the agent of one's own action) must be strictly distinguished from one's pre-reflective sense of ownership (one's phenomenal awareness of being the subject of an egoic act). In fact, neurological findings indicate two different regions of self-experience corresponding to this conceptual distinction: while mirror imaging can prove the former to be the product of efference signals, one's sense of ownership of proprioceptive action is due to visual feedback. Gallagher's claim is that, while in non-pathological cases one's sense of agency (SA) and

sense of ownership (SO) are so tightly integrated that their distinction is impossible to discover in phenomenal experience (except perhaps in the case of involuntary action), schizophrenic experiences of delusions of control are due to the disruption of the automatic integration of SA and SO. For example, thoughts and movements may be executed by schizophrenic persons whose sense of agency undergo disturbances while simultaneously their sense of ownership of the same act remains intact.<sup>22</sup>

Jaspers would call the region of experiencing under disturbance in these examples the “ego’s awareness of its own performance” (*Vollzugsbewußtsein*). In his *General Psychopathology* (1911), passive phenomena are one of four alterations discussed in relation to the disturbances in the awareness of self (what we would call pre-reflective self-awareness). Jaspers notes that these disturbances are specific to cases of schizophrenia (Jaspers: 1911) and describes them in comparatively exhaustive detail. His observations are so thoroughgoing that they merit quoting in detail:

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<sup>22</sup> We need to remain mindful of the narcissistic overtones that such a sense of agency entails, especially because all of our examples were borrowed from the realm of psychopathology. One’s “agency” already implies one’s ability to serve as the cause or agent of an act. Not only does this amount to one’s conceptualization of oneself as the active term in the performance of something, but a deliberate attribution of one’s act to the self. Thus far the issue is primarily phenomenological. But the same act also entails an accomplishment of the psyche that transforms the act into a contribution, and the self into a contributor of the act, or, as might be the case in the relatively more pathological instances, into the creator and unbridled power from which such an act issues. This level of self-appreciation requires an egoic organization at the narcissistic stage, for which reason we cannot take it for granted that schizophrenic persons are able to share in this sense of agency, or that any distinction present in the phenomenal experience of non-schizophrenic experience is also distinct in schizophrenic experience.

However, this is only the beginning of the difficulties in describing this region of experiencing in Shaun Gallagher’s terms. One might be tempted to say that what is at stake is the ego’s perceived activation to an act, but this is far from being true, because the ego’s “active participation” in the act is lost to awareness. Any sense of “agency” in these acts is absent from one’s reflective self-awareness; in fact, the sense of agency for these acts is a passive contribution to these experiences. Therefore, Gallagher argues that the distinction between SA and SO is implicit in self-experience, but explicit in schizophrenic experience. The central issue in this matter, however, seems to be the ability to distinguish between a subject acting and a subject acting upon. My argument below concludes that schizophrenic persons have the capacity to distribute these functions, while regulative principles along which selfhood becomes distinguished from others do not allow for such an “inner split.”

the thought-phenomena of schizophrenics is something quite different in that they talk about ‘thoughts made by others’ (passivity-thinking) and ‘thought-withdrawal’, using words coined by themselves, which psychopathology has had to take over. Patients think something and yet feel that someone else has thought it and in some way forced it on them. The thought arises and with it a direct awareness that it is not the patient but some external agent that thinks it (Jaspers: 1911).

But these passivity phenomena (*gemachtes*) never occur in isolation – they are always accompanied by the loss of one’s *own* thoughts, or thought-withdrawal (*Gedankenentzug*):

... just as the patients find their thoughts are ‘made’ for them so they feel that these are being withdrawn. A thought vanishes and there arises the feeling that this has come about from outside action. A new thought then appears without context. That too is made from the outside.

Thought withdrawal, therefore, is of thoughts anticipated to emerge from the pre-reflective regions of self-awareness: there is an inexplicable feeling in the patient that he or she had a thought, and yet the thought nevertheless disappears – miraculously, someone takes it away. Its place is taken by the thought inserted by someone else. Jaspers insists that these experiences impact pre-reflective self-awareness, and are not merely an objectification reflectively imposed on the pre-reflective experience. He points out that “not only thinking is affected, but walking, speaking and behaving.” As such, this is not, as one might put it, a conflict between unconscious drives and their conscious disavowal, but “an *elementary* experience of *being actually influenced*” (emphasis in original): an alteration in the pre-reflective sense of agency.<sup>23</sup>

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<sup>23</sup> Throughout this section, Jaspers returns again and again to emphasizing that, once a schizophrenic person experiences alterations to “this general awareness of one’s own performance,” these experiences “are quite incomprehensible, difficult to imagine and not open to empathy.” Or, as he puts it in a later paragraph: “It is extremely difficult to imagine what the actual experience is with these ‘made thoughts’ (passivity thinking)

## **4.2: Blankenburg's Notion of Interpenetration**

In most instances in which the term is used, the “passive” in passivity experiences refers to the will's contribution to the act, and not to the passive syntheses of self-consciousness, as illustrated by Jaspers' approach for example. In fact, the idea that what Husserl calls passive syntheses might undergo disorganization in schizophrenia and play a crucial role in “passivity experience” did not gain currency until Wolfgang Blankenburg's studied “common sense” in patients suffering from simple (*symptomarm*) schizophrenia (Blankenburg: 1969: 1971). Blankenburg treated several patients complaining of a loss of something very small and insignificant – what, in Blankenburg's words are “the immediate conditions of possibility of experiencing” a life-world, what in short he calls the loss of common sense (*sensus communis*).

Examining school essays written by his schizophrenic patients, Blankenburg notes that while the formal aspects of their reasoning is intact, even overemployed, their otherwise flawless reasoning almost consistently misses the topic (considering that Blankenburg limited his study to patients diagnosed with simple schizophrenia, these findings are even more surprising).<sup>24</sup> “The question about the manner of embedding

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and these ‘thought withdrawals’. We just have to accept the account as outsiders, relying on the descriptions we are given of these otherwise easily recognizable phenomena...” (Jaspers: 1911).

<sup>24</sup> The classification most widely accepted among psychiatrists distinguishes among four types of schizophrenia: the paranoid, the hebephrenic, the catatonic and the simple, core or non-process schizophrenic (though classification is uncertain, in the same way in which the schizophrenia diagnosis might be subject to change with the progression of an individual's case).

**Paranoid schizophrenia** is characterized by the predomination of thoughts of persecution, hallucinations and delusions. The term most often employed to characterize **hebephrenic schizophrenia** is incongruity. Hebephrenic typically responds by a surprising reaction to a variety of eliciting stimulations. Their delusions are markedly non-systematic: they have less coherence to their hallucinations and show a number of signs of the splitting of various psychic functions, most importantly those in their language functions, such as word salads and cling associations. **Catatonic schizophrenics** display an appalling immobility in their bodily as

[formal logic in the logic of the life-world] has the greatest interest for psychopathology,” he claims (Blankenburg: 1969). The schizophrenic loss of common sense, according to Blankenburg, is the loss of a practically automatic ability to endow what is keenly observed about the world with meaning: the inability to embed formal logic in a stable and reliable world design according to which objects, persons and acts receive their value, their relative priority compared to others and in relation to which specific goals emerge for one’s actions. Based on formal logic alone, the world does not amount to anything more than a collection of perplexing objects. It becomes a life-world only for those anchored in a common world of shared pragmatic concerns. The signification of objects in this life-world relies on a probabilistic calculation, and cannot be grounded in a priori necessity – while schizophrenic persons yearn for certainty, and lack trust for the contingent truths of the social world. To be sure, what they are mistrustful is not the current public opinion or the tyranny of the majority. Their intolerance is for logical problems in which choices would have to proceed by a “preponderance of evidence” rather than apodictic certainty.

As an example, Blankenburg describes a patient trying to pick a dress to wear. The choice would be perfect if she could only determine which material would be perfect for the occasion, she tells herself. Then, the material would be chosen without room for error if

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well as cognitive functions. They are often found in awkward, uncomfortable positions which they do not willingly abandon. They appear to be paralyzed, not only in their bodily functions, but in their communication: their state is known as schizoid withdrawal. The delusional content therefore is inaccessible to the therapist. Finally, cases that do not easily fit the above three molds are usually treated as **simple schizophrenia** (Blankenburg’s *symptomarme Schizophrenie*). It is commonly thought that simple schizophrenia is characterized by the “impairment of abstract thought” (Arieti: 1974). These patients rarely leave their house, are incapable of performing more than a few routine acts; social workers watch out for them in particular, because abandoned on the streets, they often become the victim of crime gangs. Current diagnostic tools provide a much richer characterization of the schizophrenic spectrum disorders, which includes diagnoses under than these outdated categories, the above was presented merely as an illustration of the significance of Blankenburg’s choice to study simple schizophrenics.



she can establish the correct color to wear. She thus moves from one detail of her dresses to another, never considering the dress as a whole, or the fact that the dress one wears is judged against the social setting for which one chooses the dress. Principles of fashion or social conventions, the appearance of various tailoring elements to those observing us from a distance, and a general idea of how a dress may become pleasing in the eyes of others are concerns too global to enter her considerations. She makes up for lacking focus on these intersubjectively anchored categories by her painstaking analysis of her own dresses.

The patient remains focused on the specifics of the problem, and the minutest details of the object under consideration: its color, material, and tangible qualities. She cannot transcend these specific particulars of the dress-picking exercise; she cannot divorce herself from the certainty of her self-evidence and contemplate the intentional correlate of her perceptions in the world of others. To be sure, Blankenburg's patient does not exhibit scorn for what she understands to be a basic fact about social gatherings, namely that picking the right dress matters. In fact, her torment over picking the right dress is assumed for the sake of fitting into the world of others as well as she can. She is nevertheless incapable of relying on something very basic and fundamental for the choices non-schizophrenics make in similar circumstances. Paradoxically, what is missing for her is so obvious we can hardly say what it is. This is the reason why Blankenburg is eager to tie the lost *sensus communis* of schizophrenics to "the immediate conditions of possibility of experiencing," and to draw on Husserl's writings to discuss schizophrenic phenomena in terms of the disordering of the ego's passive (i.e. automatic or implicit) syntheses.

Blankenburg was thus able to show that even without the most spectacular of passivity experiences, a disorder of pre-reflective selfhood is present even in the most basic

of schizophrenic symptoms. Following Blankenburg, it becomes obvious that regardless of whether we consider the ipseity disturbances prior to the passivity experiences of schizophrenia or vice versa, both in the mistaken self-attributions of implicit self-experience and when active syntheses take the place of passive syntheses in one's grasping of his or her environment, fundamental structures of subjectivity are affected. As already mentioned above, Gallagher (2005) attempts to separate the disturbances experienced by schizophrenics in their sense of ownership (which are thematized as ipseity-disturbances) from disturbances to their sense of agency. From Blankenburg's point of view, this is merely a matter of emphasis: if "what is at stake is whether the issue of activity vs. passivity or the problem of self-attribution merits greater attention for selecting our terminology," "it is disputable whether the concept of "mineness" alone can sufficiently capture what we know as schizophrenic self-disorders. Likewise, the catchword nature of "activity" is too short to be effective." While in thought-experiences (*Denkerlebnissen*), the disordering of the "active" aspects of the act are prominent, this is not automatically the case in sense-experience (*Gefühlserlebnis*), he writes in his essay *Zur Psychopathologie des Ich-Erlebens Schizophrener* (The Psychopathology of Schizophrenic Self-Experiences, Blankenburg: 1988).<sup>25</sup>

Blankenburg, however, does not want to merely engage with the dispute over whether these phenomena are best treated as ipseity-disturbances or passivity experiences. According to him, what is crucial about these experiences is not "the direction, the strength (dynamic) or the belonging of this sensed operation, but the immediacy of the sensed functioning." One may observe variations in the direction in which the sense of

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<sup>25</sup> The translations of the original German text of this essay are my own.

agency is exchanged (a schizophrenic patient might assume the powers of others, or, to the contrary, attribute his or her own to others), as well as in the intensity with which this disturbance of one's agency may be sensed, and in whether the person denies or affirms the availability of this operation as a feature of his or her experience. All of these are secondary, however, to the immediacy of these experiences as demonstrated by the person's self-description, behavior, or delusional system. In a later section, Blankenburg describes the disturbance from which these experiences issue as transgressions of a limit, or as exchanges alongside a boundary (*Grenze*) between mine and yours, I and you, my powers (*Meinhaftigkeit*) or someone else's. For grasping the disturbance in question properly, what is important, according to him, is

not the directionality, nor whether it is the self or its other who gains in power. Mineness is not involved in such an experience unilaterally (*einseitig*), the experience takes place on the border between 'mine' and 'yours' (designating the outside world). But at issue is not even just the border, but the ways and means in which it is transgressed (Blankenburg: 1988).

Blankenburg terms this transgression of the boundary between I and you upon which such curious exchanges give rise to passivity phenomena "interpenetration" (*Interpenetranz*).

What he means by the term is a specific kind of convoluting the dichotomy of self and other, with special emphasis on the interchangeability of the interaction. As such, my suggestion to think of "passivity phenomena" as phenomena in which the interpenetration of self and other becomes manifest entails two claims.

First and foremost, "interpenetration" describes a specific manner of disordering the dichotomy that obtains between self and other in "normal" experience. There is an exchange of attributes that would otherwise distinguish these two entities as sharply

opposed: certain aspects of “mineness” help to recognize another while the markers of otherness come to define an “I.” There is nothing astounding about this phenomenon considering the dialectic of ego-formation proceeds exactly along such an interplay between ipseity and alterity. In schizophrenic persons, however, this relationship lacks the structure that would allow for the emergence of a higher-order self from such a dialectic progression. As such, with the dialectic collapsed, self and other enter into a much more complex relation of intermingling: instead of being distinguishable from each other, and rather than standing opposed to each other and playing off of each other through their opposition, one term is found embedded in the other while embedding the other in the first.

Secondly, I propose the term “interpenetration” for the analysis of these symptoms because the interchangeability of this relationship – the fact that the I is seen as penetrating into the other *while* the other is simultaneously intermingled with the self – captures the dynamic of the processes at work in producing the bodily sensations from which these symptoms originate. Without recognizing this reversibility, and without trying to understand both of these processes together, one can hardly arrive at a proper description of these experiences.

In the acute psychoses, we even find that the patient might believe the survival of the world to depend on him (for example on whether he continues to breathe, or does this or that). The maximal expropriation of intentionality as one’s own stands here in contrast with the experience of omnipotence, which displays itself as the obverse of absolute self-empowerment. It is different from manic ideas of grandiosity due to the immediacy of their lived experience. Everything encountered in the outside world “magically” falls under one’s governance – often because the dissociation of the congruent affect is lacking (it is for this reason that there is a feeling of grandiosity) (Blankenburg: 1988).

The “reverse” side of these phenomena – delusions of being controlled, or experiences of experiencing thoughts inserted among one’s own – tend to dominate our knowledge of passivity phenomena, not simply because they are more interesting, but, as Blankenburg points out, because these obverse phenomena disturb diagnostic categories that focus on symptoms more than on the underlying disorders they indicate.

The recognition of the interchangeability of the self’s penetration into the other with the other’s penetration of the self was already recognized by Bleuler in what he called “transitivism” (Bleuler: 1911). For Bleuler, transitivism is one of many different types of alterations to the ego that involve “loss of the feeling of activity and, particularly, the inability to direct one’s thought.” The many examples used in illustration of this phenomenon typically mistake the “I” for a loved one, or for a member of the care staff. But Bleuler also gives a detailed description of the very same feature of these examples that Blankenburg emphasizes: the interchangeability of the “direction” in which these influences operate.

A patient is not quite clear as to whether people or his hallucinations influence him, or whether he influences them; indeed, he does not care which way it works; the direction of his actions from himself or to himself, and hence the person involved, is not clearly distinguished (Bleuler: 1911).

For example, “a hebephrenic thinks that whatever he does (for example, scratching his face) is being done by another person,” and the person to whom the action is displaced is always the person whom he happens to see at the moment. Bleuler thinks that, in such instances, it is hardly the case that an act is “transitively’ displaced onto another person.” Rather, the person is reflexively incorporated into the patient. Hyper-reflexivity on the part of the patient usually allows for a third-person perspective on one’s own actions – in this

case, this third-person perspective automatically attaches to another person, and, interestingly, to *any* other person visually present to the patient.

In the end, just as Jaspers emphasizes the simultaneity of thought insertion and thought withdrawal, Blankenburg also points out the presence of a combination of otherwise divergent disturbances in passivity experiences. On the one hand, schizophrenic persons often complain that certain feelings, thoughts, movements and sensations are “influenced.” These sensations are frequently reported by clinical practitioners; they appear adequately unusual or “bizarre,” one might say, to arouse curiosity and incite research. Experiences of feeling oneself “influencing” remain underreported for the same reason. Even though these frequently accompany (often indistinguishably) the feeling of “being influenced,” the conviction of the schizophrenic person of being able to influence others is often dismissed as a delusion of omnipotence – which precludes consideration of these claims as based in feeling and bodily sensation.

### **4.3: Interpenetration Phenomena**

Unlike Jaspers and Bleuler, however, Blankenburg urges a combined analysis of these two seemingly contrary alterations of the schizophrenic experience because, at the phenomenal level, they appear to be related. He points out that, when schizophrenic persons complain that their acts are influenced, they describe them as being “governed” by other persons, at times even by foreign powers. By using the term “delusions of alien control” in US psychiatry, we perhaps overstate the significance of a sense of being “controlled” in these cases. Blankenburg’s German-speaking patients report not so much an experience of being “controlled,” but of being “guided” or “steered” (Blankenburg: 1988).

They say that these acts were performed in their place, or that they were *gemacht*, ready-made for them. Their emphasis is on describing an eerie sensation that the act or the experience in question was adopted specifically to them, and to their bodies in particular. They often indicate that there is some kind of underlying logic that explains these feelings for them which derives from the peculiar fitting of the bodies of those who influence them to their own – or, in the obverse cases, between those whom they are able to influence and their own bodies. The sensation also extends to a sense of “being accessed” – to a bodily feeling of having had access of another person’s body, or of the access to their body of an object due to its being placed within their own.

In what follows, I am going to present four examples of phenomena dominated by similar self-reports of being “fitted with,” “accessed by” or “governed through” persons or objects other than the “I” of the patient.<sup>26</sup> What I am interested in, however, more than the relationship of self and other to which they testify, is the way in which this other is placed within the body of the patient. In all of the following four examples, the schizophrenic body comes to incorporate another body – and I limit my examples to cases where there is report of a sensation of this body taking up space within the body – while this other body also comes to envelop the schizophrenic body, for example by moving, voicing, influencing or causing it to register unusual sensations in the body. Eventually, it is on this analysis that one’s conclusions regarding the intermingling of selfhood and alterity must rely I shall

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<sup>26</sup> The term “schizophrenic person” or “schizophrenic self” would not be appropriate in this context – after all, what is under discussion is the disordering of the dichotomy between self and other. All of the patients quoted in what follows describe something other than who they are interpenetrating their body; therefore, it would be mistaken to deny that there is a certain entity recognized as an “I” in these experiences.

return to this theme in section 4.5, after completing the analysis of the schizophrenic body's interpenetrability in the subsequent section.

#### **4.3.1: Patient of Angyal's Interpenetrated By Eagle's Talon**

In his studies of the postural model in schizophrenic patients, András Angyal observed that many of his patients also reported “a sense of deformation of the body as of a light, airy substance passing through the limb and emanating from the body,” or of impressions “of a light phantom limb reaching out from the body in the direction of the pull of the muscle tonus” becomes even more interesting. These sensations are not only objectivated, but objectified: as the patients put it, “it is as though another limb, or another body” became discernible within their own. Similar phenomena were reported frequently when patients were asked to describe their sensations while moving. One of Angyal's patients even felt that during his movements he felt the talon of a bird penetrating through his body. What were like an eagle's claws reached inside his flesh, grabbed his spine and forced him into a different posture. To quote this patient:

[w]hen I move ... it seems that the whole body leaves me. The spinal column or something passes invisibly through the flesh. As if somebody would be able to get hold of me, like an eagle, and draw my flesh and bones away... They pull out another person from my body.... It is like some strong man would be able to yank out another form from mine. When they take that out of me, it feels like a quick sensation, like a jar (Angyal: 1936).

Interestingly, the patient was more preoccupied with specifying the qualities of the substance of the supposed object of sensation moving through his body than with the pain that one would think would accompany an eagle's claws reaching inside one's back. He determined that it was an “indefinite” substance; indefinite because it was subject to



intense change, and because it was sometimes felt within the body, at other times running through the body, and under even different circumstances, liberating itself from the body's confines, as the indefinite substance proceeded to slip, fly, emanate or shoot out of the body.

Implicit in these descriptions of the schizophrenic body's experience is the body's acquisition of a rather special quality. Underlying these beliefs is the conviction that, unlike the everyday world of physical objects, the schizophrenic person's body does not have to occupy its space exclusively. Extended objects occupy a given enclosure in space exclusively: without allowing for another extended substance to occupy the same space marked by its coordinates. The interpenetration of two forms within the schizophrenic person's bodily space signifies the relaxation of this limit: this belief can only originate from the possibility that more than one extended thing may share space with the body at one and the same time. This is a way of privileging the body that one would think is a testimony to a relative degree of narcissism - were it not the case that, by marking his body in this way, the patient sets himself up for absorbing an injury to the integrity of the body.

#### **4.3.2: Renée's Fluttering Birds**

A schizophrenic person described in an exquisite monograph on the symbolic treatment of schizophrenia person as Renée (Sechehaye: 1951) also reports sensations of an interpenetrated body. In an autobiography written by Renée herself, she describes a psychotic episode during which

horrible images assailed me, so vivid that I experienced actual physical sensations. I cannot say that I really saw images; they did not represent anything. Rather I felt them. It seemed that my mouth was

full of birds which I crunched between my teeth, and their feathers, their blood and broken bones, were choking me. (Sechehaye: 1951).

The crunching of her teeth broke the bones of the animals, the blood that is released dammed up in the isthmus to choke her: each of these details suggest a situation in which material entities interact in accordance with the physical laws of force and counter-force, but in complete defiance of laws that prescribe that any object must occupy its space exclusively, by itself alone. Her emphasis is on the material aspects of her body and the foreign object, arranged inclusively in the space of her body: the birds fluttering in her mouth not only fitted there, but enlarged the space attributed to it, as if she were conducting an experiment in setting up an impossible spatial relation.<sup>27</sup>

Just as in the above case, fundamental laws about the spatiality of extended bodies are transgressed in this case as well. Renée truly thinks that there are birds fluttering in her mouth. The irrationality of this hallucination is not simply due to the fact that it does not correspond to reality, what really strikes one as irrational is the idea that a number of birds would have enough space in the oral cavity to fly around, and that their movement would only be constrained by the violent destruction of the teeth. What is challenged is the idea that “the human body” occupies space by itself alone, although in a manner that is unquestionably instructive, because of course the human body is interpenetrable, and is in fact composed of regions of relative interpenetrability; moreover, these interpenetrable regions correspond to the erogenous zones of the body. While it is an “absurd” idea that the

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<sup>27</sup> Of course much is owed to her recollection of her bodily sensations in these terms: her therapy stressed the symbolic importance of the interpenetrating objects to which she related as to the real in her original state. Sechehaye’s case study, published in 1951 is also notable as what appears to be the first publication of treating schizophrenic on the symbolic interpretation of its symptoms.

mouth may hold a number of birds, the mouth is one of those parts of the body where the human body does not occupy space exclusively.

While Angyal's patient thinks his body interpenetrable beyond the skin on his back, in a region of the body that cannot be simultaneously occupied by the talon of a bird, Renée posits an interpenetrating object into a space within the body that could accommodate other extended objects to a certain degree. Both of them confuse sensations that would recede into the background of bodily awareness for sensations that would dominate in such circumstances. In chapter 3, a patient in Angyal's study (1936) complained of the "disappearance" of his food beyond his throat. At the time of hallucinating the birds Renée is regressed to the point of refusing to eat anything solid.<sup>28</sup> The hallucination presents her with the experience of an interpenetrable oral crevice: birds are lodged in its space, without any apparent perturbation to the mouth. Yet Renée does not suffer from this curious co-existence of the birds in the place of her mouth, in fact, as Sechehaye's analysis demonstrates, the experience is symbolic of her sadistic fantasies: her mouth is interpenetrated by birds while simultaneously it is interpenetrating the birds.

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<sup>28</sup> Renée's case would highlight the psychoanalytic contributions to understanding the schematas of the body understood in the above sense. It would not at all be spurious to state that this "coding" emerges from the child's experiments with other objects, objects that previously, in his or her pre-narcissistic, undifferentiated world, he or she merely experienced through their varying degrees of interpenetrability with the body.

Mme. Sechehaye finds Renée regressed to the oral-sadistic stage – sensations of crunching live birds but choking on the remnants of her oral aggression correspond to a stage where Renée's own refusal of nutrition reaches a perilous stage. She refuses eating anything but green (unripe) apples. The therapist at first overwhelms her: she brings them apples specifically selected for their ripeness and desirability and presents her with pounds of them. To the patient, this carries the suggestion that she must desire punishment, though this is the case, Renée's desire is compromised by her guilt over having desire for even the most basic means of self-sufficiency, so she refuses them – their sight visibly exasperates her. But Mme. Sechehaye does manage to feed her the apples when she decides to hand them over cut into pieces, and delivered at a regular time interval – as if they were solid bits of maternal milk. It is this establishment of a feeding routine that marks the establishment of a transference relation in the course of the therapy.

### **4.3.3: Berze's Patient Is Interpenetrated By Hallucinated Choir**

While Angyal's patient demonstrated what one might call a fully manifesting interpenetrated body, Renée's interpenetrated body shows merely the failed negotiation of the extensive qualities of the human body. An even "subtler" example of interpenetration will be taken up next, in which the interpenetration occurs between the spatially extended human body and certain intensive qualities.

In a case documented by Berze (1914), a woman suffering from schizophrenic delusions on his ward stated that "there was an 'electric' assortment of different people inside her," as well as "an officer of the Guard of Honor, Ernst Ritter von Proheim, Dr. K., a conference of doctors and a men's choral society". Of course I am not going to argue that the schizophrenic patient has physical sensations of a choir of men singing inside her. The choir "inside" her is the objectification (or "the morbid reification," to use the jargon of clinical psychiatry) of her hallucinated voices. She endows these auditory sensations with spatial qualities: she posits them as if they were extended objects taking up space in the inner regions of her body.

This is not to say, however, that the state she describes does not originate in bodily sensations. But the bodily sensations are not of an extended object interpenetrating her body, as is the case with Angyal's patient, but stem from the intensive quality of her hallucinations.<sup>29</sup> Either way, she provides evidence that she thinks it possible that her body

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<sup>29</sup> I should clarify on this point that I am not of the opinion that Angyal's patient *has* a sensation comparable to an eagle's talon reaching through his spine. This, of course, is hardly the issue here. I am not interested in whether the patient has a sensation comparable to what it would feel like for me to have a bird's claws reaching deep into my back. I am not interested in this way of putting the question because, first and foremost, I am not claiming to have access to this patient's experience; what is more, I approach this problem with the assumption that, since he is a schizophrenic individual, I have a lesser ability to have an empathic understanding of this experience than if the same experience were reported by a non-schizophrenic

may occupy space non-exclusively, allowing another object to be situated in the same space as that occupied by her back. What is at the core of these phenomena, I have argued, is an interpenetrable body. A body with the kind of materiality or substantiality that can be manipulated, or modulated, so as to allow for these delusions is also a condition of the schizophrenic woman's mistaken attribution of her voices to others, and indeed of all interpenetration experiences.

This woman's reported experience helps to trace these unusual sensations to intensive qualities – a development in our investigation that connects interpenetration phenomena to another important group of bodily symptoms of which schizophrenics frequently complain. Louis Sass provides a lengthy catalog of sensations of interpenetrating intensive qualities that are typical of a diagnosis of schizophrenia:

Still another cluster of 'basic symptoms' are the cenesthesias: sensations of movement or of pulling or pressure inside the body or on its surfaces; electric or migrating sensations; awareness of kinesthetic, vestibular, or thermic sensations; and sensations of diminution or enlargement, of heaviness or lightness, of sinking or emptiness, or of numbness and stiffness of the body or its parts. Generally unpleasant, and frequently accompanied by feelings of decline of vital energy, these experiences are combined with a loss of automatic skills and with various forms of interference or blockage of the smooth flow of motor activity (Sass: 2000).

In other words, beyond the voices, electronic currents, thermic sensations, pressure or pulling may also be located with precision in specific parts of the body. They are present as

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individual. Even so, I am not familiar with the sensation of a bird causing me such an injury. I note that it must be painful, and that the patient does not seem to attach the same stipulation to the experience, but only to report on the lack of his affective response. My claim relates to the pre-reflective body that makes one's awareness of such sensations possible – a body that is interpenetrated and interpenetrable (and, as I am to show later, a body which is considerably more vulnerable to interpenetration than the body of "normal" persons, since the human body by its very nature is interpenetrable in a specific degree).

sensations connected to motor functions or emotional activity. One might even find such sensations accompanying ipseity-disturbances, as is reported by Thomas Fuchs:

one of my patients reported that that she often felt a pressure on her tear glands; she then had to cry without being aware of a motive, and it felt as if she were made sad... Here the intentional content of the emotion is only grafted on the sensation subsequently, so to speak. Similarly, normal sensations of sexual desire, hunger and other visceral and muscular sensations may lose their contextual meaning and come to be explicitly experienced as *cenesthesis*, strange, unpleasant, and object-like states of tension, movement, pulling, pressure, or electric flow, which more and more appear to be caused by an outside source manipulating the patient's body. (Fuchs: 2005a)

I emphasized already in Renée's case that what is disturbed in these examples is the body schema, in an infrequently noted sense: as a field of localization inscribed with an implicit sense of the body's differing manipulability. No human body can serve as the "locus" of embodiment without operating on the basis of some version of this "code," which supplies an implicit sense of the relative degree to which one's body is penetrable to other objects. This "inscription" of the body with gradations of its penetrability serves a normative function, not only in a sexual sense, but also as presupposed in kinaesthesia, and certain acts of touching, grasping, and other similar activities in which the body participates as a physical object interacting with other physical objects. This pre-reflective ability differentiates between "object-like" regions of the body (those that occupy space exclusively) and regions with a relative degree of interpenetrability (parts of the object-body that may nevertheless take in or expel matter independent of the body).<sup>30</sup>

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<sup>30</sup> This notion of the body as a map is already present in Deleuze and Guattari's early concept of the body-without-organs (Deleuze and Guattari: 1972) – even though the latter are more concerned with a bodily surface abstracted into an unliveable homogeneity. It seems to me that, before proceeding with the notion of a body schema stripped of its various organs, it would have been a productive juncture to consider the body

It is perhaps imprecise to call the schizophrenic body an “interpenetrated body,” because interpenetrability is a crucial prerequisite of any collection of matter that serves as a human body, as embodied subjectivity. The schizophrenic body is interpenetrable, but its interpenetration is regulated by a different code. In the examples I cite, there is a vulnerability to interpenetration beyond the level characteristic of the narcissistic self, that is, to an ego and a bodily entity properly differentiated from the world. The cenesthesias further contribute to the above conclusion that the schemata of the schizophrenic body are disorganized in this respect. When the body becomes objectified in the explicit bodily self-awareness of the schizophrenic individuals as conductive of electricity, or of pushing and shoving, pressure, and so on, the affectivity of the human body is expressed in terms of properties attributed to a material entity “conductive” of intensive qualities. It would be mistaken to think of this manner of thinking about the body as “pathological,” because a sense of this implicit materiality of the body is part and parcel of pre-reflective bodily awareness, though awareness of these experiences in schizophrenics is unusual and “abnormal” when compared to most people’s experience.

#### **4.3.4: Katie’s Delusional Machine**

Delusions involving devices planted in one’s head, or worms crawling in one’s flesh, are so well-known even in popular culture about schizophrenic delusions that there is hardly any need to point these out as examples of “interpenetration.” To be sure, these

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schema as the *body-with-organs*. Deleuze and Guattari’s argument that only outside the realm of schizophrenia is the body inscribed with meaning by desire (a technical term in the context of their schizoanalysis) is to be reversed, therefore: in fact, the schizophrenic body displays an even more vividly experienced, and an even more variable map of functionality, which should inform one’s account of the bodily schemata to a considerably greater extent than Deleuze and Guattari thought.

better-known delusions only indicate the introverted modality of the body interpenetration: these are merely examples of three-dimensional objects taking up space within the body's own bounds of extension.

Let us therefore consider a clinical vignette that illustrates a schizophrenic experience in the delusional stages of the psychosis that gives an indication of both the inner and the outer aspects of the interpenetration.

Katie repeatedly claimed that everyone thought they had the right to “tell her off.” Furthermore, she said, everyone had a ‘device’ that transmitted information about her. If something happened to Katie in one place, then information about these events was transmitted to other places. She would hear comments on a topic at work, and hear references to these when she entered a shop. When asked what made her believe in such a ‘device’, she would answer that, although she had not seen it, she was sure such a thing must exist; how else could her personal information be circulating to so many strangers? Why else would a bus driver suddenly start to argue, be aggressive and “tell her off”? As a consequence of these happenings, Katie had stopped socializing and was fearful of public places [...] (Rhodes and Gipps: 2008).

In this case, others are thought to be in possession of a device to which information about Katie is transmitted. Quite the opposite of thought insertion, Katie's delusion is about thoughts intermittently becoming “known” to other people.

The body interpenetrates the world of others in this case, metaphorically speaking. If it is true, as I above argued, that what is at stake in these experiences is a body schema in which a relative “penetrability” – belonging to the three-dimensional substantial aspect of the body – is inscribed, in so far as the subjective embodiment of such a material entity requires this, then Katie's example is instructive because it shows the “projection” of this specifically schizophrenic, intensely interpenetrable body schema occurring in terms of the embodiment of others. Katie hears comments about her private experiences from those



who could hardly be privy to this information (e.g., comments on her work as referenced during her shopping, and, though she does not say so explicitly, likely comments about thoughts she is too afraid to share with anyone else). She attributes these beliefs to the device through which everyone receives information about her. In other words, her own bodily experiences are posited as also being characteristic of everyone else's.

A psychiatry textbook would point out the "imperviousness" of the delusion to reason and its contrariness to "reality." But something considerably more important takes place here: Katie posits that everybody else's body is set up just like hers. For Merleau-Ponty, this important constitutive feature of the body's pre-reflective experience becomes the basis of the intersubjective world: "intercorporeity," an extension of one's own modality of embodiment, always and already projects the embodied subject into an intersubjective world in which the same modality of embodiment is shared in common by others – pre-reflectively, as an "internal relation," before any methodological attempt to know others as others.

I experience my own body as the power of adopting certain forms of behaviour and a certain world, and I am given to myself merely as a certain hold upon the world; now, it is precisely my body which perceives the body of another, and discovers in that other body a miraculous prolongation of my own intentions, a familiar way of dealing with the world. Henceforth, as the parts of my body together comprise a system, so my body and the other's are one whole, two sides of one and the same phenomenon, and the anonymous existence of which my body is an ever-renewed trace henceforth inhabits both bodies simultaneously. (Merleau-Ponty: 1946, 412).

The intercorporeity that structures Katie's delusion is counterfactual – the body of others cannot incorporate devices connecting her own experiences to that of others. Nevertheless, the belief in the device suggests that she is attuned to an intersubjective world, regardless

of how few others share her specific mode of constituting this world given her alienated and mechanical rendering of her connection to a world of others.<sup>31</sup> There is no reason to deny her belonging to an intercorporeal world, with the caveat that the self-formation based on this constitutive aspect of the intersubjective world takes place differently than in non-schizophrenic persons. In fact, the specific content of Katie's delusion is further proof in support of this conclusion. With the help of the transmission device, Katie objectifies this pre-reflective "internal" relation to others: it is as if the less she is assured of the existence of this connection by implicit feedback from the behavior of others, the more she is willing to actively constitute evidence of the connection. She hallucinates an object operating within the body of others that mechanically ensures her on-going participation in an intersubjective world, "miraculously prolonging" her body schema in the most literal sense.

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<sup>31</sup> The objection is going to be brought up against this claim that the well-known inability of interpersonal attunement so frequently observed about schizophrenic persons contradicts this conclusion (I discussed schizophrenic disorders of attunement in Chapter 1). Schizophrenic persons indeed find it difficult to participate in a social world due to their inability to discern implicit social cues, but this social world *is* a social world structured by "normal" intercorporeity. From this, however, there is no reason to conclude that they are incapable of constituting an intersubjective world based on their pre-reflective bodily experiences, though the fact that their interactions continually obey laws different than those they would find predictable no doubt contributes to their sense of isolation. Their difficulty is not simply that of understanding emotions or implicit social principles of social behavior. Their problem in understanding another's assertion of "I am sad" is not simply the inability to empathize with "sadness," but lies in prescribing this emotion to an "I" properly differentiated from a nexus of intersubjective relationships. The schizophrenic self, as understood by psychoanalytic theories, is formed on the basis of introjecting others, as I am to discuss in the concluding chapter of this dissertation; as such, the delimitation of sadness to a narcissistic self itself poses a problem for them (the intensity of schizophrenic transference is the direct proof of this suggestion). It would not be unreasonable to argue that the eventual failure to recognize another's body as another subjectivity – as is the case with some schizophrenic patients, e.g. the woman described also in Chapter 1 who no longer has a "corporeal signifier" – is due to the failure of encountering other embodied others who conform to this schizophrenic sense of intercorporeity and is employed as a defense mechanism against this type of disappointment.

#### **4.3.5: Interpenetration Phenomena: A Summary**

What the above described interpenetration phenomena share is a more or less perfect participation in bodily sensations that involve the simultaneous occupation of space by more than one body. In cases in which this phenomenon is tampered with, specific imaginary forms of the human body, though still recognizable, become interpenetrated with other bodies – with the result that the body is experienced as an intensive quality.

In the previous chapter, I traced the distortions of the schizophrenic body image through cases in which it might lose not only its integrity or its boundaries in the fractured and flowing body image, but also its singularity and uniqueness. While these are unusual experiences, so is the inability of most persons to understand the so-called disorders of the schizophrenic body as constituted by the penetration of the same relationship with others into the “inside” of the body. Readers of Merleau-Ponty are often surprised about just how far the notion of intercorporeity “extends” the sphere of our bodily actions. Schizophrenic persons testify to another, similarly important consequence of the body’s experience: that the intersubjectively constituted aspects of the body schema penetrate well within our bodies, and that any process which leads to the emergence of something distinct and independent is merely an isolated aspect of the ego’s formation, and one which cannot and should not be understood in isolation from the sense of alterity that constitutes the self from within. In the objectification of these bodily schemata – of structures of the body’s experience which are not to be brought to explicitness beyond their implicit role in human behavior – schizophrenics no doubt exhibit an extreme, though not necessarily anything more radical than the narcissistic self’s conception of the interpersonal world as being centered around its unique singularity. Yet there is more to be said about the schizophrenic

person's splitting of its body between an interpenetrated and an interpenetrating doublet in the next section.

#### **4.4: The Interpenetrated Schizophrenic Body**

From among the examples discussed in the previous section, the case of Angyal's patient is known in sufficient detail to determine the specific manner in which two distinct body constructs are subject to sensation in the interpenetrated schizophrenic body. Andras Angyal, who was born in the rural areas of what at the time was Hungary and who went on to receive his PhD at the University of Vienna, where he was a part of Freud's circle, emigrated to the US in 1932 and came to be known during his later career as the proponent of "holistic psychoanalysis". At the time of publishing his paper, "The Experience of the Bodily-Self in Schizophrenia" (1936), in which only one patient's self-descriptions and "anomalous" bodily experiences are treated by Angyal in detail, other patients also participate in the case study to support the thesis that these experiences are not unique among schizophrenics. Angyal was especially influenced by Head and Schilder's writings on the postural model of the body. This model was later subsumed (in part because of Merleau-Ponty's refinement of its theory), into the more recent concept of the body schema. Working as a psychiatrist in the 1930s, at the forefront of Angyal's analysis are theories related to the subjective experience of the most verifiable aspects of the body – aspects that result from the body's material qualities.

One of these theories held that the intensity of weight perception in normal persons is proportional to the strength of the muscle contraction employed in lifting or balancing a weight – in other words, that the longer one holds a weight, the heavier the object appears.

For Angyal, this theory provided the basis for examining the somatic complaints of schizophrenic patients through experiments testing the felt muscle contraction that might serve as their perceptual basis.

Testing this hypothesis among his schizophrenic patients, however, Angyal's attention quickly turned to their perception of their own body weight. Coinciding with kinaesthetic phenomena also experienced by normal persons, he noted that when focal attention is placed on the impressions of one's own body – when the patient is prone to explicating otherwise implicit processes in the body schema – “peculiar deformations of the postural model of the body” may result. “Today when I carried the laundry [on the shoulders] I seemed to become shorter, my back seemed to give way; when I put down the laundry I became higher, I gained,” one of the patients complained. Angyal found that

the impression of shrinking and elongation in his patients must be very intensive. [The same patient] reported once: “This morning after I put away the rugs and jumped down from the table, it felt like jumping down from a high building; my knees came up nearly to my stomach. I felt like somebody would force me down.” I asked him to step up on the chair and then step down and asked what he felt. When stepping up he felt an elongation of the body “as if the middle of the body would be elastic”; when stepping down he said: “You are pushed down, as if your feet would go to meet your head, like an accordion” (Angyal: 1936).

Previously the same patient also noted that “[w]hen walking on stairs I feel sometimes like a lift-up, like by air pressure; my spinal column expands like rubber; then it snaps together again. When I stand up from the chair it feels as if a spring underneath the spinal column would give me a push” (Angyal: 1936). Angyal therefore theorized that the most common of the body image deformations of schizophrenic persons could be led back to the unusual intensity with which they experience changes in their muscle tonus.

Given their tendency for hyper-reflexivity, these “unexplainable” fluctuations in the body’s sensation understandably lead schizophrenic persons to search for a cause, and to objectify the outcome of the change, or to attribute the process by which their body arrives at such a curious state of sensation to another person or object. This is the context in which Angyal’s patient speaks of the eagle that reaches through his back. It is the same patient, quoted in Chapter 3, who complains of “not having” a back, or of feeling nothing between his chest and the chair when he leans back during an interview. What is at issue in these sensations, however, is more than the porous boundaries of his body. The same patient describes other circumstances when he has an experience of other people populating his body. “When I ate this morning I felt as if somebody else’s head would also be there and would eat with me”, he says. “It feels like other people would stick their head into my head. When I am chewing it seems that another tongue comes and takes the food.” Sometimes these alien bodies are also engaged in actions initiated on their own. “When I do some work, like swabbing, somebody else is working with me,” stated the same patient. “Just like another person stepped in. ... It is as if they would be able to put their head in yours, to fit their shoulders, their hands, their legs into yours. When you move, they grab; sometimes it seems they are scared that you would fall. They try to help you, but they are clumsy.” On a different occasion, the same person noted that turning the page of his book, “it is as if a couple more pair of hands would try to do the same thing that I do” (Angyal: 1936).

It is noteworthy that the bodies placed within the body of this patient are extremely “helpful”: they cooperate with him in his movement, they even help him along (though some of them are too clumsy to be of much use); all in all, there is in general a sense of harmony in this arrangement. The only reason they are noticed as different from the body

proper is because “they” also have the “form” of a body. The emphasis is on the conformity of the shape of his helpers’ body: the tongue placed inside his mouth for example takes the food he is already chewing; the second head is “with” the patient, and the helping men fit their shoulders within his body just snugly enough that he can complete his work with ease. In other words, they are not simply some aspect of the physical body “paired” in some sense with the self as its worldly manifestation; they are persons in their own right. What gives them this status, and what completes their object-like presence within the body is that they have a form “fitting” with the body’s form. As the patient states, their shoulders, their hands and their legs fit perfectly within his own. These other men appear by “slipping” inside him, or by sticking a part of their body inside his, in particular into body parts engaged in work. This is why he finds them “sticking their head” into his own while he eats, or lending a tongue when he needs to chew. A beautiful example of this “cooperation” is presented in the example of how “they” save him from falling. “When *you* move *they* grab; sometimes it seems *they* are scared that *you* would fall. *They* try to help *you*, but *they* are clumsy” – meaning that whenever *I* get scared that *I* might fall because sometimes *I* am so clumsy, *I* am grabbed by *their* matching form – it is only in this case that *they* are felt as moving and helping.

I have already indicated that the bodily basis for this sensation is located in the schizophrenic body schema’s propensity to become exempt from obeying the laws of material physics, and to allow for the simultaneous occupation of space by more than one extended object. As we saw above, the argument can be made that this same tendency is at work in producing other bodily symptoms of schizophrenia, such as objectified voices and thoughts, as well as cenaesthesias and even delusions of control. Insofar as this is true, the

schizophrenic search for a “cause” behind the body’s experience – certainly a source of curiosity inviting schizophrenic hyper-reflexivity – need not result in an object-like representation of the body, or in experiencing the body as a machine-like and foreign entity. The same alienating curiosity about one’s bodily experience could also disorder the reflective representation of otherwise implicit features of the thing-like human body, including its extension, its spatiality, its materiality, and substance.

We must revisit the quote in which the eagle’s talon is localized within the patient’s body to become convinced of the significance of the substance of the interpenetrating and the interpenetrated bodies.

[w]hen I move ... it seems that the whole body leaves me. The spinal column or something passes invisibly through the flesh. As if somebody would be able to get hold of me, like an eagle, and draw my flesh and bones away... They pull out another person from my body... It is like some strong man would be able to yank out another form from mine. When they take that out of me, it feels like a quick sensation, like a jar (Angyal: 1936).

The much-discussed eagle draws out “another person” from the patient’s body which he describes as “another form of mine.” It is in this sense that he senses “that the whole body leaves” him when he moves. What passes through his flesh (either the spinal column or an eagle) “passes invisibly through.” The various forms harmoniously arranged in his body become separated under other circumstances as well: “[n]ow, when I leaned back on the chair my body seemed to slide out of me. Not exactly my body, but another form of mine.” Although his two forms agree in shape and form, they are sensed in their duality on occasion of his body’s movement, and then one of them usually tries to get away from the other: stepping out or, when the movement is sudden, yanked out as if from a jar.



A distinction in terms of the substance of the bodily forms lodged within is even more in the forefront in cases where the patient reacts to some kind of a hindrance on the outside. In these cases, the patient speaks of the other form as being composed of an “indefinite” substance. This indefinite substance is sometimes felt within the body, at other times running through the body, and under even different circumstances as liberating itself from the body’s confines, as the indefinite substance proceeded to slip, fly, emanate or shoot out of the body. In one specific instance, we may even observe the forms change from solid to airy, and upon encounter with a third object that provokes his hostility, back into a destructively concrete and localizable thing which no longer shares the body’s form.

As the patient describes it, “invisible things... parts are flying out of me. When I move quick, something is flying up from me, like air, like wings ... The worst thing is that when this invisible thing swings away from me, it feels that [like?] it hits somebody,” the patient continues. “You know, if somebody does something against me, I try to forget, let it go, but this thing hits out from my body automatically, shoots through space and hits people.” Here the patient practically made himself capable of striking out with rage against people without moving a limb. The second form slips out of the body with the lightness and indeterminacy of a wave of air. By the time it reaches its intended place, however, this same substance forms bullet-like projectiles – objects determinately extended and solid, and moreover hard enough to harm others.

Angyal adds that many of his patients also reported “a sense of deformation of the body as of a light, airy substance passing through the limb and emanating from the body,” or of impressions “of a light phantom limb reaching out from the body in the direction of the pull of the muscle tonus.” These sensations are not only objectivated (since they

produced by reflective awareness) but also objectified: they are given representation not as the experience of the lived body, but as an object-like entity. As the patient puts it, “it is as though another limb, or another body” became discernible within their own. Similar phenomena were reported frequently when patients were asked to describe their sensations while moving.

It is in this way that descriptions of bodies made up of a composite of substances are produced. For sometimes the distinction is not so much between two different substances, but between two kinds of solid material: one organic, which retains the body’s automaticity, while the other is inflexible but, precisely because of its rigidity, mechanical in its operation. Even in these cases, however, it is interesting to trace the distribution of the body’s function along this distinction. “When I go along the corridor it feels as if a flexible glass would be put through my body and touch the wall. When I go it feels as if I would push everything before me like a snow-plow; as if the glass would hold me back.” Or, in another example:

When I go on the street or through a door, it feels as if I would not have enough place, as if I would touch the walls. I feel large – I mean, the body is the same size, but the air around is large. If I go by a tree, I touch the tree with my air and it holds me back (Angyal: 1936).

In both of these examples, two bodies – one constituted as moving, the other as being moved – emerge, and their distinction is marked by the difference of their substance: the body moving has the solidity characteristic of the human body, while the body moved is made up of air. The two bodies are interpenetrated: the additional airy regions of the body moved are anchored in the body moving, but they form a second body around the solid body to encapsulate it.

Notably, in the first example, the sensations of being moved forward are experienced in terms of their heaviness: the glass-pane extending from the body's core and tracing the very limit of the physical environment holds him back – he must exert effort to move it forward. Metaphors implying weightiness as an obstacle to the free movement of the airy substance return in other examples as well, especially when the two “forms” of the body are found in strife. The patient might be stopped in his speech, for example, because little persons situated within him tend to “just drop some words on your tongue,” making it hard to control the movements involved in speaking. In these instances, his tongue feels heavy, “like if someone would hold it” (Angyal: 1936).

The fluctuations between the body's incorporation of interpenetrating bodies and their externalization of the same substance in the form of a solidity function analogously to the adjustments one makes in one's posture in response to the affordances of the environment. These are reactions to the changed constellation of the environment monitored by and counteracted through an implicit adjustment of the pre-reflective body. The same way one might adjust one's posture in preparation for taking down a soccer ball bent in ways unexpected as it is flying toward us, the schizophrenic patient under discussion here finds his “second” form in various degrees of solidification in order to counteract his physical environment. The patient seems to be capable of “normal” postural adjustments, but also of adjustments made to the comportment of his body and its placement within the world by way of modulating his body's substance.

What is more, there is a psychic achievement to differentiating “bodily forms” in this manner. Two different ways of placing oneself within the world come to expression in these examples. A harmony of forms, which makes it possible for the patient to complete

his daily routines – when the two forms play a role of co-production in eating and in sweeping, for example – testify to the mechanical “co-operation.” Their “strife,” which usually occurs on the occasion of the failures of the body, and especially in the instances of becoming immobile in the face of something overwhelming, result in greater degrees of objectification, and an increased focus on explicating the body in terms of its material attributes. The modulation of the body’s substance, or its bifurcation in terms of material qualities, also appears at times, and is also the feature of situations where the schizophrenic person is either overwhelmed or has lost a hold on the precarious unity of his or her sensations.

In his later writings on the body, Husserl distinguishes between an original bodily awareness, which is different from the experience of the body as a spatial object, and which is constituted via the self-objectification structured by an unthematized awareness of the body as a thing – as one among the many thing-like objects in the world. This original bodily awareness relies on the co-functioning of a motivated double series. Husserl calls these the *interiority* and the *exteriority* of the body, *Innen-* and *Aussenleiblichkeit*, respectively. This two-sidedness of the body composes not the body as an object of consciousness, but as a unified field of activity and affectivity (the “I can”) of the body. Together, these two aspects of the body of original awareness, which is the implicit dimension of the body’s experience as an object and its prerequisite, produce a double sensation of the body (as touching and touched, or moving and moved, etc.). What is more, these double sensations are produced out of a series of changing appearances, which require not so much objectification as two different aspects of the body as the singular manifestation of one body. The self-sameness of this original body of unthematized

awareness is already constituted by the co-ordination of a double series of sensations, which are acts contributing to self-experience by automatically functioning passive syntheses.

Not, however, in the case of the schizophrenic body. As Aaron Mishara writes (Mishara: 2007), in the case of schizophrenics, there is a “dysfunction” in the “pre-attentive binding” which would contribute an original sense of bodily unity to schizophrenic self-experience. Mishara is in search of determining a “pre-reflective” or “minimal self,” a self that comes to the fore specifically in the disruptions of self-experience characteristic of schizophrenia.<sup>32</sup> Subcomponents of bodily self-sensation, such as the proprioceptive information necessary for updating the postural body frame, are processed in the ventral system, and the exteroceptive multimodal information that underpins the central representation of the body and which is located in the ventral system are dissociable from the interoceptive pathway (Paillard: 1999; Milner and Goodale: 1995; De Preester: 2007). More importantly for Mishara, the schizophrenic pre-reflective self is vulnerable to failures of pre-attentive binding, and as such it is disordered as a system of prospective (or protentional) openness, which includes the ability to be affected by any point in an the experiential field, as structured by momentary, possible movement, prior to focal awareness (Mishara: 2005).

Rather than explaining these processes in neurobiological terms, however, I think one should rather take the cues for a positive characterization of the schizophrenic self by appreciating the psychic achievements that we see schizophrenics perform by the above

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<sup>32</sup> Though this remains unstated, I assume that this specific type of self in neurophenomenology, this self is not the same as the pre-reflective self of non-schizophrenics, or, at the very least, its similarities to a non-schizophrenic pre-reflective self have yet to be determined.

“abnormalities.” Only from the perspective of these unique capabilities may these be understood as “achievements.”

Let us consider, for example, the two different ways of placing oneself within the world that come to expression in certain examples already discussed: in particular, their distinction between being embodied via two “fitting” forms that work together, as opposed to feeling their two forms at cross-purposes in their activities. A harmony of forms, which makes it possible for the patient to complete his daily routines – when the two forms play a role of co-production in eating and in sweeping, for example – testify to their “co-operation.” Though this co-operation is mechanical, and requires reflectivity to maintain, thereby disturbing other ego-functions, it nevertheless maintains a sense of stability in a psychic sense. The “strife” of the forms, on the other hand, occurs on the occasion on which the lack of co-ordination in the body’s pre-reflective experience fails in one sense of another. This could be due to being overwhelmed (typically, schizophrenics are extraordinarily sensitive to abrupt changes in their environment, to which their mechanical way of unifying their self-experience cannot immediately adopt), or to being so “lost” in explicating the body that the external world no longer is able to attract them.

This process may indeed be taken to such extremes as to modulate the “substance” of the body, this ambiguous entity that is both embodied and material. In normal experience, a unity emerges out of these disparate elements, so as to conceal their disparateness. In the schizophrenic experience (at least during periods in which these phenomena characterize the condition), the distinction of the disparate constituents of self-experience dominates the structure by which self-experience is organized, and rather than being directed at a unity, the emphasis is on distributing what does not cohere.

Conceptually, schizophrenic persons make sense of the world by avidly sorting and categorizing: they engage with the details at the cost of forsaking what may provide overarching unities for the particulars. This tendency originates, however, from the body's inability to function as it does for "normal" self-consciousness.

## Conclusion

'Give me a body then': this is the formula of philosophical reversal. The body is no longer the obstacle that separates thought from itself, that which it has to overcome to reach thinking. It is on the contrary that which it plunges into or must plunge into, in order to reach the unthought that is life.

/Gilles Deleuze: Cinema 2, The Time Image/

So far, I only considered alterity in the schizophrenic body's experience, holding the problem of other selves at arm's length. In this final section of the dissertation, I revisit this problem, this time by drawing on a different source of evidence: on the psychoanalytic investigation of the other in the experience of the schizophrenic individual. It is often assumed that, in the rare moments in which analyst and patient do succeed in transcending their differences – as evidenced by the therapeutic progress made, or by the emergence of concrete details of the patient's psychosis – some form of understanding of the schizophrenic Other results from the interaction. An other who announces herself in her radical difference, a person ready to be domesticated in categories that establish her sameness, can finally be grasped with comprehension. To the contrary, I argue that the very setting in which such an understanding is obtained already distorts what comes to be known under these circumstances.

I choose to pursue this line of inquiry in this concluding section of the dissertation contrary to indications in the more theoretically oriented treatises on the phenomenology of intersubjectivity: which one might easily take as an indication that this line of reasoning is an unnecessary addendum to the previous chapters. The dismissal of the need to consider the problem of understanding in the treatment of schizophrenia is most



convincingly stated by Zahavi (2001), who thinks that by properly foregrounding the “genuine goal of Husserl’s theory of intersubjectivity,” one no longer needs to be halted by the “considerations of the (misguided) problem of whether Husserl’s concept of empathy implies a direct or mediated access to others.” Zahavi’s argument relies on a distinction made in Husserl’s writings between the constituting and the constitutive experience of others. Constituting intersubjectivity is the problem inherent to the first-person experience of the other, since other subjectivities can only be clarified for a phenomenological inquiry by recourse to one’s subjective experience. This problem is distinct from the problem of constituted intersubjectivity, i.e. from the theoretical difficulties grounded in the fact that others, as transcendental objects, and as persons with their own freedom and constituting subjectivity, are Others; “personalities,” as Jaspers would put it, who in their full existence continually escape even our best attempts at understanding them.

Zahavi makes the case for bifurcating what is commonly collapsed into the problem of empathy: he suggests treating the problem of “the possibility of the *constitutive* experience of others” separately from “the constitutive *experience* of others.” The former of these two resulting levels of analysis is what I noted with ethical concern in my introduction. In the end, the problem of *constituting* one’s experience of other subjectivities must focus on difficulties issuing from the fact that, when considered as transcendental objects, other persons, unlike most objects of consciousness, are not merely an intentional correlate of my own transcendental consciousness. It is by our disregard for an ethics of encountering this transcendental Other that we objectify fellow human beings; driven by our interest in psychiatry, it is because of missing this philosophical point that one might

objectify schizophrenic persons and compose them either too much in one's own image or, to the contrary, without recognizing their humanity.

The problem of the constitutive *experience* of others is preoccupied with the issue of what makes one's subjective experience of transcendental others possible. Categorical operations that apply with a lawful regularity, prior to any participation of the active ego in the object's constitution, are at stake in answering this question. Husserl contends that the eventual possibility of the kind of intersubjectivity agreement that guarantees the objectivity of the lifeworld relies for its possibility on these passive syntheses, among them passive syntheses which grasp objects as objects available to the experience of other subjectivities. Co-intended with what is intuitively given as an object are the inner and the outer horizons of an object: horizons which determine the sense of an object in view of the relationship between its given profiles with profiles not immediately given on the one hand and horizons which provide a similar relatedness of the apperception of the object to an outer horizon on the other. This outer horizon does not simply indicate a world-horizon and does not merely embed every object in the world, but also supplies the shared characteristics of the world. The constitutive experience of objects and other subjectivities, in other words, is due to the primordial intersubjectivity of the world of objects.

What is more, Zahavi argues quite convincingly that it is this latter problem of constituting intersubjectivity that sheds light on the problem of constituting intersubjectivity, not the other way around – as a more precursory account of Husserl's writings on intersubjectivity might indicate. If the constitution of objects already presupposes its availability as the intentional correlate to another constituting subjectivity, a plurality of perspectives by which an object may be grasped is always already assumed, at

the level of subjective constitution, in constitutive experience. Husserl considers this claim to have a universal scope, and not even the problem of schizophrenia perturbs him enough to reconsider this conviction.

Anyone may become insane, and I have my own representation of my having become insane if I experience others in a concordant way and feel conversely that my experiential unities are bursting out, that they are then unified again,

he writes in the *Analyses Concerning Passive and Active Syntheses* (1966), suggesting not only that the experience of schizophrenia remains within the scope of intersubjective constitution universally available to all constituting subjectivity, but that it is in fact accessible through empathy.

What I would like to show in the remaining pages of my study of schizophrenia is that this is an overly optimistic pronouncement. As I already stated in the introduction, one must take into account the radically other perspective of the schizophrenic individual at every step of one's analysis. Furthermore, in intersubjective encounters involving schizophrenic and non-schizophrenic individuals one cannot simply take it for granted that one's counterpart shares one and the same world. This is not to deny the possibility of a shared world; nevertheless, prior to admitting of this possibility, this shared world requires proper characterization.

The question of how we come to inhabit the same world across the divide initially separating schizophrenic and non-schizophrenic subjectivity forces itself upon our attention, especially in view of the fact that the main chapters of the dissertation invariably emphasized the idea that a specifically schizophrenic mode of alienation is central to its first-person experience. I engaged in the characterization of various levels of this

experience, and yet was forced to return on every occasion to a global feature characterizing the schizophrenic person's experience, which issued first and foremost from the schizophrenic person's extreme sensibility to the alienating features of self-consciousness. This sense of alienation is rooted in particular in the schizophrenic person's reflective awareness of his or her exposure to the foreignness of various facets of pre-reflective experience, and especially those supplied by passive syntheses. Put differently, that the world of objects is constituted along an outer horizon of intersubjectivity cannot simply be our final conclusion for how a shared world might come about in the interactions of schizophrenic and non-schizophrenic individuals.

### **Understanding Schizophrenia through Psychoanalysis and Object-Relations Theory**

During the initial chapters of the history of the psychoanalytic movement, the question of others or other objects did not even pose itself as anything worthy or possible of investigation. According to Freud (1914), schizophrenia was a psychic possibility only upon the exclusion of other-relatedness, and what proved this above anything else was the schizophrenic modality of withdrawal from the world.

Freud argued that the paraphrenic (his preferred term for schizophrenic) state of withdrawal was fundamentally different in its aetiology from the withdrawal experienced in hysteria, the obsessional neuroses, or even in organic pain. In schizophrenics, these processes take place without a prior differentiation of sexual energy as other- and self-directed. It cannot be the case therefore, argues Freud, that the schizophrenic person "has ceased to direct his motor activities to the attainment of his aims in connection with real

objects,” while retaining these objects in phantasy, which is normally the process by which states of withdrawal indicate that a person has “broken off his erotic relations to persons and things” (Freud: 1914). Instead, the schizophrenic withdrawal runs parallel to a certain “megalomania characteristic of these conditions,” which is a disturbance not of the narcissistic ego, but of a primary form of narcissism.<sup>33</sup>

Freud’s pronouncement that a schizophrenic person’s abandonment of reality stems from his or her inability to invest any object or person with libidinal energy – and that, consequently, the relationship he or she maintains with others need not become the topic of further study – was driven by methodological considerations.<sup>34</sup> In the writings of Klein (1946), Fairbairn (1952), and Guntrip (1968), we find a contrasting characterization of the withdrawal of schizophrenic persons, one which does not deny that schizophrenic persons become “shut-in” as a result of these processes, but which disagrees with the hypothesis that this state is due to their inability to become other-directed. In fact, according to Melanie Klein, desire and its object are mutually dependent upon one another, and an image or an idea of an object construed in fantasy is always already present not only in desiring something, but also in approaching an object with aggression (Klein: 1930).

In the theoretical framework Klein and her followers contributed to the study of schizophrenia, objects are not located in the external world to be approached by an instinctual directedness; to the contrary, an internal situation already expressive of one’s relationship with previously internalized objects determines the kind of object upon which

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<sup>33</sup> As Freud notes, this theory originates from his study of Dr. Schreber (1911) which focuses on the symptoms of paranoia and not to the conditions of schizophrenia put to analysis in this dissertation.

<sup>34</sup> As Freud himself states, it was developed specifically as part of an attempt to “bring our knowledge of dementia praecox (Kraepelin) and schizophrenia (Bleuler) into line with the hypothesis upon which the libido-theory is based” (Freud: 1914).

these internal processes may settle and choose as their receptacles. The introjection and the projection of bad, persecuting objects oscillate with the conjuring of unrealizable good objects, which threaten a person with the dread of loss – the more ruthlessly the more these objects manage to entice. The tendency to possess, control or destroy objects in order to deflect the same motivations from his or her ego is therefore present even in the earliest stages of psychic development, and what leads to a state of withdrawal is the specific impossibility of maintaining the kind of relationships that schizophrenic persons crave, rather than any kind of constitutional inability to progress beyond the stages at which the intensity of these processes is dominant.

The schizophrenic person is not driven by “love” (a term Guntrip struggles to reserve for a relationship between an ego already differentiated from the object toward which this emotion is directed), but by “a destructively frustrated ‘need’”: a yearning for an object which, based on previous experiences, is wanted proportionately to its tendency to desert or reject this demand (Guntrip: 1968). Because desire and an expectation of refusal are co-mingled in this way of connecting, the schizoid personality can only master this experience by emotional withdrawal. Freud’s characterization of the process that takes place parallel to this introspective turn is misguided, therefore: it is not “megalomania,” but a specific type of aloofness and an essentially self-defeating form of self-sufficiency.<sup>35</sup>

Since love as such would be too dangerous to express, the schizophrenic person thus resorts to emphasizing her independence and her striving on the only relationships she can

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<sup>35</sup> As discussed in Chapter 2, Stanghellini (2004) insists on using the term “heteronomic vulnerability,” perhaps because it indicates that it is intended in defense against the impact of the interaction with the other. Indeed, on superficial observation, these statements might strike one as issuing from paranoid processes, which is what occupied Freud primarily in his analysis of Schreber’s autobiography. But the fear here is not occasioned by the potential persecution of the other, but, to the contrary, by the expectation to be left unsatisfied in one’s need for developing a relationship with others.

sustain by herself: her inner psychic preoccupation with internal objects. The anxiety that arises in connection with capitalizing on an opportunity to establish a relationship with another object simultaneously brings forth the fear of one's abandonment by the needed object, as well as a dread of losing herself in the process, of becoming annihilated by this extreme longing for another person, most typically one's mother.

It is extraordinarily difficult to conceptualize the person obeying both of these opposing directives as a "schizophrenic self," simply because the concept of selfhood is directed at capturing some dimension of permanence and continuity in the other. What emerges in the analyst's interactions with a schizophrenic patient is a transitive self-construct, an "I" which gradually becomes able to differentiate between self and objects but which, while undergoing this development, is a person only characterizable in terms of the palpitations of her contradictory psychic energies.

Any stability obtained in this self-construct is due to a regressive turn, which brings about the consolidation of the internal objects of the inner world of the schizophrenic individual, leading to the gradual ossification of transient bad-object situations into more and more permanent objects, which protrude into the schizophrenic self's inner folds. One can posit that these bad objects are in place the deeper the regression and the more impermeable the state of withdrawal are.<sup>36</sup> Once a schizophrenic person is limited to finding her bearings in the world in this way, the tendency is to objectify the psychic drive directed at a given object: to preserve, in the form of a definite object, the shifting forces that play a tug-of-war with the ego. In the previous chapters, I pursued an analysis of the

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<sup>36</sup> As such, this type of permanence to the "schizophrenic self" is reached in a state that requires considerable analytic work *before* the contradictory desires I describe above can reach expression.

various ways in which an internal object is capable of becoming “felt” as a material object, at times explicitly interpenetrating within one’s own body and signifying both the body’s pre-reflective sense of its own alterity and the otherness of the various objects at which a specific individual’s desire is directed. In the psychoanalytic context, these internal objects show up as remnants of past relationships with others, formulated as introjected versions of the situations in which one’s outer experiences failed to satisfy early needs.

Once analytic work becomes feasible, however, the schizophrenic patient’s tremendous fear of losing her independence naturally requires compensatory retreats into an inner mental world, where she may carry on relationships with a world of fantasied internal objects. Still, the most crucial aspect of this state is hardly the schizophrenic person’s emotional withdrawal. Basing herself on the secure hinter-ground of her inner world of internalized objects, she is likely to model her interactions with other persons on bad-object relations, and this also poses difficulties that can only be surmounted through lengthy therapeutic collaboration. But the relationship in the end is unfeasible because of the impossible demands it places on the non-schizophrenic observer. To be in one moment intensely wanted, but almost as immediately to turn into the source of influences to be avoided at all costs – these are irreconcilable extremes that one would have to sustain simultaneously if one were to master this relationship.<sup>37</sup> Not only would one be expected to overcome the incompatibility of the schizophrenic person’s intensely emotional excesses;

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<sup>37</sup> One of Guntrip’s examples from a real-life analytic scenario demonstrates the shifts typical of this stage of the analytic work: “I felt I must get possession of something of yours,” the patients says, “I thought I’d come early and enjoy your arm chair and read your books in the waiting room.” A genuine advance, a statement of love and admiration is made with these words, but as the story goes on, without a moment’s notice, “she switches over to: ‘You can’t possibly want to let me take up your time week after week’” (Guntrip: 1968) Abuse follows, for example charges that the therapist wants to dominate the patient and to keep her under his control, to drain all of her financial resources by the weekly sessions and make her life impossible, etc.



even more importantly, one would have to be able to synchronize oneself with the rhythm of her inner flow. What would be required for capturing this other beyond the present moment is to be steeped just as inescapably in the schizophrenic person's inner psychic life as she herself is.<sup>38</sup>

### **Empathic Understanding During Therapy**

Another paradoxical confluence of forces directly operating on the person of the therapist also convolutes the object of any possible interpersonal understanding in the analytic setting. The analyst finds himself engaged in the therapeutic exchanges both in an utterly impersonal (even selfless) way as well as in a powerfully personal manner. On the one hand, the schizophrenic person's transference relationship originates in the projection of "bad" internal objects onto the therapist. The relationship is not directed at him in a personal way; rather, he is grasped only in so far that he can serve in the role of the rejecting, abandoning and persecuting internal object. In these cases, the therapist's interaction is not only with the patient, but with a shifting matrix of interpersonal relationships structuring the patient's specific psychosis.

But the therapist also reacts to the difficulties involved in sustaining any form of understanding of the schizophrenic person in a manner so deeply personal that its self-

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<sup>38</sup> This is not to reject attempts to arrive at a "schizophrenic self" by means of a phenomenological analysis. My objection here relates specifically to the unexamined premise that this schizophrenic self would be a mere variant of the ideal transcendental self, and that its difference may be determined solely in terms of its "disorders." The most prominent aspect of schizophrenia is the inability to employ the self/non-self distinction. The "selfhood" of schizophrenia, therefore, is not to be confused with the way in which selfhood becomes a theme for philosophical investigation (and while, as it happens to be the case, this investigation is limited to individuals with more developed levels of self-differentiation). Accordingly, the psychoanalytic means by which we understand this schizophrenic self – or by which we understand just how much we do not understand it – ought to find their way into any conclusions formulated about the disordering of the schizophrenic self.

related implications often go unnoticed by the therapist himself. This phenomenon is sometimes thematized as counter-transference, though what is at issue here is certainly not the sometimes dreaded effect of becoming psychotic, or fundamentally split as a result of being too attentive to the patient (I met psychiatrists who did not think anything more was meant by the term). Any unconscious fear of this possibility would already have a formidable impact on the interactions that emerge in therapy, but the range of emotions induced by the patient's behavior extends considerably wider than this. During analytic work, it is sometimes impossible not to feel used as a mere stand-in for the patient's intense transference needs, and the aggression and the hostility expressed by the patient is often unconsciously reciprocated. Other therapists are more prone to reciprocate by themselves relying on the patient for their own emotional self-gratification. Even the sometimes overwhelming feeling of the uselessness of the therapy, and the debilitating despondency about one's own ability to do anything for the patient – the very sentiments that may have made Freud's original pronouncements regarding the schizophrenic patient's incapacity for transference relations attractive to his followers – are typical manifestations of a counter-transference reaction (Spotnitz: 1999).

While these feelings or impulses are nebulously formed in the therapist, the schizophrenic person is acutely aware of them. This often strikes the therapist as close to miraculous, but in reality it has a simple explanation: it is due to the fact that schizophrenic individuals rely on introjection mechanisms just as much as on projection for forming relationships with others. In a paper dedicated to the significance of introjection in the therapeutic setting Searles (1958) describes several examples demonstrating the extensive

range of schizophrenic symptoms that are explained by the patient's introjection of contributions made by the therapists to the session often unbeknownst to him.

The recognition of these processes is hindered by the fact that the schizophrenic patient has an uncanny ability to select exactly those aspects of the therapist's conduct which he is incapable to come to terms with (or which, for reasons absolutely personal, he would prefer not to face). Searles' examples, describing schizophrenic patients treated during the 1950s in Chestnut Lodge, include a woman patient in a fairly stable state, and as such capable of demonstrating how introjections of the therapist's attributes fed into her own self-concept; a male patient whose hallucinations were formulated on the basis of the introjection of the therapist's perceived contempt; and several examples in which the patient's compulsive "acting out" was made comprehensible by scrutiny of the therapist's retroactively recognized and by most standards rather negligible contributions to the patient-therapist relationship.<sup>39</sup> Interestingly, all of these examples operate with a nuanced recollection of the comportment of the therapist's body or the changes he made to his appearance during or in between sessions.<sup>40</sup>

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<sup>39</sup> In a cursory note, Searles also adds that "the schizophrenic patient's so frequent delusion of being magically 'influenced' by outside forces (radar, electricity, or what-not) is rooted partially in the fact of responding to unconscious processes in people about him" – which accords with my suggestion regarding the interpenetrated body's experience in Chapter 4.

<sup>40</sup> To demonstrate how subtle are the details about the therapist's participation in this relationship that are subject to perception and subsequent introjection by schizophrenic individuals, here is a shortened version of the case of the woman patient, who expropriates the attributes of the therapist for her own purposes:

... in one of the first week's sessions, as she was prattling on in a self-deprecating and rather absent-minded fashion, I took my ease by tilting my head over, at a sharp angle, against the wall. She continued rambling on, but apparently taking in, with her eyes, this shift in my posture; one of the features of her behavior which had impressed me during these early sessions was her apparently taking sharp visual note of every least thing about my appearance and bodily movements, but never making any verbal comments about these ... In this instance, what I heard within a few seconds, in the midst of her prattling, was, 'I know I looked awkward on the tennis court', whereupon it occurred to me that this unusual, head-tilted posture

We merely begin to understand the many ways in which any understanding from an empathic approach is intrinsically incapable of allowing a reliable object of understanding to come forward in these interactions. The problem is not simply that the patient projects upon the therapist in ways that convolutes their collaboration and any understanding that might result from it. Nor can we be satisfied by noting that the schizophrenic's proneness to introject the therapist's unconscious tendencies play a crucial role in what is being formulated as the outcome of the collaboration. The therapeutic setting allows for the actualization of potentialities in its two participants – actualities that are, in the end, specific to the relationship that serves as the background of their collaboration: rather than characterizing its individual participants, any knowledge that may emerge as a result reflects only on the unique self-other configuration brought about by the work of analysis.

Yet it is important not to overestimate the role and the potential contribution of understanding obtained via empathy, especially given the specific circumstances in which schizophrenic and non-schizophrenic persons – and patients and analysts in particular – come to establish successful means to communicate. Empathy is not simply a positive means of accessing another subjectivity. In the form in which non-schizophrenics deploy it,

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might well look awkward to her. In another session soon thereafter, the day was so hot that I removed my coat and loosened my tie; within a few seconds I heard, in the midst of her self-critical prattle, the statement 'I'm a very slovenly person.' Thereupon I realized that in the eyes of this woman who had come from a highly genteel background and even in her illness was generally neatly groomed, I might well appear slovenly ... But the fascinating thing was that she evidently experienced these traits as being aspects of herself and was quite unable to perceive them as traits of mine ... In subsequent hours, I found her to be referring to herself variously as 'smug', 'swaggering', 'blah', 'sleepy', and so on, at times when ... I was feeling thus. ... It was evident that at the conscious level she genuinely perceived only *herself* as being thus and so, as, to be sure, she indeed was at times; but she seemed quite unable to perceive, consciously, that *I too* was being smug (or what not) and being so, oftentimes, when she showed nothing in her demeanour which would warrant her self-accusation along this line (Searles: 1958).

empathy is part of an unavoidable compulsion to anticipate commonalities with the other person. From the perspective of those who find it difficult to relate to others, the expectation to be accessed through empathy calls for the kind of transparency with which they cannot possibly comply. The schizophrenic person in particular is incapable of revealing herself in interactions directed at her closed determination. What she expects of others is a self in the same kind of transition that characterizes her idiosyncratic excursions into the world of external objects, but at the very least a counterpart who also escapes the kind of totalistic grasp that understanding of others claims.

Interactions that take place between schizophrenic and non-schizophrenic individuals are structured by incongruent expectations. This conclusion is reached not simply because one expects the schizophrenic person to be an Other – under the approach beyond empathy, there is nothing axiomatic about the Otherness of the schizophrenic person. The impossibility of reaching a congruence of similitude characterizes first and foremost the relationship by which the schizophrenic person's otherness is grasped, and only secondarily and in a derived manner the schizophrenic Other understanding attempts to reach.

The nature of the fundamental difference of persons schizophrenic and non-schizophrenic may come to be determined however even on this approach, though only in a way that, instead of settling the matter in the form of a definite answer, raises further questions. While our familiar experience suggests a self outwardly open to a world of otherness and multiplicity, schizophrenic persons are preoccupied with a mode of constituting a world of others within. For the schizophrenic person, introjected versions of others form a vital sphere of psychic activity within the folds of the self; so much so that

participations in the external world become structured in projected and in introjected relationships, and the schizophrenic person experiences the inside on the outside and the outside within. In their experience, the kind of being-in-the-world well known for most persons becomes a style of incorporating the other in a mode we might call a way of being-within-in-the-world.

Enveloping the external world within their framing unity, as we recall, the distorted body image constructs that dominate the bodily experiences of schizophrenia – to the limited degree in which these may, if at all, qualify as characterizations of a self-concept – are composed in ways that render the schizophrenic person deflated, collapsed, multiplied, overflowing its boundaries and torn into bits and pieces. There is not a question here of a devouring and merely placing on the inside what the narcissistic self so wisely situated on the outside due to its dread of bursting at its own seams. There is hardly a trace of the narcissistic self's striving to maintain a balance between the inside and the outside by selectively incorporating what would serve as its basis for a subjective position of supremacy over the world. Instead, the schizophrenic being-within-in-the-world is a way of bearing the interconnectedness of self and non-self in one's body and self on a day-to-day basis, in a moment-to-moment constitution and in a precarious version, captured more often with lesser than with greater completion.

### **An Ethics for Schizophrenia**

Driven solely by theoretical considerations, one would likely remain content with the conclusions of the previous section. The conceptual framework developed for psychoanalytic theory is extraordinarily well fitted for explaining the possibility of

constituting a *shared* world for successful interaction, as well as the concrete reasons why any understanding at which the parties to this situation might arrive is necessarily a fleeting construct constantly undergoing the revision of subjective as well as intersubjective interpretation. Psychoanalytic theory explains why it is impossible to engage in a mutually shared world with others, but it also explains why, for as long as we make intersubjective understanding the very aim to approximate in our cooperation, one may nevertheless inhabit a mutually shared world in a different sense of this word. Psychoanalytic practice is often characterized by its unusually intense reflective awareness of one's inner psychic events. The psychoanalysis of schizophrenia, however, brings to the fore an even more important prerequisite for the success of this method: its reflective awareness on the collective constitution of a shared world of meaning.<sup>41</sup>

To be sure, the world shared in the psychoanalytic setting is neither a mundane world nor a transcendental world of objectivity – it is a world too concrete and unique to warrant phenomenological characterization in these lofty terms. This is not to say that what it demonstrates – the shifting and precariously instable nature of the moments of understanding arising in interactions between analyst and schizophrenic patient – has no

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<sup>41</sup> I do not want to claim that either the analyst or the analysand has reflective awareness of the constitution of the precarious understanding that emerges between them from time to time. The analyst does not have such reflective awareness at all times: though it is the analyst's job to continually remain mindful of the interpersonal dynamics that structure the progress of the patient, he or she performs this task in order to rectify the inevitable and expected failures of the analyst in this regard. The patient is not supposed to have explicit awareness about having created a situation of understanding for the therapist, yet he or she wonders about the success of this conscious effort, especially in the beginning stages of the analysis. The awareness of each of the participants to this collaboration is imperfect, in other words. But this is not what I intended to point out. These imperfections stem from the artificial construction of the patient-therapist interaction. The rules of how to structure this situation are stated most famously in Freud's technique papers and its various revisions in psychoanalytic theory: these were designed first and foremost for endowing the work of analysis with a reflectively accessible framework of the analyst-patient relationship – so that by reliance to these unconventional rules of a person-to-person interaction, they are able to resolve misunderstandings hindering their cooperation.

place in phenomenological analysis. Given the transitory character of any insight into the schizophrenic person's experience, intensive labor is required for sustaining this mutually shared world. Quite remarkably, this shared world is constituted by processes in every way reminiscent of the non-automaticity by which schizophrenic persons engage in reflective intentional acts for processes that would otherwise be automatically available to self-consciousness.

It is rare – outside of schizophrenic phenomena, it is perhaps impossible – to find the constitutive experience of a mutually shared world disordered in the above manner: a world formulated by the active participation of the ego in supplying the categorial operations that are to guarantee its transcendental objectivity. Because of the possibility of a difference between the constituting activity of schizophrenic and non-schizophrenic subjectivity, the world we at times collectively inhabit is not automatically or of necessity shared. This conclusion is difficult to maintain because of its obvious ethical consequences: because, taken out of the context of the kind of philosophical investigation I have pursued on these pages, it could easily be taken to mean that we need not insist on including schizophrenic persons in the life of our societies. Thus it is a conclusion that must be immediately supplemented with a statement about the ethical implications of this specific kind of difference.

Unlike our interactions with the type of alien subjectivity which is nevertheless embedded in a shared world, in our interactions with schizophrenic patients even our collectively inhabited world must be actively built. The day-to-day reality of performing this task does not compare to the ease with which this abstract treatment of the problem usually proceeds. A better indication of the difficulties involved in complying with this



demand would be to recall the arduous task by which schizophrenic persons must supply missing passive syntheses in order to maintain the unity and the coherence of their body image, or to reconcile the subjective embodiment of their body with its participation in material world. The ethics of schizophrenia demands the performance of a comparable task, though not with regards to our bodily existence, but in the sphere of intersubjectivity.

An intersubjectively shared world inclusive of schizophrenic people requires similarly active participation in sustaining an artificial construct, a collectively constituted world created by effort on the part of schizophrenic and non-schizophrenic persons alike. To provide a substitution for the shared world which is not continually available as a constitutive groundwork for our interactions cannot remain the responsibility of the schizophrenic person alone. The non-schizophrenic person's active participation is required if this construct is to attain intersubjective validity: not only a constant learning and relearning of the possibilities (and the limits) of our co-existence, but the learning and relearning of a co-existence structured by principles not available in everyday experience. Instead of being a matter of automatically availability, the framework of this type of cooperation must be supplied by our genuine availability to the other. We must make ourselves equal partners in the building of a shared world with our schizophrenic counterparts by refraining from using the advantages afforded to most persons but not to those suffering from the disorders of consciousness brought on by schizophrenia. At stake here is the ease with which we find concordances between the experience of the other and that of our own. To be ethical toward persons subject to the delusions and distortions of psychosis means that we must be constantly on the guard against our tendency to constitute the other as merely familiar. The ethics specific to schizophrenia involves an

approach in which, instead of gestures designed for a generic other, we engage in original performances specifically designed for the particular Other (in this case, the schizophrenic person) with whom we create this shared world.

For the above reasons, we have to do with an ethics continually hindered by disappointment over the unpredictability of the other. In the end this is an ethics of hope, because on this approach the experience of the impossibility of meaningful cooperation never suffices as the final determination of the subject matter. On this approach, it is merely a point of impasse informing a continually renewed effort to find a different opening, and a different glimpse, into the otherness of our counterparts.

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