A Phenomenological Investigation into the Formation of Primary Delusion

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Abstract

In this thesis, I seek to provide a systematic phenomenological account on the formation of the delusion characteristic to schizophrenia, i.e., primary delusion. Although there has been a strong phenomenological research tradition that identifies the altered basic self experience and mood experience as the precursor experiences that underpin the formation of primary delusion, comparatively few investigations have been carried out with respect to their underlying affective dimension. In this thesis, I employ Husserl's phenomenology to clarify the nature of the altered affective experience present in the early stage of schizophrenia. To be precise, I focus on the kind of experience wherein a person experiences pervasive 'attraction' or 'pull' coming from different temporal modes of experience (past, present and future) and from every insignificant details of one's familiar surroundings. In this thesis, I term this kind of experience as 'affective dysregulation experience'. By carefully demonstrating how such an experience could globally alter the way one experiences time, oneself, and world, I aim to provide an affective centred phenomenological account that can coherently chart out the development of primary delusion from its identified precursor experiences. In developing this affective centred account, I critically assess and refine the predominant phenomenological accounts of primary delusion formation and further chart out a possible way toward a mutual commerce between phenomenologically oriented research and neurobiological research into delusion formation.

This thesis is organised into two parts. The first part consists of three chapters. Chapter 1 and Chapter 2 clarify, respectively, the theoretical and the methodological orientation of current research. Chapter 3 addresses the enduring challenge in providing a phenomenological account of primary delusions; the challenge that primary delusion is, in principle, un-understandable. The second half of this thesis critically assesses the predominant contemporary phenomenological account and proposes an affective centred account regarding self-fragmentation (Ch.4), delusional mood (Ch.5), and primary delusion (Ch.6).

A Phenomenological Investigation into the Formation of Primary Delusion

A Thesis Submitted for the Degree of PhD

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2022

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Declaration

I confirm that no part of the material contained in this thesis has previously been submitted for any degree in this or any other university. All the material is the author's own work, except for quotations and paraphrases which have been suitably indicated.

Acknowledgment

I would like to thank my supervisors for their patience, guidance, and encouragement. To put it mildly, Dr Benedict Smith had to endure all kinds of ramblings I spewed at him for all these years. I tend to get lost in my ramblings, and I use a (somewhat) odd metaphor to navigate my way around. Whenever such an occasion happened, Dr Ben used his own metaphor to cut through his way into the rabbithole I dug myself into. Without his guidance and insightful feedback, I would have been very lost and writing this thesis would not have been possible. Sadly, Dr Joe Saunders shared the same fate with Dr Ben. He had to deal with half written drafts, broken sentences, and late-night-out-of-nowhere email threads. He patiently listened to all my concerns, combed through each draft and each essay-length email I bombarded him with, and instilled a good sense into me. Without this, I would have given up a long time ago. These two stood by me no matter what. Thank you. I will remember this.

I would like to thank Dr Clare Mac Cumhail, Dr Jeremy Dunham, and Dr Richard Stopford. To this day, I am not sure why it is that they listened to me and trusted me when they did not have to and when they could have very easily not done so. This would have saved them from my surprise visit(s) to their office and numerous emails I have sent them. Their constant support and encouragement have been proven invaluable in completing this thesis. I will remember this.

I would like to thank the John (Jack) Simpson Greenwell Memorial Fund for funding parts of this thesis project. I extend my gratitude to a dozen anonymous reviewers who combed through parts of this thesis. Those reviewers have carried out their duty even during the times of pandemic. I do not know who you are. But, if you find yourself reading this, please note that I genuinely appreciate your service and dedication to this field of inquiry. Two chapters (Ch.4 and Ch.5) of this thesis have been published, respectively, in *Phenomenology and the Cognitive Sciences* and *Philosophical Psychology*. Lastly, I would like to thank my family for all their support and patience. Thank you.

Introduction

The aim of this thesis is to provide a systematic phenomenological account of the formation of the delusion characteristic of schizophrenia, i.e., primary delusion. Although there has been a strong phenomenological research tradition that emphasises the altered basic self experience and mood experience as the precursor experiences that underpin the formation of primary delusion, comparatively few investigations have been carried out with respect to their underlying affective dimension. In this thesis, I employ Husserl's phenomenology to clarify the nature of the altered affective experience present in the early stage of schizophrenia. By carefully demonstrating how such an experience could globally alter the way one experiences time, oneself, and world, I aim to provide an affective centred phenomenological account that can coherently chart out the development of primary delusion from its identified precursor experiences. In developing this affective account, I further propose a possible way toward a mutual commerce between phenomenologically oriented research and neurobiological research of delusion formation.

In the context of phenomenologically oriented psychiatric research (in short, phenomenological psychopathology), primary delusion has been one of the central objects of investigation (Jaspers, 1913/1997, Beluer, 1924, Parnas, 1991, Parnas & Bovet, 1993, Sass & Parnas, 2001, Sass & Byrom, 2015, Parnas & Henriksen, 2016, Parnas & Stefensen, 2020, Feyaerts et al., 2021). It refers to the type of delusion typically present in the case of schizophrenia whose content reflects ontological, cosmological, or ecastological themes[1]. Another well-known feature of this delusion pertains to its seemingly contradictory belief attitude. Despite the purported certitude in the delusional content, one does not act on it and exhibits an inconsequential attitude. This seemingly contradictory attitude has been coined as double bookkeeping or double registration of reality[2].

Against the backdrop of over a century old research traditions[3], contemporary phenomenologically oriented researchers have targeted two altered aspects of experience present

[1] I discuss this feature of primary delusion in detail in Chapter 6.
[2] I discuss this feature of primary delusion in detail in Chapter 6.
[3] For a brief summary of this research tradition, please read: Mishara, 2007, Mishara et al., 2014, Nelson et al., 2014.

in the formative stage of primary delusion. The first alteration pertains to the way one experiences oneself. The 'self' here refers to the experiential self, or, to be precise, the basic, immediate sense of existing as a self-identical subject of one's own experience across time[4]. The general idea has been that in the early stage of schizophrenia there involves a severe 'weakening' or 'splitting' in such a sense of self, (Jaspers, 1913/1963, Bleuler, 1911, 1968, Minkowski, 1922, 1933, Binswanger, 1943,1960, Scheinder, 1959, Straus, 1962, Scharfetter, 2001, Moskowitz & Hein, 2011, Wiggins et al., 1990, 2003, Fuchs, 2003, 2005, 2007, 2013, Vogley & Kupke, 2007, Stanghellini et al., 2015, Stanghellini, 2016, Sass & Pienkos, 2016, Fuchs & Dupen, 2017). The disturbance of which radically dissociates oneself from one's own experience, leading to the ideation that one exists outside the reality articulated through one's experience, or that the world one lives in is existentially different from the world of others, or that one is a existentially different being than other humans are[5]. Closely related to this self disturbance, the second disturbance is the mood alteration, coined as delusional mood (Jaspers, 1913/1997, Conrad, 1958, 2002, Mattusek, 1988, Wiggins et al., 1990, 2003, Parnas & Bovet, 1995, Fuchs, 2005, Mishara, 2010, Mishara & Fusarpoli, 2013, Sass & Byrom, 2015, Parnas & Henriksen, 2018). It refers to the diffused, ominous tension wherein one experiences that 'something' is going to happen[6]. This sense of non-finality has been known to permeate every aspect of one's life, crystallising the initial delusional ideation into a fully formed delusion.

In contemporary research, Husserl's phenomenology has been consistently employed to clarify the underlying structure of the aforementioned alteration in the self and mood experience. Although the proposed accounts differ with respect to the exact nature of such structure[7], the general consensus is the following. First, schizophrenia involves a total breakdown in the coherent

[4]I discuss this in detail in Chapter 4 and Chapter 6.
[5] I explain this psychopathological development in detail in Chapter 6.
[6]Delusional mood is much more complicated than this. Here I am just mentioning its most notable feature. I discuss this experience in detail in Chapter 5 and 6.
[7] The disagreement largely stems from the different understanding regarding the reality status of 'underlying structural disturbance'. Schwartz, Wiggins, and Norko (1995) propose that the structure of the target phenomenon identified by phenomenologists is a thought-construct. Whereas Parnas (2011), Sass and Parnas (2003), Parnas and Gallagher (2015) argue that it is not only a thought-construct but also a real gestalt alteration that gives meaning to and defines the target phenomenon. In this thesis, the structural claim I make functions as a thought-construct.

regularity of time consciousness (or inner time consciousness[8]) in virtue of which one can experience one self and time in their coherent unity (Wiggins et al., 1990, 2003, Fuchs, 2003, 2005, 2007, 2013, Vogley & Kupke, 2007, Sass & Pienkos, 2016, Fuchs & Dupen, 2017, Stanghellini et al., 2015, Stanghellini, 2016). This structural breakdown underpins above mentioned fragmentation in the basic sense of self, henceforth "self-fragmentation" experience. Second, the structural disturbance in the time consciousness radically destabilises otherwise stable ontological-existential framework of experience, to be precise, the taken-for-granted certainty in the existence of the world and oneself (i.e., "urdoxa"[9]) (Wiggins et al., 1990, 2003, Fuchs, 2005, Sass & Byrom, 2015, Sass, 2014, Stanghellini et al., 2016, Parnas et al., 2020, Feyearates et al., 2021). This disturbance underpins the pervasive uncanniness of the world characteristic of delusional mood. Taken together both structural disturbances lead to the formation of primary delusion. This type of structural analysis has been further employed as a theoretical basis for a more empirically oriented classificatory study wherein researchers categorise heterogeneous experiential features present in the early stage of schizophrenia with respect to the identified underlying structural disturbance (Cermolacce et al., 2007, Nelson et al., 2014, Parans & Henriksen, 2019, Stanghellini et al., 2016, Sass & Pienkos, 2013a, Sass & Pienkos, 2013b, Stanghellini & Raballo, 2015, Fuchs, 2017). This research effort resulted in providing one of the most systematic psychopathological profiles of schizophrenia, contributing towards the construction of semi-structured psychometric checklists designed for its early detection, i.e., the Evaluation of Anomalous Self-Experience (Parnas et al., 2005) and the Evaluation of World Experience (Sass et al., 2017).

This thesis is a contribution towards this rapidly growing field of phenomenological psychopathology. In this thesis, I critically assess the prevailing phenomenological accounts proposed for primary delusion formation and bring attention to the largely overlooked aspect of the self-fragmentation experience and the delusional mood experience. That is, to be precise, the pervasive 'attraction' or 'pull' one experiences from the different temporal modes of experience and from one's familiar surroundings. With respect to the temporal experience, in this thesis, this kind of experience refers to the one wherein a person feels as though one is "sucked up" by the past, something of the past "returning towards" oneself (Minkowski, 1933/1970, p.287-290,

[8]I explain this concept in detail in Chapter 4.
[9] I explain this concept in detail in Chapter 5.

Stanghellini et a., 2016, Fuchs & Van Duppen, 2017) and as being constantly pulled into the alluring immediate future, that "something" is impending (Minkowski, 1933/1970, p.287-290, Stanghellini et al., 2016, Fuchs & Van Duppen 2017). With respect to the world experience, the aforementioned experience refers to the kind of experience wherein every insignificant detail of one's familiar surroundings exercises a peculiar allure to oneself, captivating one's attention. This type of experience has been described as follows: "I developed a greater awareness of … my senses were sharpened. I became fascinated by the little significant things around me"; "Sights and sounds possessed a keenness that he had never experienced before", "It was as if parts of my brain awoke, which had been dormant" or "my senses seem alive.. Things seemed clearcut, I noticed things that I had never noticed before" (Kapur, 2003, p.74). By highlighting these kinds of temporal and world experiences and demonstrating their generative role in primary delusion formations, I aim to provide a more nuanced *and* systematic phenomenological account that can further the development of contemporary phenomenological investigation into primary delusion.

The core argument that motivates current research targets the prevailing phenomenological explanation for the self-fragmentation experience and the delusional mood experience. That is, the claim that the structural breakdown in the inner time consciousness and urdoxa underpins those experiences. I contest this claim with the following argument. The structure of inner time consciousness and urdoxa are the basic necessary conditions for the first-personal presentation of an experience. Simply, they are the precondition of subjective experience. Therefore, their structural breakdown implicates the impossibility in having subjective experience, not the self-fragmentation *experience* nor the delusional mood *experience*. In short, the thus-far proposed phenomenological explanations are too radical to accommodate the self-fragmentation experience nor the delusional mood experience. With this, I contest prevailing phenomenological accounts and pave a way towards providing a more *nuanced* phenomenological account of primary delusion formation.

Drawing on Husserl's phenomenology, I clarify the nature of the aforementioned target experience wherein one experiences pervasive attraction or pull coming from the different temporal modes of experience and from every insignificant detail of one's familiar surroundings. To be specific, I employ Husserl's account of affection to carry out this task. I do so for the

following two reasons. First, he defines affection as an inseparable relationship between consciousness and the world whereby the former is always-already "allured by" or "pulled into" the latter (Husserl, 2001b). This descriptive similarity renders the affection concept as a good candidate for describing the target experience as an instance of affection. In this thesis, I term it as 'affective dysregulation experience'. Second, Husserl systematically describes how affection and the coherent regularity inherent to it (i.e., affective syntheses) are responsible for meaning constitution, perceptual field organisation, habitual expectation, implicit/explicit memory, and temporal unity of (self-) experience (Husserl, 2001b). As such, his account of affection provides a conceptual means to clearly demonstrate how altered affective experience, such as the one found in the early stage of schizophrenia, could globally alter various structures of experience, e.g., temporality, selfhood, habitual certainty, and perceptual intentionality. This will help provide a *systematic* account that can pinpoint and describe the structural alterations responsible for the self-fragmentation experience and the delusional mood experience.

In this thesis, as opposed to structural breakdown in the inner time consciousness or urdoxa, I argue that in the instance of the self-fragmentation and the delusional mood experience there occurs a structural alteration in the usual modulation in the affective vivacity of temporal and world experience. I term such an alteration as 'affective modification dysfunction' and 'affective repression failure' for, respectively, the self-fragmentation experience and the delusional mood experience. I employ these concepts as conceptual scheme with which I organise otherwise seemingly chaotic experiential features[10] present in both experiences in their coherent unity. In so doing, I aim to provide a more detailed phenomenological account that can do justice to the intricate nature of the formative stage of primary delusions. After contesting the prevailing accounts and providing an affective centred alternative account, I argue that the identified affective dysregulation experience is revelatory and solipsistic in nature. I demonstrate how such an experience could elicit the pressing need to find a new conceptual framework to make sense of the

[10]For the case of self-fragmentation,.1.) time stop 2.) ante-festum 3.) dejavu/vecu and 4.) time fragmentation. For the case of delusional mood, 1.) the bewildering, enigmatic manifestation of the world 2.) the loss of the determinate, familiar meaning of an object, 3.) the pervasive sense of uncanniness and intoxicated anticipation.

alien affective attraction one has experienced, ultimately leading to the formation of primary delusion. In developing this affective centred account, I further chart out a possible way towards a mutual commerce between phenomenologically oriented research and neurobiological research into delusion formation, specifically, aberrant salience hypothesis and prediction error hypothesis.

This thesis is broadly organised into two parts. The first part consists of three chapters. Chapter 1 and Chapter 2 clarify, respectively, the theoretical and the methodological orientation of this thesis. Chapter 3 addresses the enduring challenge in providing a phenomenological account of primary delusions; the challenge that primary delusion is, in principle, un-understandable and it indicates the end of a phenomenological investigation. The second half of this thesis critically assesses the contemporary phenomenological account of primary delusion formation and provides an alternative account regarding self-fragmentation (Ch.4), delusional mood (Ch.5), and primary delusion (Ch.6). In a little bit more detail, this thesis unfolds in the following order.

Thesis Outline

Depending on the theoretical orientation of a research, the nature of the object under investigation changes. To study schizophrenia from a neurobiological perspective is to study it as an epiphenomenon of brain functions. To study schizophrenia from a quantitative psychopathological perspective is to study its diverse individual instances with respect to (more-or-less) clearly demarcated categorie(s) or spectrum and identify its statistical regularity. To study schizophrenia from a quantitative linguistic perspective is to study the syntax regularity particular to its speech pattern. The theoretical orientation of a research pre-defines the nature of the object under investigation, which, in turn, delimits the scope of the research. As such, in Chapter 1, I clarify the theoretical orientation of this thesis. In so doing, I clarify the nature of schizophrenia posited as the object of current research and delimits its scope. As it is with philosophical phenomenology I orient current research, I provide its working definition. Phenomenology will be construed as a branch of philosophy that aims to describe and clarify a very close relationship between human existence or consciousness and the world, whereby the former features into analysis as the constitutive dimension that enables the world to appear in the way it does with its

meaning. With this, I clarify the nature of schizophrenia predicated as the particular object of this thesis research. The clarification is the following. In this thesis, schizophrenia will be studied as a constitutive dimension or a particular form of subjectivity whereby the object, space, time, mood, oneself, others, and events acquire and articulate their (albeit unusual) meaning. The specific focus of current research is time and affection, and it aims to describe in detail the altered temporal and affective modes of experience present in the early stage of schizophrenia and demonstrate how such an alteration could contribute to the formation of primary delusion. Afterwards, I turn my attention to the mainstream psychiatric and psychological research and ask if this type of phenomenological analysis is needed. I answer positively as it can provide two types of specialised understanding that can aid the classificatory and the neurobiological research into schizophrenia: nosographic understanding and structural understanding. After explaining these types of understanding, I deflate their value outside a research context and delimit the scope of current research.

Having the general theoretical orientation of current research and its implication clarified, in Chapter 2, I critically assess two notable particular methods proposed, employed, and clarified by various researchers in the phenomenological study of mental disorder: ideal type approach (Schwartz et al., 1995, Schwartz and Wiggins, 1987a, Schwartz and Wiggins, 1987b) and essential type approach (Parnas and Zahavi, 2003). I critically assess both and chart out a possible way whereby both approaches can complement one another. In short, I advance a mutual complementarity thesis. Employed in current research, the proposed thesis carries the following implication. First, as an ideal type analysis, the subject matter of this thesis is not the concrete totality of the formative stage of primary delusion nor its essential features. The target experiences are the types of experience that have been deemed characteristic/typical to the formative stage of schizophrenic delusion: self-fragmentation experience and delusional mood experience. Second, as an ideal type analysis, the set of claims I make with respect to their underlying structure (i.e., “affective modification dysfunction” and “affective repression failure”) is an analytic construct. It is a conceptual scheme that helps one to better understand otherwise seemingly disparate features of the pre-delusional experience in their coherent unity. Third, as an ideal type analysis complemented by the essential type approach, I employ phenomenological concepts that

articulates the basic, essential structure of temporality and mood to clarify the nature of target experiences.

After having clarified the theoretical (Ch.1) and the methodological orientation (Ch.2) of current research, in Chapter 3, I turn my attention to its specific object of investigation: primary delusion. In this chapter, I address the enduring challenge in providing its phenomenological account, which was raised by none other than one of the founders of phenomenological psychopathology, namely Karl Jaspers. The challenge is this: primary delusion is, in principle, un-understandable, and it indicates the end of a phenomenological research. In this chapter, I term this point 'the incomprehensibility thesis' and critically assess it. I systematise Jaspers' argument into two strands: a.) closed-to-empathy argument and b.) psychological irreducibility argument. I reject both. I argue that in an attempt to clearly define primary delusion Jaspers raises the bar for satisfying its understandability inclusion criterion too high, such that even most ordinary mental states fail to satisfy such a requirement. The implication being that, as shall be demonstrated, if the incomprehensibility thesis is correct one must rule that most mental states are un-understandable; and given that the un-understandability of a mental state is the essential feature of primary delusion, one must rule that almost everyone is having primary delusion. After having rejected the incomprehensibility thesis, I venture into the recent phenomenological account of empathetic understanding and provide a more nuanced account of understanding that can do justice to the intricate nature of the primary delusional experience. This will open up the possibility for providing a phenomenological account of the experiences that have known to precede the emergence of primary delusion: self-fragmentation experience and delusional mood experience.

Having opened up the possibility to provide a phenomenological account of primary delusion, in Chapter 4, I turn my attention to the specific target phenomenon: self-fragmentation experience. I highlight its much-neglected aspect of experience in the contemporary phenomenological analysis of schizophrenic temporal experience. That is, its non-emotional, affectively prominent experience whereby one experiences pervasive 'attraction' or 'pulls' coming from different temporal modes of experience: the past, present, and future. I argue that this kind of experience is not yet another experience that happens to be present in the case of schizophrenia but indicative of the core disturbance that underpins schizophrenic temporal experience. I begin

by reviewing one of the most systematic phenomenological accounts proposed by various prominent figures using Husserl's account of inner time consciousness (Fuchs, 2007, 2010, 2013, 2017, Fuchs and Van Duppen, 2017, Sass and Pienkos, 2013, Stanghellini et al., 2016). The account according to which the total breakdown, fundamental disintegration, or collapse in the structure of inner time consciousness underpins the self-fragmentation experience (in short, 'structural account'). In an anticipatory summary, I reject it. Its rationale is as follows. The structure of inner time consciousness not only constitutes the temporal unity of an experience but also, in that moment of constitution, its first-personal presentation as well. Therefore, its structural breakdown does not implicate self-fragmentation experience. It implicates the impossibility in having any first-personal, subjective experience. After contesting this structural account, I propose a provisional account that details the structure of schizophrenia temporal experience with respect to its affective dimension. As opposed to its total breakdown, in the case of schizophrenia, I argue that the structure of inner time consciousness no longer modulates the affective intensity of temporal experience. I term this malfunction as the "affective modification dysfunction" and employ it as a core concept with which I organise and synthesise heterogeneous components of schizophrenic anomalous temporal experience in their coherent unity — not limited to the self-fragmentation experience but also its closely related temporal experiences, i.e., time stop, ante-festum, déjà vu/vecu, and disarticulation of time. I conclude by demonstrating how this affective centred approach can further help us illuminate the nature of the pre-psychotic phase known to precipitate primary delusion, i.e., delusional mood.

In Chapter 5, I sustain my focus and develop an affective centred account of delusional mood. I begin by discussing its notable features which have been the constant object of phenomenological psychopathology since the days of Karl Jaspers. They are as follows: a.) the bewildering, enigmatic manifestation of the world, b.) the pervasive sense of uncanniness of the world, and c.) the loss of the familiar, determinate meaning of an object. In this chapter, I highlight the underlying experience that transpires through all of those features. That is, the experience in which every insignificant detail of one's familiar surroundings exercises an alien 'pull' or 'attraction' to oneself. I begin by reviewing contemporary accounts of delusional mood (Fuchs, 2005 and Wiggins et al., 1995) endorsed and developed by various prominent figures (Stanghellini et al., 2016 and Sass & Pienkos, 2013b). The account according to which a disturbance in temporal

synthesis (or the structure of inner time consciousness) and urdoxa underpins the emergence of delusional mood. In an anticipatory summary, I contest it on the following two grounds. First, as argued in the previous chapter, the structural disturbance in temporal synthesis implicates the impossibility in having any subjective experience. Second, urdoxa, as shall be explained, is the precondition of doubting/affirming a given state of affairs. Therefore, its disturbance or 'shattering', as opposed to what the contending view suggests, does not lead to the global sense of uncanniness and suspiciousness characteristic of delusional mood. Afterwards, I appeal to Husserl's account of affection and affective syntheses (Husserl, 2001). In doing so, I aim to chart out a new avenue for providing a more detailed and nuanced phenomenological account of the delusional mood *experience.* From the discussion of affection and affective syntheses, I glean two conceptual tools necessary for providing an alternative account of the delusional mood: affective repression and affective propagation. Briefly, the former regulates the prominence of a perceived object and its encompassing context, the latter enables the past experiential life of a subject to provide a framework of determinate sense and familiarity to the present experience. Employing those concepts, I identify the structural underpinning of delusional mood as "affective repression failure". I argue that this structural alteration underpins the above mentioned experience whereby every insignificant detail of one's familiar surroundings attracts one's attention and term this kind of experience as 'affective dysregulation experience'. I demonstrate how such an experiential abnormality could implicate the notable characteristics of the delusional mood. I conclude by relating the above finding to the aberrant salience hypothesis (Kapur, 2003, 2005) and advance a mutual enlightenment thesis between phenomenologically oriented research and neurobiological research into delusion formation.

In Chapter 6, I focus on the affective dysregulation experience and provide a detailed account on how such an experience could contribute to the formation of primary delusions. In contemporary phenomenological investigation, it has been proposed that the anomalous self-experience present in the delusional mood (or minimal self or ipseity disturbance) underpins the formation of primary delusions (Sass, 2014, Sass & Byrom 2015, Parnas et al., 2020, and Feyaerts et al., 2021). In this chapter, I link the affective account I provided in the previous chapter to the ipseity disturbance account. In so doing, I highlight the possibility that the current overemphasis laid in identifying anomalous self-experience present in the delusional mood could have

overshadowed other possible modal alterations involved in the early stage of schizophrenia. The alteration with which one can better accommodate the formation of primary delusion from the delusional mood experience, that is, as identified in the previous chapter, the affective repression failure and its correlating experiential abnormality, affective dysregulation experience. I demonstrate how this experience could elicit the pressing need to find a new conceptual framework of understanding oneself and the world. That is, to specify, the particular mode of understanding whereby one makes sense of such an alien experience with respect to oneself and the world. In so doing, I aim to provide a more coherent and detailed phenomenological account of primary delusion formation. I conclude by demonstrating the relevance of the affective centred account I propose in relation to the significant development in the neurobiological research of delusion formation, i.e., prediction error model.

In summary, this thesis contributes to contemporary phenomenological psychopathological research in the following ways. Firstly, it critically assesses the validity of various phenomenological postulates proposed to explain primary delusion formation *within* their own phenomenological theoretical context. In so doing, current research provides a strong reason for contemporary researchers to, at least, reconsider and nuance their theoretical postulates and, at most, to look for other dimensions of experiences that have fallen out of their initial scope of inquiry, i.e., affective dimension. Secondly, by carefully analysing the altered modes of temporal and affective experiences present in the early stage of schizophrenia, this thesis provides an alternative (albeit provisional) account that can better accommodate the formation of primary delusion from its precursor experiences, i.e., self-fragmentation and delusional mood. To be precise, an account that can a.) appreciate the basic existential fact that such experiences are possible and b.) organise their otherwise seemingly disparate features in their coherent unity. Lastly, by identifying the affective dysregulation experience as the core disturbance for delusion formation, this thesis charts out a possible way toward a mutual commerce between phenomenologically oriented research and the neurobiological research that also posits such an experience as its target phenomenon.

Ch.1 Philosophical Phenomenology, Phenomenological Psychopathology, and Schizophrenia

§1. Introduction

This is a phenomenological study of the formation of schizophrenic delusion[11]. In simple terms, this thesis asks the following question: How does schizophrenic delusion come about? To answer this question, I orient current research with philosophical phenomenology. I answer the thesis question in the following manner. First, identify the structural alteration in consciousness that underpins the two types of experiences known to precede the emergence of schizophrenic delusion, i.e., self-fragmentation experience and delusional mood experience. Second, demonstrate how such a structural alteration can lead to the development of schizophrenic delusion. The simple answer to the thesis question, that is to say, an answer with no qualification, is this: affective modification dysfunction underpins the self-fragmentation experience and affective repression failure underpins the delusional mood experience; both structural alterations contribute to the development of schizophrenic delusion.

Before I qualify and explain this affective centred account, in this chapter, I proceed with a general aim in mind. I aim to delimit the scope of current research and situate it within the contemporary and traditional research context of schizophrenia. In doing so, I seek to clarify the nature of 'schizophrenia' predicated as the object of current phenomenological investigation and discuss the value and the limit of this type of research. This chapter unfolds in the following order.

First, as it is with philosophical phenomenology I orient current research, I provide its working definition. I do so against the backdrop of the hundred years of interaction philosophical

[11]I do not use the term "primary delusion" until I introduce it in Chapter 3. By schizophrenic delusion in Chapter 1 and Chapter 2, I specifically mean primary delusion. That is, the type of delusion characteristic to schizophrenia whose content reflects ontological themes and whose belief attitude is seemingly contradictory (absolute certitude in the belief content *and* inconsequential attitude). Introducing the term "primary delusion" necessitates its characterization in the main body. This has little to no relevance to the argument proposed in Chapter 1 and Chapter 2. Chapter 1 and Chapter 2 clarify the theoretical and methodological orientation of current research. So, I do not use the term "primary delusion" until Chapter 3.

phenomenology had with psychopathology. This, as shall be explained soon, means that phenomenology will be construed as a branch of philosophy that studies an inseparable relationship between 'human consciousness/existence' and 'the world' -- whose particular aspects have been studied under various themes, e.g., temporality, affection, intentionality, selfhood, embodiment, intersubjectivity, etc. In the research context of phenomenological psychopathology, the general argument has been that schizophrenia can be best understood as a modification/loss/disturbance in such a relationship. The specific focus of this thesis is temporality and affection. Second, after having the general theoretical orientation of this thesis and its implication clarified, I turn my attention to contemporary psychiatry and psychological research into schizophrenia. In doing so, I locate this thesis within the general intellectual environment in which phenomenologically oriented research is called for and note what it is asked of phenomenologists to aid contemporary research into schizophrenia. Third, I argue that phenomenologically oriented research can offer two types of specialised understanding that can aid classificatory and neurobiological research: nosographic understanding and structural understanding. If the first offers the possibility to refine the psychiatric category in use, the second, I argue, can be used to complement the 'mind-level' explanation of neurobiological research into schizophrenia. Fourth, in recognising the limit of these kinds of phenomenological understanding, I deflate their value outside research context. Although they can help one to organise certain aspects of schizophrenia in their coherent unity and further, if used prudentially, can *help* one to better understand a person living with schizophrenia, I resist the necessity claim. That is, the claim that phenomenologically oriented research is *needed to* understand a person living with schizophrenia — such that if one is not a philosophical phenomenologist or does not use phenomenological methods, concepts, or conceptual framework, then one cannot understand a person living with schizophrenia. In resisting this necessity claim, I explicitly state the limit of current research, delimit its scope, and specify its object of investigation. Let me proceed.

§1.1. What is Phenomenology[12] ?

As is the case for almost all attempts to define a philosophical movement riddled with intense sectarian debates, the attempt to define phenomenology consists of two moves: a.) acknowledge the difficulty involved in providing a clear-cut definition and b.) provide a provisional, big-church definition. In the context of philosophical phenomenology, the first move usually entails accentuating the alleged categorial difference between Husserl's phenomenology and his successors', usually, that of Heidegger, Sartre, and Merleau-Ponty. The story is that Husserl's phenomenology concerns itself with the 'essential' or 'invariant' aspect of human consciousness, while his successors concern themselves with the concrete determination of human existence, i.e., situatedness, facticity, historicity, and embodiment[13]. To use the term of arts, Husserl studies something like "transcendental ego", Heidegger studies "being-in-the-world", and Merleau-Ponty "embodied subjectivity". If this story is true, then even providing a provisional, working definition of phenomenology seems extremely difficult. Phenomenologists, to be specific (and problematically), the founding figures of phenomenology all study something different from one another[14]. So, the second move for providing a big-church definition of phenomenology kicks in in this specific manner: place more emphasis on the methodological identity than on the subject matter (Fernandez, 2017). Luft and Overgarrd write: "[...] the importance phenomenology assumes today would be inconceivable if phenomenologists did not share certain methodological commitments as well as closely related ideas about the proper domain of phenomenological research" (Luft and Overgaard 2011, p. 1). Despite the difference in the subject matter, the story is that the people who call themselves 'phenomenologists' are usually subscribed to the first-person centred and descriptive approach, and these 'phenomenologists', as such, study, in general,

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[12] Unless otherwise specified, in this thesis, by "phenomenology", I mean philosophical phenomenology. I do not mean subjective experience. When I have to use the expression "subjective experience", I just use that.

[13]For its critical assessment, please read Ch.15 'Phenomenology' by Zahavi in *The routledge Companion to Twentieth Century Philosophy* (2008) and 'Husserl, Heidegger, and Transcendental Philosophy: Another Look at the Encyclopaedia Britannica Article' (1990) by Crowell.

[14]For a pessimistic appraisal regarding the project to define phenomenology with respect to its common subject matter, please read: 'Phenomenological Movement' (1981) by SpiegelBerg, specifically, p.xxvii, 'The Routledge Companion to Phenomenology' (2011) by Luft and Overgaard, p.1, and also 'The End of Phenomenology: Metaphysics and New Realism (2014), by Sparrow, p. xiii.

something like intentionality, experience, meaning, sense, and so on (Luft & Overgarrd, 2011, p.10-12).

Although the particular emphasis laid on the methodological identity can help provide a broad, big-church definition of phenomenology, it has its own shortfall. The subject matter of phenomenology remains to be clarified. This question remains unanswered: So, what *exactly* it is that phenomenologists study? Simply saying its subject matter is experience, meaning, sense, etc. will not cut it. To say so, as most brilliantly put by Anthony Vincent Fernandez (2017), "is equivalent to telling an aspiring physicist that her subject matter is nature, motion, or the physical universe. None of these answers is incorrect. Yet they fail to instil the researcher with a clear picture of what, exactly, she will be researching" (Fernandez, 2017, p.3544). Further, if unclarified, the subject matter question poses a particular difficulty to the people who do applied phenomenology, that is to say, a group of people who see some value in philosophical phenomenology and use it in the context other than philosophical phenomenology, i.e., psychiatry, psychology, psychopathology, anthropology, sociology, geography, law, and so on. Why bother with a branch of philosophy that cannot even clearly articulate its common subject matter, to answer the question of — to provide one example — "How does schizophrenic delusion come about"? Given that the theoretical orientation this thesis takes is philosophical phenomenology and it is with such an orientation I specify the object of this study (schizophrenia as a "form of subjectivity") and aim to clarify its so-called "structural underpinning", the difficulty does not amount to a general complaint. It amounts to the lack of clarity regarding the approach I take and the answer I provide to the thesis question.

So, in the following, I answer the question of "what is phenomenology?" with respect to its subject matter. I do so against the backdrop of the hundred years of interaction phenomenology had with psychopathology. What does this mean? This: regardless of the internal sectarian debates which may have plagued the history of philosophical phenomenology, clinical psychologists and psychiatrists have, since the days of Karl Jaspers (1913), constantly employed phenomenological insights in their study (the usual roster call goes: Karl Jaspers, Eugene Minkowski, Ludwig Binswagner, Erwin Straus, Wolfgang Blankenberg, Henri T. Ellenberg, Medrad Boss, Kimura Bin among many others). One of the core phenomenological insights that guided their study is that

human consciousness and the world are inseparably related with each other, and researchers have, to put it generally, viewed schizophrenia as a result of perturbation in such a relationship. This thesis is a phenomenological study of schizophrenia, and it is a work of applied phenomenology in the context of psychopathology. The following presentation will therefore unravel the subject matter of phenomenology with respect to the inseparable relationship between human consciousness and the world my predecessors have focused on. I unpack this relationship by focusing on the concept of "phenomenon". So, what is phenomenology?

§1.1.1. It's in the Name

It is the study of phenomenon. To dispel the deceptive connotation of this simple definition, phenomenon here does not mean 'outward appearance' or 'mere appearance'. Phenomenologists, for some odd reason, do not study what something 'apparently' is in favour of what it actually is. What then is this "phenomenon"? At the little risk of kicking off a sectarian trench warfare, phenomenon can be defined as the appearance of the thing itself. Briefly summarising the subject matter of phenomenology and its general aim, Dan Zahavi writes:

> The phenomenon is understood as the manifestation of the thing itself, and phenomenology is therefore a philosophical reflection on the way in which objects show themselves -- how objects appear or manifest themselves -- and on the conditions of possibility for this appearance (Zahavi, 2005, p.55).

Similarly, Heidegger famously defined phenomenology as "let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1986, 60). Of importance, this "phenomenon", or the "very way in which a thing shows itself *from* itself", or "the manifestation *of* the thing itself" should be read and understood quite literally: phenomenon belongs to the thing itself. Hence, Heidegger's definition of phenomenology as "let that which shows itself be seen from itself", Zahavi's construal of phenomenology as "a philosophical reflection on the way in which objects show themselves". or simply, Husserl's well heralded

proclamation “back to the things themselves” -- these are not calls to turn our attention inwards, to our mind. It is a call to have it focused on the things themselves.

To obviate some confusion, by claiming that phenomenon is the appearance of the thing itself, phenomenologists are not saying that we are always acquainted with the ‘actual reality’ of an object via its immediate appearance. Appearances can be deceptive. A boulder I see afar on a late night walk can appear to me as a man hiding in a bush. The greeting smile of a stranger I come across on my walk can appear to me as a sneer. A certain economic indicator can appear to show a stable economic development in the coming quarter, when, in actual fact, it doesn't. However, by walking closer to what I initially saw a man hiding in a bush, I can see that it was just a boulder. By asking my friend who is well aware of the culture of this nation, I can come to see that it was simply a habitual smile people of this country put on when they see another stranger on their walk. By finding a set of data that shows the economic indicator reflects nothing but the rapid formation of underlying credit bubbles and bringing such a hypothesis to its confirmation following a set of specific rules established within the community of economic researchers, one can come to see that the economic indicator actually signifies that a financial crisis is on its way. The point is that, for phenomenologists, the distinction between the appearance of an object and its actual reality is not the one between the realm of the merely phenomenal world and that of the true reality, that exists independent of the phenomenal world. Instead, it is a distinction internal to this phenomenal world wherein its essence manifests itself, this world that manifests itself with its meaning, validity and objectivity, or, to be concrete, that is to say, this world where the categorical identity of a perceived object does not abruptly change from ‘actual’ to ‘non-actual’ and, as such, I can walk closer to the same-actually-existing-object, where the confirmation of my judgement by other can matter at all and, as such, I can bother correcting my initial belief with respect to what my friend say about the stranger, and where some recorded number can present itself as ‘data’ and the confirmation of a given hypothesis is possible within the community of researchers. As such Zahavi writes:

> If we wish to grasp the true nature of the object, we had better pay close attention to how it manifests and reveals itself, be it in sensuous perception or in scientific analyses. The reality of the objects is not hidden behind the phenomenon, but unfolds itself in the phenomenon [...] Although the distinction between appearance

> and reality can be maintained [...] it is not a distinct between two separate realms, but a distinction internal to the realm of appearance. it is a distinction between how the objects might appear at a superficial glance, and how they might appear in the best of circumstances (Zahavi, 2005, p.56)

In short, phenomenology is the study of phenomenon. And this is not to say that phenomenology is the study of mere appearance. Construed as an integral moment of the reality itself, to study phenomenon is to study the way the world shows or manifests itself in the way it does with its meaning, validity, and objectivity. Correlatively, on a phenomenological analysis, human consciousness or existence features into phenomenological analysis as the dative of manifestation, to be specific, as the condition of possibility for the manifestation of the reality itself. Louis A. Sass and Josef Parnas (2003), phenomenologically oriented clinical psychologists (arguably, most strategically) construes consciousness as "the subject *for* the world, or to paraphrase Wittgenstein (1992), *the limit of the world.*" (p.429) They continue: "Consciousness does not create the world but is the enabling or constitutive dimension, the "place" "in" which the world is allowed to reveal and articulate itself" (Sass & Parnas, 2003, p.429). To clarify such a correlation[15] whereby the world shows itself with its meaning, validity and objectivity, phenomenologists' inquiry is usually guided by a question like this: What has to be *necessarily* the case of our consciousness or what kind of a being *must* we be so that the world can show itself with its meaning, validity, and objectivity as it already does? The so-called "transcendental structure of consciousness", "transcendental subjectivity", "existential" or "ontological structure" aim to describe the inseparable relationship between human consciousness or existence and the world, without which neither term can be the kind it is. What falls under those terms and what has been often called as the 'themes' of phenomenological investigation, e.g., temporality, embodiment, intersubjectivity, affection, intentionality, and so on, are the concepts that denote and detail the particular determinations of such a relationship. In the context of phenomenological psychopathology, they have been understood as the basic, essential feature of human

[15]That is, if there exists the world that shows itself with its validity, meaning, and objectivity, then there exists consciousness to which the world shows itself as such *and* if there exists consciousness to which the world shows itself with its validity, meaning, and objectivity, then there exists such a world. For a further discussion, please read: Husserl, 2003, p.30,56, Merleau-Ponty, 2012, p.454, Heidgger, 1996,p.58, Zahavi, 2018, p.114, Dastur, 2011, p.320-321 and Kelly, 2011, p.41,43

consciousness and existence. Under this approach, the lived experience of a certain mental disorder has been studied as the dimension or the very place in which certain objects, events, or people articulate and acquire its (albeit unusual) meaning, and the general argument has been that mental disorder can be best understood as a result of loss, disturbance, modification, or alteration in the basic, essential features of human consciousness and existence[16].

Before I detail the kind and the content of phenomenologically oriented understanding of mental disorder, in the following section, I begin by clarifying how schizophrenia has been studied in contemporary mainstream US and UK psychiatry. I do so by highlighting the theoretical assumptions that guided the development of the Diagnostic and Statistical Manual of Mental Disorder-III and the neurobiological research into schizophrenia. This will help contextualise the intellectual environment in which a phenomenologically oriented research into schizophrenia is called for, not only by already phenomenologically oriented researchers but also by the contending mainstream psychiatrists and psychologists. Afterwards, I clarify how exactly it is that phenomenologically oriented research can aid contemporary research into schizophrenia. I argue that it can do so by providing two specialised kinds of understanding, namely nosographic understanding and structural understanding. So, let me start by answering this question first: how has schizophrenia been studied?

§1.2. Schizophrenia as a Psychiatric Object

Schizophrenia has been studied as a psychiatric object. This simple statement carries two implications, one epistemological and the other metaphysical. Let me unpack the epistemological one first. What does it mean to study schizophrenia as a psychiatric object? It is to study it as a collection of symptoms (experiences) and signs (expressions) (Berrios, 2002 and Marková & Berrios, 2009). To study schizophrenia as a collection of symptoms and signs of schizophrenia is to study the lived experience of schizophrenia as a mental phenomenon that can be, in principle,

[16] I clarify this claim in §1.3. Schizophrenia as a Form of Subjectivity and explicate its implication throughout §1.3.1. Nosographic Understanding by Phenomenological Coordinates and §1.3.2. Structural Understanding by Deductive Interpretations.

rendered into a set of clearly defined categories. Acquiring the knowledge of schizophrenia then is to identify a set of its observable features and turn it into an intuitive, observation-like statement for its clear categorisation. This descriptive and supposedly a-theoretical knowledge acquisition process is a particular instance of the "operationalist epistemology", which was first introduced by Carl Hempel in the 1959 to the general audience of psychiatry and subsequently reinterpreted for its use in nosological (classificatory) study (Hempel, 1994, p.317 and Thornton, 2016). The Taskforce of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, sums up the purpose of taking such an approach as follows:

> To improve communication between clinicians; To provide reliable diagnoses that would be useful in research; To enhance teaching: to train psychiatry students in clinical interviewing and differential diagnosis; To realign American psychiatry with the rest of the world and to be consistent with International Classification of Diseases, Ninth Revision (APA, 1980).

Under this operationalist approach, those features of schizophrenia that are 1.) observable and 2.) easily transcribable into simple record-like statements by using "colloquial" English terms have been deemed relevant for the classification of schizophrenia. Those that are not have been disregarded, and the descriptions interlaced with speculative causal accounts or technical psychoanalytic terms were removed during the development of the DSM-3 and onwards (Andreasen, 2007, Flaum & Andreasen, 1991, p. 28, and Parnas & Bovet, 1995, p.167).

If the first operationalist epistemological implication is related to the classificatory or nosographical study of schizophrenia, the second metaphysical implication relates to the etiological study of schizophrenia (i.e., a study regarding its cause). To unpack its implications, it goes something like this. To study schizophrenia as a psychiatric object is to study it as a collection of signs and symptoms. To study schizophrenia as a collection of signs and symptoms is to study its lived experience as an epiphenomenon of brain malfunction (Insel & Quirion, 2005, p.2221, Uhlhaas & Mishara, 2007, p. 142, Pérez-Álvarez et al., 2016. p.2, and Parnas & Bovet, 1995, p.167). Acquiring the knowledge of schizophrenia then is to identify a particular neural causal substrate dysfunction for its symptoms and signs. This etiological knowledge acquisition process

is a particular instance of neurobiological reductionism in psychiatry. Detailing this theoretical assumption entrenched in psychiatry, Ian Gold (2009) writes:

> It is a near universal belief among psychiatrists that the future of psychiatric theory and treatment lies in a reductionist research program. A belief in reduction in psychiatry is the view (roughly) that neuroscience--- primarily cellular neurobiology-- and molecular biology will, on their own, eventually provide an exhaustive explanation of mental illness and form the basis for treating it successfully (Gold, 2009, p.507).

As Thomas R. Insel and Remi Quiorion begin their influential editorial article: "mental illnesses *are* brain disorders" (Insel & Quirion, 2005, p.2221). They continue: "[...] mental disorders need to be addressed as disorders of distributed brain systems with symptoms forged by developmental and social experiences. While genomics will be important for revealing risk, and cellular neuroscience should provide targets for novel treatments for these disorders, it is most likely that the tools of systems neuroscience will yield the biomarkers needed to revolutionize psychiatric diagnosis and treatment" (Insel & Quirion, 2005, p.2221). Under this approach, schizophrenia—let me be specific here—its symptoms and signs, has been viewed as a thing-like entity, "well-delimited, atomic entities that could be easily captured and quantified" for its successful reduction into its correlating physical neural substrates (Parnas et al., 2013, p.272). This neurobiological approach has been one of the most dominant etiological research into schizophrenia[17], which has generated vast amounts of data regarding the putative causal role dopaminergic dysfunction plays in precipitating psychotic symptoms of schizophrenia, such as delusions and hallucinations.

The intended consequence of studying schizophrenia as a psychiatric object is well known. With the use of colloquial English terms and the documentation of its observable features into a simple observation-like statement, the revised schizophrenia category was hoped to increase the

[17]The historical root of this approach can be traced back to the 'objectifying trend' which, with the operationalist revolution, swept across the mainstream U.S. and U.K. psychiatry in the 1980s. For a succinct summary of this historical trend, please read: Lieberman, 1989.

intra-reliability of its diagnosis among clinicians. That is to say, the degree to which two or more clinicians coming to the same diagnosis of the person exhibiting the same signs and symptoms at approximately the same time. The neurobiological explanatory approach, in turn, was intended to identify the physical cause of schizophrenia for its effective treatment. The unintended consequence of this approach, however, is just as well known. It is "the death of phenomenology". In the influential editorial article, titled "DSM and the Death of Phenomenology in America: An Example of Unintended Consequences" (2007), none other than Nancy Andreasan, a leading figure in biological psychiatry and operational psychometrics, list out the problems of the operationalist approach and its reception among psychiatrists. The problems are as follows:

> First, the criteria include only some characteristic symptoms of a given disorder. They were never intended to provide a comprehensive description. Rather, they were conceived of as "gatekeepers"—the minimum symptoms needed to make a diagnosis. *Because DSM is often used as a primary textbook or the major diagnostic resource in many clinical and research settings, students typically do not know about other potentially important or interesting signs and symptoms that are not included in DSM. Second, DSM has had a dehumanizing impact on the practice of psychiatry.* History taking—the central evaluation tool in psychiatry—has frequently been reduced to the use of *DSM* checklists. *DSM* discourages clinicians from getting to know the patient as an individual person because of its dryly empirical approach. *Third, validity has been sacrificed to achieve reliability. DSM* diagnoses have given researchers a common nomenclature—but probably the wrong one. Although creating standardized diagnoses that would facilitate research was a major goal, *DSM* diagnoses are not useful for research because of their lack of validity (Andreasan, 2007, p.111; italics added).

The first two problems are most evidently shown in a clinical context. In the absence of contending alternative psychiatric guidelines, most clinicians have been trained to view the DSM as a list of comprehensible descriptions of mental disorders. In an interview article published at Psychiatric Times, Nev Jones, a philosopher of psychiatry who was diagnosed with schizophrenia during her doctoral program, writes:

> A few indicators [symptom criterion listed on the DSM] have, in essence, become the thing itself in working clinicians' minds. The consequences of this, only some of which Andreasen herself describes, cannot be overstated. Misunderstanding, misrecognizing, reducing, and over-simplifying psychosis can and does impact everything from translational neuroimaging (dependent on the use of standardized measures) and new drug development, to clinical conceptualization and the capacity of clinicians to engage more deeply with clients. Clients who feel profoundly misunderstood may never open up in therapy or consultations (Aftab, 2021).

The fact of the matter is that clinicians do not come across a psychiatric object in their practice. They come across a person. They see a particular person. They not only look at a person sitting in their office as their patient but also see their facial expression, bodily postures, and bodily gestures. They not only listen to what that person says about their experience but also hear the tone of that person's voice, the patterns of the used words, and the silence in between the spoken words and sentences. They ask specific questions geared towards eliciting certain reactions and information from that person. They see the face of their caretaker or friends or family members, if they are present, and ask a set of questions to obtain psychosocial and historical information relevant for making a particular diagnosis for the patient. Against the backdrop of this clinical environment wherein a psychiatrist perceives and interacts with a *person,* a specific pattern or a repeated speech and/or behaviour of that person *starts to emerge as signs or symptoms of this and that disorder*. It is in such a clinical context clinicians start to perceive certain aspects of the person as an instance of this and that type of disorder. The point is that signs and symptoms are not a thing-like entity that exists independent of this clinical environment. They are not a thing-like entity that one can perceive as one would perceive a physical object. Symptoms and signs are not referents but *references* whose relationship to their referents can be established only in a clinical environment.

Take delusion as an example. A person does not come to a psychiatrist's office because they have developed this thing called "false beliefs due to incorrect inference about external

reality" on their hand, or in their brain, for that matter. A person comes to see a psychiatrist (or, most likely, is brought to see one by other people) because the objects they perceive, the people they interact with, the events they have experienced, and the way one experiences oneself, very likely, have prompted them to act in a manner that deviates from the social norms. The psychological reality of delusion is not a thing among many others that one can easily pick out. For a person living with delusions, it is a reality within which objects, people, events, and even one's self appears to be, just to list a few of its characteristics, dead, vivid, visceral, dull, ecstatic, fragmented, tensed, staged, authentic, suspicious, threatening, and ineffable. The psychiatrist's job, the point of history taking, empathetic communication, and establishing trustful and open relationships with the patient, is to construct an environment wherein such an altered mode of experience and its correlating reality can be laid out in their clear sight, so that they can provide a personalised and effective way to cope with the distress the particular person they see in their office have to live with. Taking the DSM categories as a comprehensive description of mental disorders, considering some signs and symptoms as a definitive indicator thing itself, disregarding the ontological context within which a certain behavioural and/or speech component of a person can emerge as clinically significant signs and symptoms, emphasising the use of the DSM psychometric checklist, specifically designed to elicit a simple "yes/no" response, over establishing a trustful, open relationship with the patient for maintaining "dryly empirical approach" -- all of these-- could have contributed towards the brute reduction of the psychological reality of a person into a set of signs and symptom, into a psychiatric object. Hence, Andreasen's sombering claim that "DSM has had a dehumanizing impact on the practice of psychiatry."

If the above is the ramification of 'the death of phenomenology' most explicitly shown in clinical context, it has its ramification in the research context as well, specifically, in the validation of psychiatric classification. In psychiatry, the classic understanding of validity goes as follows. The validity of a category is judged to be high if it 1.) describes all the relevant facets of the disorder in question, 2.) delimits its boundary from other mental disorders, and 3.) if its clinical group 3.1.) exhibits characteristic signs and symptoms of the disorder in question irrespective of demographic and cultural variations, 3.2.) shows a similar pattern of treatment response and outcome, and 3.3.) shares a common pathogenic mechanism or etiological factors responsible for the disorder (Robins & Guze, 1970). Most of the DSM categories do not satisfy these conditions.

Importantly (for psychiatrists and psychologists), they do not satisfy the 'gold standard' of validation, that is, the linking of the disorder in question to its underlying etiological factors (or the 3.3. condition). Hence, most of the DSM categories are not valid categories. They were never meant to be taken as such. As briefly mentioned above, the DSM categories are made with the purpose of establishing a common nomenclature among clinical practitioners. Hence, they were defined based on the consensus among the experts. Andreasan reminds the readers of this point by quoting the DSM:

> It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised (APA, 1980, p.8)

However, despite this precaution, the DSM categories have been treated as valid categories. Steven Hyman, the director of the National Institute of Mental Health (NIMH) from 1996-2001, voiced his concern as follows:

> Unfortunately, the disorders within these classifications are not generally treated as heuristic, but to a great degree have become reified. Disorders within the DSM-IV or ICD-10 are often treated as if they were natural kinds, real entities that exist independently of any particular rater (Kendell & Jablensky 2003) [...] Outside of their ongoing research projects, most investigators understood that the DSM-IV was a heuristic, pending the advance of science. In practice, however, DSM-IV diagnoses controlled the research questions they could ask, and perhaps, even imagine [...] *My alarm was heightened when, early in my tenure, negative results were reported from several genetic linkage studies. I was baffled that many (although thankfully not all) research groups had been funded to collect only enough phenotype data to diagnose DSM-III-R (Am. Psychiatr. Assoc. 1987) or DSM-IV (Am. Psychiatr. Assoc. 1994) disorders, as if these were natural kinds that would map onto the human genome* (Hyman, 2011, p.157; italics added)

The reification of the DSM categories in this manner into natural kinds has gone hand in hand with neurobiological reductionism[18]. With the understanding that mental disorders are natural kinds, their symptoms and signs have been posited as a set of delimited, atomic-like entities whose distinctive expressive features can be causally produced by their underlying physical constituents or dysfunctional modules in the brains. As mentioned above, one of the most contending explanations of schizophrenia is the neurobiological one, namely dopamine hypothesis. It is the view that targets the dysfunction in dopamine production and transmission as the underlying cause of the psychotic symptoms (delusions and hallucinations) of schizophrenia. It is an undeniable fact that this neurobiological approach, since its initial inception in the 1960s to its recent refinement into Dopamine Hypothesis-III, produced a vast amount of empirical data that suggests the dopaminergic dysfunction is strongly correlated with the psychotic symptoms of schizophrenia. However, it is also an undeniable fact that the growing amount of data and various models proposed in connection to the dopamine hypothesis have been met with growing skepticism[19]. Reviewing the compiled 77 pathophysiological facts of schizophrenia Mario Maj, the president of World Psychiatric Association (2008-2011), writes: "The huge mass of "data" or "evidence" which is being accumulated in this area is not perceived anymore as an indication of accounting increase

[18] By this claim I do not mean that an account that commits to the view that mental disorder is a natural kind, by default, also commits to neurobiological reductionism. The point of the footnoted claim is the following. The DSM classification, though it was made for a pragmatic, diagnostic purpose (as a practical kind), has been reified into a natural kind by researchers. That is to say, the DSM classification has been considered to denote an entity that a.) exists independent of particular raters, b.) whose boundary is clearly circumscribed by the classification, c.) whose observable features are c.1) exhaustive and c.2) casually produced by the properties within the entity itself (or in the brains) (Zachar, 2015,p. 288). It is this reification Hyman noticed in his review, hence his surprise. The footed claim is saying that, historically, the reification of the DSM classification into natural kind has gone hand in hand with the reductionist view. It is not saying that a view that considers mental disorder as a natural kind automatically commits itself to a reductionist view.

[19]Michael Hengartner and Joanna Monstcrieff (2018) list out the following reasons that fueled this scepticism. First, the sample size of the research has been constantly small, leading to the problem of false positive associations (Jauhar et al., 2017). Second, clozapine, which plays a less regulative role in the uptake of dopamine (75 times less than risperidone and 100 times less than haloperidol), has been proven to be either as effective or more effective in treating the psychotic symptoms of schizophrenia (Seeman, 2014). Third, postmortem studies regarding dopamine concentration and its receptors in the brain tissue have been inconclusive (Tost et al., 2010). Fourth, environmental stress (McEwen, 2015) and substance abuse (Sulzer, 2005) have shown to involve many more mechanisms than simply dopaminergic neurotransmission, undermining the idea that dopaminergic dysfunction is the "final common pathway" to schizophrenia.

of "knowledge" (Maj, 2011, p.20). Why so? Because "This mass of data, with its inconsistencies and with the postulated involvement of so many different cerebral structures, neuronal circuits and neurotransmitters, is increasingly seen as a sign of uncertainty and confusion" (Maj, 2011, p.20). Meaning, the picture the contemporary empirical findings paint of schizophrenia is not the one wherein its symptoms and signs neatly correlates with its common underlying neurobiological mechanism. Instead, it is the one wherein its multifarious underlying mechanisms show that schizophrenia cannot be a discrete, atomic-like entity with a clearly delimited boundary but, very likely, a complex phenomenon with fuzzy boundaries whose constituents just cannot be curtailed to its DSM symptoms.

It is against the backdrop of this intellectual environment, the DSM's operational definition of schizophrenia and its reification into natural kinds have been publicly put into question by the prominent figures in psychiatry and psychology. Roughly, the consensus among the experts is this: the DSM schizophrenia category should not be used for a research purpose and its use has to be reserved only for diagnostic purposes. Their rationale is as follows: there is a structural and pragmatic difficulty involved in obtaining an internally homogeneous clinical group necessary for its research using the DSM diagnostic system. The structural difficulty is pointed out by Hyman and Maj. The DSM diagnostic approach is a polythetic one: a person has to meet a certain number of symptom criteria listed out in the DSM. For the case of schizophrenia, at least two of the five criterions have to be met. Therefore, even if the individual members of a given clinical group all have the same diagnosis of schizophrenia, two individuals in that group might be alike on as few as one of the five criteria (Hyman, 2011, Maj, 1998). Practical difficulty is related to the misuse of the DSM categories. Given the current diagnostic practice, wherein clinicians view the DSM symptoms of schizophrenia as all or nothing indicators for its diagnosis, it cannot be ruled out that a significant group of people who have the diagnosis of schizophrenia, on a closer inspection, could have been diagnosed with other kinds of disorder. Take the recent retrospective examination study conducted at the Johns Hopkins Early Psychosis Intervention Clinic (EPIC) as an example (2019). This study shows that among 78 people referred to the EPIC only 26 people received a confirmed diagnosis of schizophrenia and 18 people were re-diagnosed to have no mental disorder (Coulter et al.,, 2019). Almost all misdiagnosed people exhibited hearing the voice symptoms, indicating that this experience alone led previous clinicians to make a diagnosis of schizophrenia.

Russell L. Margolis, a clinical director for the Johns Hopkins Schizophrenia Center, claims that "checklist psychiatry" could have contributed to the prevalence of such a misdiagnosis. In an interview article, he explains:

> A patient says he hears voices. It becomes very easy in the EMR to check off them as positive for hallucinations. But hearing voices can mean many, many things… Forty-five minutes is not enough to sort out the case. We have to have time to sort out the diagnoses. It's a great luxury in a consultation clinic like ours, to have hours to spend on a patient at a time (Kunzman, 2019).

In a research context, what this implies is that a clinical group whose individual members have the DSM schizophrenia diagnosis and whose diagnosis have not been confirmed and assessed by other clinicians/specialists may not be as internally homogeneous as a researcher initially suspects it to be. Why does it exactly matter if a clinical group is "internally homogenous" or not? It matters because if a clinical group includes a group of individuals who do not have schizophrenia, even if some researchers do identify a common pathophysiological underpinning or the common final pathway (call it X) to schizophrenia, their empirical finding is not telling us that X is the cause of schizophrenia. Their object of empirical investigation, their target phenomenon, has never been "schizophrenia" from the beginning. This is the reason that Jones wrote "*Misunderstanding, misrecognizing, reducing, and over-simplifying psychosis can and does impact everything from translational neuroimaging (dependent on the use of standardized measures) and new drug development,* to clinical conceptualization and the capacity of clinicians to engage more deeply with clients." Having these issues in mind, it is not then so surprising that Insel, the director of the National Institute of Mental Health (the world's largest funding body for mental health research), made a public announcement that the institute will not fund a research that exclusively relies on the DSM-5 categories two weeks prior to its publication.

§1.2.1. Back to the Things Themselves

If empirical research aims to validate a psychiatric category by identifying the etiological factors responsible for the phenomenon so categorised, that category better picks out features that are (most ideally) essential or (most feasibly) typical to the phenomenon in question -- not simply those features that are most agreed upon to be characteristic of schizophrenia among clinicians. Put it easily, answering this question would be a good start: What really *is* schizophrenia? Andresan agrees and ends her editorial article (2007) with the following quotes from her previous work (published 15 years prior, arguably, with great foresight)

> In the United States an older generation of clinical researchers who led the field for many years have died—Eli Robins, Gerry Klerman, George Winokur. Very few younger investigators are emerging to replace them. The word is out—if you want to succeed as a serious scientist, you need to do something relatively basic. Fortunately, the Europeans still have a proud tradition of clinical research and descriptive psychopathology. Someday, in the 21st century, after the human genome and the human brain have been mapped, someone may need to organize a reverse Marshall plan so that the Europeans can save American science by helping us figure out who really has schizophrenia or what schizophrenia *really is* (Andreasen, 2007, p. 116; original in Andreasan, 1994; italics added).

> We need to make a serious investment in training a new generation of real experts in the science and art of psychopathology. Otherwise, we high-tech scientists may wake up in 10 years and discover that we face a silent spring. Applying technology without the companionship of wise clinicians with specific expertise in psychopathology will be a lonely, sterile, and perhaps fruitless enterprise (italics original; Andreasen, 2007, p. 116; original in Adreasan,1997,1637–1639).

Maj ends his review article (2011) with the following:

> What is probably needed is a reformulation of the prototype of schizophrenia, on the basis of classical descriptions and more recent acquisitions (e.g., those concerning the psychopathology of intersubjectivity). Patients could be classified

> on the basis of their degree of typicality, and pathophysiological research could focus on the most typical cases, or its findings could be correlated with the degrees of typicality (Maj, 2011, p.21)

Similar to Andreasan's foresight, Maj writes a decade prior to his 2011 article:

> [...] it is possible that the form and content of the subjective experiences of individuals who are diagnosed as having schizophrenia require a more in-depth investigation and characterisation, reversing the recent process of reduction of psychotic phenomena to their smallest common denominator, of which the DSM-IV laconic formulation is the outcome. A renaissance of psychopathological research, focusing on the above issues, should be, in my opinion, encouraged (Maj, 1998, p.459).

How does one go about answering a question like "what really is schizophrenia?" Andreasan answers: by appealing to descriptive psychopathology. How does one formulate a category that picks out the features that are most typical of schizophrenia? Maj answers: by appealing to the classical descriptions of psychopathology. What do these answers mean in the contemporary research context of psychiatry? In the situation where the very category of schizophrenia and its reification into natural kind have been put into question and, further, its pathophysiological findings puts pressure on the validity of the category in use, one must go back to the things themselves such a category initially aimed to denote and such a theoretical attitude initially aspired to explain: the lived experience of schizophrenia. A faithful description of the lived experience of schizophrenia, wherein a researcher, at the very least, does not reduce its psychological reality to its smallest observable denominator and, at the most, describe its invariant and essential or prototypical features, is called for. What for, exactly?

So that, for the case of clinicians, they can have an enhanced sense of what it is that they are dealing with in their practice — not a constellation of symptoms and signs, not a broken brain whose stability is to be achieved by the antipsychotic or SSRI medications, not an unstable thing but a person living with the altered mode of experience and its correlating reality. That is to say,

at the risk of sounding overly pedantic but to bring back and holdfast the common sense that has wandered away— a person who may invite others into such a reality to make one's situation understandable no matter how hard is, and, equally, who simply may not and cut everyone off, especially, just as anyone would when the intention of the interlocutor is clearly "listen to report", "listen only to ask "did you take your medications?"", or "listen only to ask "how's your medication working?"".That is to say, a person who may find it extremely difficult to communicate their predicament without sounding "nonsensical" or "insane" and thus, just as anyone would, simply give up talking about their condition in any detail and deflect. That is to say, a person who may hide certain experiences to clinicians for its repercussions, and equally, who may talk about specific experiences in great detail and 'play along' to elicit empathetic reactions from clinicians. To emphasise, once more, that is to say, not a thing but a person and thus whose understanding takes time and effort and requires clinicians to establish a trustful and open relationship with the patient in question. So that, for the case of researchers, they can clearly grasp what it is that they are trying to reduce into the "final common pathway"— not a schizophrenia thing, but the altered mode of experience whose constituents must be disentangled, detailed, clarified, and organised into a meaningful whole for its neurobiological explanation and classification.

In this context, taking the subjectivity of the people living with schizophrenia, seriously amounts to the following: to better understand what schizophrenia really is, one must pay attentive regards to what people with schizophrenia, as a person, have to say about one's own experience. Granted. If so, if all that is required to better understand schizophrenia is listening to the people living with schizophrenia, then why does one have to appeal to the philosophical domain of phenomenology? A short answer is this: to construct the kinds of understanding specialised in aiding the nosgraphical and etiological inquiry into schizophrenia. In the following, I first explain these types of understanding and deflate their value outside the domain of psychiatric and psychological research, specifically in everyday life context.

§1.3. Schizophrenia as a Form of Subjectivity

Before I detail the types of understanding phenomenologically oriented research offers, let me first clarify the central premise with which phenomenologists generally orient their analysis of schizophrenia. If this premise remains implicit, the understanding phenomenologists offer will risk

a case of its own reification and lack of clarity. What is this premise? This: schizophrenia is a form of subjectivity[20]. Let me first clarify what it does not mean and then go on to say what it means.

Firstly, to say that schizophrenia is a form of subjectivity is not to say that schizophrenia is a particular personality type, nor is it to say that schizophrenia is a disease entity that has its own clearcut, rigid form. In the statement "schizophrenia is a form of subjectivity", the "form" does not denote the extension of an entity and the "subjectivity" does not mean "personality[21]". Secondly, to say that schizophrenia is a form of subjectivity is not to say that schizophrenia is a mental phenomenon, nor is it to say that schizophrenia is an epiphenomenon of a broken brain. In the statement "schizophrenia is a form of subjectivity", its predicate does not express that schizophrenia is a subjective phenomenon enclosed in one's mind, nor that, as such, its objective explanation involves the identification of its observable physical underpinning in the brains. Instead, to say that schizophrenia is a form of subjectivity is to say that, first and foremost, it is the dimension of phenomenon. Let me unpack this claim.

As suggested in the first section, for phenomenologists, "phenomenon" belongs to the thing itself. Construed as such, consciousness does not enter into a phenomenological analysis as a container or a creator of phenomenon. Instead, it features as the dative of manifestation to which

[20] Although I use the term "subjectivity", as shall be clarified in the main body, I do not use it to mean some sort of a wordless, solipsistic ego. To spell it out, by "subjectivity" I mean "subject-world". It essentially denotes the hyphen "-": the a priori correlation between the subject and the world, without which neither can be the kind it is. To mean exactly in Husserlian's terms, it denotes the interdependent relationship between the pre-egoistic self and pre-objectivistic world where the basic form of awareness is neither fully 'subjective' or 'objective' in kind (Husserl, 2001). In Heidegger's coinage, I just mean being-in-the-world. The only reason I do not use Heidegger's or Husserl's terms is because phenomenological psychopathology is a research area that, even if one limits its scope to the traditional figures, one can see that not only the philosophy of Husserl and Heidgger but also that of Immanuel Kant, Wilhelm Dilthey, Max Weber, Freidriche Nietzche, Henri Bergson, Soren Kiekeggard have exerted their influence (for a more in-depth discussion read: Stanghellini et al., 2019). I had to a.) settle for the term that is commonly used, at least, among contemporary researchers, and b.) unpack such a term that accommodates the interdependent relationship between the subject and the world. So, I settled for the term "subjectivity".

[21] It is true that Jaspers claims schizophrenia involves "a global personality change". However, this term 'personality', as Jaspers uses it, does not mean an aggregation of an individual's behaviours, emotional, and cognitive patterns as its contemporary use has it. Instead, the 'personality', in Jaspers' terms, refers to the structure of experience, or the way one experiences the world, others, events, time, space, etc. As Parnas unpacks it: "It [personality change] points to a shattering of the basic forms of experience and hence a transformation of the patient's total awareness of reality (Jaspers 1963/1997; Schneider 1959).What is changed is not an opinion about reality but the very structure of the global perspective on the world: the patient's existential-ontological framework" (Bovet and Parnas 1995; Parnas, 2004) (Parnas, 2013, p.219).

a thing can manifest itself as such, or as its condition of possibility or dimension. Hence, to say that schizophrenia is the dimension of phenomenon is to say that the conscious life of the person living with schizophrenia — in short, the lived experience of schizophrenia — is "the "place" "in" which" one's reality *can* articulate itself in the way it does with its meaning (Parnas & Zahavi, 2001, p.114)

Under this phenomenological approach, the lived experience of schizophrenia is not something that happens in one's mind. This conceptualisation — let me cut to the core — the attribution of the "subjective" or "mental" property to a given phenomenon (be this delusion, delusional meaning perception, hallucinatory experience, etc.) is always *ex post facto;* it always happens after the fact. Easily put, the judgement "it was just all in my head" comes after the psychosis subsides, usually, with the help of others and/or medications, or, for some cases, not at all. In finding the world as a place of immense threat, one does not perceive some immanent world conjured up in one's head. It is this world, nothing but this world that brutally imposes an existential threat to the person (Laing, 1965/2010, p.40-43) — in much the same way it is this actually existing world that immediately shows itself as a place of practical significance that affords one's bodily and practical engagement. In seeing the red coat of one's psychiatrist as an alarming indication that "she knows everything", it is not some imagined red coat and imagined meaning one perceives in their mind. It is that actually existing particular coat, that red coat that particular psychiatrist is wearing, that shows itself that she knows everything (Seeman, 2015) — in much the same way the water bottle sitting on my desk immediately shows itself as an actually existing thing I can just grab to drink its content. Schizophrenia just does not happen in one's head. Nor does this suspension of the lived experience of schizophrenia as a mental phenomenon imply that schizophrenia is something that happens out there in the world as a publicly accessible, objective event. What then? What does this 'lived experience of schizophrenia' supposed to mean under phenomenological approach?

The lived experience of schizophrenia, denotes, first and foremost, the necessary correlation between the subject and the world. Correlating to the world imposing an imminent threat, there, by necessity, exists a subject who find the world *as such* and is thrown into a state of hypervigilance; correlating to the sound of bell toll signifying one's death, there, by necessity, exists a subject who hears the bell *as such* and is thrown into a state of despair (Fuchs, 2005,

p.131); correlating to the sudden emergence of the peculiar saliency of one's familiar environment, there, by necessity, exists a subject who *is drawn into* such a saliency and is thrown in the state of bewilderment (Jaspers, 1963, p.100); correlating to the fragmentation and disarticulation of temporal experience, there, by necessity, exists a subject who *is having such an experience* and is thrown into a state of complete disorientation (Sass & Pienkos, 2013, p.140). A person living with schizophrenia *exists in* and *is caught up in* such a relationship. To mean the same point differently, the proper focus of phenomenological study of schizophrenia is not an aggregate of its isolated symptoms but the person's *being-in-the-world.* R.D. Laing writes:

> Unless we begin with the concept of man in relation to other men and from the beginning "in" a world, and unless we realize that man does not exist without "his" world nor can his world exist without him, we are condemned to start our study of schizoid and schizophrenic people with verbal and conceptual splitting that matches the split up of the totality of the schizoid being-in-the-world (Laing, 1965/2010, p.19-20).

In what sense is this "correlation", or in Heidegger's coinage, the inseparable, interdependent relationship between the subject and the world, so exemplified by the hyphens in "being-in-the-world", supposedly necessary? It is necessary, in that without this relationship between the phenomenon in question and the subject to which such a phenomenon appears, that phenomenon cannot be *the kind it is* and cannot *show itself as such.* Just as this laptop cannot appear to me as a perceptual object with its determinate significance without its correlating perceptual act, no bell toll can be given to oneself as a 'perceptual object' with its determinate significance that one's husband is dead without its correlating perceptual act that intends the bell toll *as such*. Here, the move that phenomenologically oriented clinical psychologists, namely, Karl Jaspers, Eugene Minkowski, Ludwig Binswagner, Erwin Straus, Wolfgang Blankenberg, Henri T. Ellenberg among many others[22], or let me now call them by their proper title, *phenomenological* psychopathologists, make is this: if one aims to understand schizophrenia, it is important to pay close attention to not only 'what appears' to the person living with schizophrenia and describe it in as much as detail possible but also identify and describe its correlating dimension without which the phenomenon under investigation cannot be the kind it is and cannot show itself as such, i.e.,

[22]Or the "Europeans" as Andreasan called them.

its structure. As such, Karl Jaspers, one of the founders of phenomenological psychopathology, writes: “For the phenomenologists, forms have the utmost interest, while contents appear to him always casual” (Jaspers, 1963, p.59). In a similar vein, Ludwig Binswanger writes: “In mental diseases we face modifications of the fundamental or essential structure and of the structural links of being-in-the-world as transcendence. It is one of the tasks of psychiatry to investigate and establish these variations in a scientifically exact way” (Binswagner, 1958, p.194). In line with such a tenant, Fernandez, a contemporary researcher, concisely summarises the aim of phenomenological psychopathology as follows: “Phenomenological psychopathologists describe not only “what it is like” or “what it feels like” to live with a mental disorder, but also how the structural features of human experience and existence — for example, intentionality, selfhood, temporality, and affectivity — alter in psychopathological cases.” (Fernandez, 2019, p.1016)

In sum, the clarification is the following. To study schizophrenia as a form of subjectivity is to study its lived experience as the dimension of phenomenality. To study the lived experience of schizophrenia as the dimension of phenomenality is to study the necessary correlation between the subject and the world. Under this approach, understanding schizophrenia involves the description of such a necessary correlation, or its structure, and its experiential content. Having this clarification in mind, as promised at the start, let me now present the types of understanding phenomenology can provide: 1.) nosographic understanding and 2.) structural understanding.

§1.3.1. Nosographic Understanding by Phenomenological Coordinates

Nosology is a branch of medicine that aims for the classification of illness. Its practical purpose is to provide a description of the subjective experience of a given illness (i.e., symptoms and its aggregation into syndrome) and a set of symptom criteria with which a clinician can make a diagnosis. This practical purpose can be realised without making a reference to the physical cause of the given illness, usually out of diagnostic and treatment needs. The DSM is a prime example of this inquiry. This type of inquiry wherein a researcher outlines provisional and conventional characteristics of an illness is ‘nosographic inquiry’. Since there are no known extra clinical indexes for classifying schizophrenia, this is to say, since there are no known distinctive biological causes of schizophrenia that can licence the classification of schizophrenia as a natural clinical entity (Fusar-poli & Meyer-lindenberg, 2016, Kapur et al., 2012), its categorisation has to rely on psychopathologically defined symptoms and signs (Stanghellini et al., 2019, p.2). Given that

phenomenological psychopathology provides a detailed description of the lived experience of schizophrenia, it can aid nosographic inquiry into schizophrenia. How exactly so?

Take Sass' and Parnas' the minimal self (or core-self, ipseity) disturbance model as an example (Parnas & Sass 2001, Parnas & Sass, 2003, Sass, 2010). Although the researchers make a reference to the DSM categories, they primarily orient their research with the view of understanding a person living with schizophrenia. In the actual investigation, this orientation radically changes the theoretical assumption that has thus far underpinned the relevance criteria for the nosographic study of schizophrenia, i.e., the DSM operationalism. If, under the operationalist approach, those features of schizophrenia that are observable and easily renderable into an intuitive, record-like statement have been deemed relevant for its nosographic inquiry, under the phenomenological approach, it is the structure of experience and its correlating reality that take the centre stage of investigation. In actual investigation, what this effectively means is that the researchers cannot dismiss what a person living with schizophrenia says about one's experience with the reasoning that it is a diagnostically irrelevant experience — no matter how odd and nonsensical it sounds to them. That, or the content of the lived experience of schizophrenia, exactly is the object of investigation. That's where the investigation starts. The general question that intiaties and guides a phenomenological investigation can be put as follows: "How does a person living with mental disorder experience X?" [X= oneself, one's body, others, world, objects, time, and space]. The general aim of raising this kind of question is to identify a possible alteration in the structure of one's experience and (if there is any) detail its individual make-ups or constituents in as much detail as possible.

Going back to the minimal self disturbance model, the specific structure of experience Sass and Parnas focuses on is the way a person living with schizophrenia experiences one self, or 'selfhood'. The researchers specify this selfhood into 'minimal self'. Minimal self here essentially refers to the implicit sense of existing as the self-identical subject of one's own experience. Their investigation finds that in the case of schizophrenia such a sense of self is altogether lost or severely diminished. Sass and Parnas (2001) provide the following case studies:

> Case 1. Robert, a twenty-one-year-old unskilled worker, complained that for more than a year, he had been feeling painfully cut off from the world and had a feeling of some sort of indescribable inner change, prohibiting him from normal life… He

> summarized his affliction in one exclamation: "My first personal life is lost and is replaced by a third person perspective" He reflected on self-evident daily matters and had difficulties "in letting things and matters pass by" and linked it to a long lasting attitude of "adopting multiple perspectives," a tendency to regard any matter from all possible points of view (p. 124–25).

The researchers coin this type of anomalous self-experience as the 'minimal self-disturbance' and specify it into the following three individual features: "a.) Hyper-reflexiivity= exaggerated self-consciousness involving self-alienation; b.) Diminished Self-Affection = diminished intensity or vitality of one's own subjective self-presence; c.) Distrubed "hold" or "grip"= loss of salience or stability with which objects stand out in an organised field of awareness" (Sass & Parnas, 2003, p.429). Here I do not detail these concepts any further nor explain how exactly they are derived from the self-reports. What's important here is the general phenomenological conceptual framework that orients the researchers' investigation. Let me first clarify what is going on in this kind of investigation and then articulate its importance in the nosographic study of schizophrenia.

Firstly, the concept of 'selfhood' functions as one of the *general domains* of human existence and experience that can alter in the case of mental disorder[23]. This concept serves the following purpose. The 'selfhood' domain delimits the object of investigation — from the panoply of experiences implicated in schizophrenia to its 'self-experience'. Secondly, the 'minimal self' concept functions as the specific constituent of the selfhood domain, as a *particular dimension* (or a particular mode of self-experience) that can alter in the case of mental disorder. This concept serves the following purpose. The 'minimal self' dimension specifies the object of investigation from the 'general' schizophrenic self-experience to the 'particular' mode of self-experience, i.e., altered minimal self experience present in the case of schizophrenia. Thirdly, "hyper-reflexivity", "diminished self-affection" and "disturbed hold or grip" function as the most specific constituents

[23]Recently, Fernandez developed this kind of phenomenological analysis and proposed a phenomenologically oriented classificatory approach for psychiatric conditions, namely, dimensional approach. The above presentation of ipseity disturbance with respect to its general domain and particular mode owes much of its inspiration to Fernandez' dimensional approach. This approach has been further used as the theoretical basis for a more empirically oriented research method, i.e., Phenomenologically Grounded Qualitative Study. For a further discussion, please read: Fernandez, 2016, 2019, and Køster & Fernandez, 2021

of the minimal-self dimension, denoting the individual features of schizophrenic self-experience. Why is any of this move important?

If one aims to delimit and test the categorial boundaries of schizophrenia, especially the DSM ones, it is essential that a researcher operates with a system of coordination that a.) does not presuppose the discriminative validity of the category in use and yet still b.) orients the research to the common aspect of the object under investigation that is other than the umbrella term of "schizophrenia". Phenomenological concepts can serve that purpose. Not limited selfhood but also temporality, embodiment, affection, intentionality, intersubjectivity, and so on can orient a nosographic research by targeting the specific mode of human existence and experience (e.g., the particular way a person living with schizophrenia experiences one self, time, others, space, etc.) within its correlating general domain. They can be used as the coordinates that pinpoint the specific aspect shared among the individual members of the mental disorder under investigation, and that targeted aspect can operate as one of the general domains in a nosographic inquiry. The end result of which is the systematic description wherein the lived experience of schizophrenia is organised from the general domain (for the case of minimal self model, 'selfhood'), to the particular dimension or particular mode of experience (disturbed minimal self), and down to its concrete, individual features (hyper-reflexivity, diminished self-affection, and disturbed grip or hold). Let me now term this type of description as nosographic understanding by phenomenological coordinates. But what exactly would be the point of this kind of understanding for contemporary researchers? Clearly, accepting an approach like this comes at the cost of accepting a whole host of assumptions phenomenologists make. What's the pay off here?

The pay off is that it opens up the possibility to test the categorical boundary of schizophrenia by carrying out a comparative analysis. It can go as simple as follows. First, delimit the object of investigation to selfhood. Second, specify it to minimal self. Third, see if the individual features of schizophrenia (hyper-reflexivity, diminished self-affection, and disturbed hold or grip) are present in the kinds of disorders other than schizophrenia. If one does not accept the legitimacy of phenomenological concepts, ignore the first two steps and orient the research with the identified individual features that are actually present in schizophrenia. On what grounds? Empirical one that suggests those features are predominantly present in the case of schizophrenia (Parnas et al., 2011, Raballo et al., 2011, Nordgaard & Parnas, 2014). If an empirically oriented

comparative investigation shows that those individual features are also present in the disorder other than schizophrenia, then it can be demonstrated that schizophrenia shares an overlapping boundary with other disorders with respect to that self-experience with empirical support. If they are not, then, at least with respect to the dimension of selfhood, schizophrenia can be differentiated from other kinds of disorder. If the latter is the case, then the identified individual features can play a pivotal role in a differential diagnosis, especially in that of the disorder that exhibits overlapping psychotic symptoms of delusions and hallucinations and thus has often led to misdiagnosis, i.e., bipolar disorder (Thaker, 2008; Parnas et al., 2003). Those features can be used to construct a category with discriminative validity, and their description can directly feed into its content validity. The latter turned out to be the case for the minimal self model (Haug et al., 2012; Nordgaard & Parnas, 2014; Parnas et al., 2005; Parnas, Handest, Saebye, & Jansson, 2003; Raballo & Parnas, 2012) — hence its current popularity and development into a working psychometric-checklists, i.e., the Evaluation of Anomalous Self-Experience (EASE) (Parnas et al., 2005) and the Evaluation of Anomalous World-Experience (EAWE) (Sass et al., 2017)

The recent success of the minimal self model is not the point here. The point is that the phenomenological description of the altered structure of human existence and experience can provide a type of understanding that can aid nosographic study. The kind of understanding that, in sum, firstly, articulates the taxonomic order of the lived experience of schizophrenia from its general domain down to its individual features and, secondly, provides a set of individual features as the target phenomenon for an empirically oriented comparative analysis. If, through such an interplay between phenomenologically oriented investigation and empirically oriented psychological analysis, a set of features particular only to schizophrenia can be identified then that set can be employed as clinical criterion to construct a clinical category with enhanced discriminative and content validity. If no set of such features can be identified, then the categorical approach should be put into question and a new classificatory approach should be sought after.

With all these being said, there is something unclear about this kind of understanding. To cut to the core, what do concepts such as “selfhood, intentionality, temporality, affection, intersubjectivity, embodiment” actually mean? What does it mean to say that they are the “most basic, essential feature” of human existence and consciousness? Call this the clarification concern. Closely related to this concern and pertinent to the core of the phenomenological account of

schizophrenia (or, for that matter, any mental disorder under phenomenological inquiry), what do phenomenologists mean when they make claims such as "modifications in the fundamental or essential structure and of the structural links of being-in-the-world as transcendence" (Binswagner, 1958, p.194) or "total breakdown in the structure of time consciousness" (Sass & Pienkos, 2013) or "ontological insecurity" (Laing, 1965/2010) with respect to a given psychopathological experience? For the sake of expediency, let me term a set of claims that attributes disturbance/modification/alteration to the structure of human existence and experience as "structural claim". What is the role of this structural claim? How is this structural claim justified? Call it the epistemological concern. And, importantly, what is actually being understood by this structural understanding ? In the following, I look to address these concerns.

§1.3.2. Structural Understanding by Deductive Interpretation

A general conceptual classification is necessary to address the clarification concern. As briefly discussed in the first section, phenomenologists, in general, are concerned with describing the a priori correlation between the subject and the world. To put it differently, phenomenologists are concerned with describing the formal regularity of such a relationship that must hold true for the world to manifest itself in the way it does with its meaning. A set of terms has been provided to describe such a relationship. This set usually bears the title of "transcendental structure", "ontological structure" or "existential" in phenomenological psychopathology. The individual members of such a set are what I have so far called "phenomenological concepts" such as selfhood, intentionality, temporality, affection, embodiment, and intersubjectivity[24]. Going back to the clarification concern, what these concepts essentially capture is a particular moment or a distinct aspect of the inseparable relationship between the subject and the world. The relationship of which must hold true for both relata to be the kind they are. To put it negatively, those concepts denote the limit condition whose transgression implies a change in the kind of being for both relata.

[24]This does not exhaust the list of 'phenomenological concepts'. This list of 'phenomenological concepts' have been often mentioned by applied phenologists in their broad characterization of philosophical phenomenology, to claim that that's what philosophical phenomenologists study. To be precise, phenomenologists, philosophically oriented ones, study various structural moments of consciousness and existence under the heading of 'temporality', 'embodiment', 'intentionality', etc. Under each heading, there are other various concepts.

Take ‘temporality’ as an example. I have been looking at this page for some time. Although many words have been deleted and many points have been edited, this page stands to me as the same page, as a temporal object whose identity persists across time. The same goes for myself. Although my stomach has been rumbling and my mood has been fluctuating, I experience myself as the same subject who has been looking at this page for some time, as an experiential subject whose identity persists across time. How is this possible? Or what is the so-called ‘limit condition’ whose transgression implies the change in the kind for both relatas? The short (and arguably) classic answer offered by phenomenology is this: the present has to be extended beyond the actual now. To be precise, in the present, there has to be a constant interplay between the actual now and the just-past, wherein the present consciousness retains its own just-past phase and anticipates its own yet-to-come phase. If not, I will experience my self as an ever new subject and this page will stand to me as an ever new object in every (succeeding) actual now moment. To put it negatively, this page will not be given to me as a temporal object and I will not be able to experience myself as a self-identical subject without the present consciousness constantly retaining and anticipating, respectively, its own just-past and yet-to-come phases[25]. In short, what this ‘temporality’ concept aims to capture is this coherent regularity between the temporal modes of experience (the now, the just-past, and the immediate future) and that which appears through such a mode. The regularity without which neither I can exist as a self-identical subject nor this page can appear to me as an object whose identity persists across time.

The reason that phenomenological analysis has been deemed useful in psychopathological analysis is because its concepts can be used to initially categorise a given psychopathological phenomena and clarify the altered relationship between the subject and the world that underpins the manifestation of a given psychiatric condition, i.e., its “structure”. Take one of the most characteristic experiences of schizophrenia as an example, namely self-fragmentation experience[26]. It refers to the kind of experience wherein one experiences one self and the world as a series of fragmented moments. Professor Saks details this experience as follows:

> But explaining what I’ve come to call ‘disorganization’ is a different challenge altogether. Consciousness gradually loses its coherence. One’s center gives way.

[25]I explain this claim in full detail in Chapter 4.

[26]This experience has been one of the central objects of investigation in psychopathology since the days of Bleuer (1912). I provide its systematic account in Chapter 4.

> The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal (...) No core holds things together, providing the lenses through which to see the world, to make judgements and comprehend risk. Random moments of time follow one another. Sights, sounds, thoughts, and feelings don't go together. No organising principle takes successive moments in time and puts them together in a coherent way from which senses can be made (Saks, 2007, p.13).

Firstly, what phenomenological concepts can do is to provide a general conceptual framework within which a researcher can conceptualise the target phenomenon. For this case, by employing the temporality concept contratistively, the above reported experience can be provisionally interpreted as a particular kind of temporal experience whose characteristic feature is the loss of coherence in self and world experience. In a little bit more detail, *in contrast to* everyday life experience whereby the now, just-past, and yet-to-come phases are experienced in their coherent unity, researchers can initially characterise schizophrenic temporal experience as the loss in the temporal coherency of experience[27]. In essence, phenomenological concepts can function as a conceptual tool that can be used to clearly pinpoint and articulate (albeit provisionally) the feature of a given psychopathological experience that differentiates itself from everyday life experience — in this case, as the loss of temporal coherency. Secondly, after having identified the characteristic feature of a target phenomenon, phenomenological concepts can be employed to identify its underlying structure. The inference involved in clarifying the structure of schizophrenic temporal experience would *very roughly* go as follows.

[27]Consider the following classic analysis offered by Straus (1962). After describing the content of self-fragmentation experience, Straus goes on to write: "...in *disturbances* of consciousness, the continuum falls apart, the present *is no longer* the fulfilment of anticipation, nor does it reach out ahead of itself in new anticipations. Therewith the stability of things disintegrates, the order of experiential connections break down and thus the possibility of abstraction and critical deliberation is abolished" (Straus, 1967, p. 164; italics added). Although claims like this appear as though it is a simple description, or to be precise, documentation of a target psychopathological phenomenon, it is not. Straus is not simply reporting back what his patient has said to him. To cut to the core, he has a foreknowledge regarding the 'norm' of temporal experience and its correlating 'normal' structural regularity. It is against the backdrop of this foreknowledge he differentiates schizophrenic experience from everyday life experience and attributes "disturbance" to "consciousness" to describe its correlating alteration.

a.) Temporality refers to the structural interplay between the present and the just-past, wherein the present consciousness retains the just-past and anticipates the yet-to-come moments.

b.) This interplay establishes the temporal coherence in the self and world experience.

c.) Schizophrenic temporal experience is characterised with the loss in such a coherency.

d.) Therefore, the disturbance/alteration/modification in temporality underpins schizophrenic temporal experience.

In contemporary terms, the disturbed temporality, or to be exact, the disturbance in the "inner time consciousness" has been termed as the structural disturbance that "underpins", "elicits", or "implicates" the self-fragmentation experience. This type of an analysis wherein a researcher identifies the underlying structure of a given psychopathological condition or certain experience has been traditionally termed as "structural analysis" or "constructive-genetic consideration" (Ellenberger, 1967, p.100). Let me here address the glaring issue. We are now approaching the epistemological concerns.

The issue is this: the target phenomena does not necessarily follow from the structural claim. To go back to the above case, even if a.) and b.) are the case, all that disturbed temporality claim implies is a change in the way one experiences one self and the world across time. This change does not have to be schizophrenic temporal experience, or "self-fragmentation experience". Hence, the deductive inference involved in the structural analysis is invalid.[28] More to the point, the inference involved in the structural analysis should not be, *strictly speaking*, counted as deduction. Although it is true that traditional figure such as Straus (1967) — in line with Minkowski and Von Gebsattel — does suggest that the aim of structural analysis is to identify the "basic disturbance[29] (trouble genérateur), from which *one could deduce* the whole content of

[28] There has to be another premise that delimits the domain of "disturbed temporality", and this domain must include the "self-fragmentation experience" as its individual member.

[29] The conceptual standing of this "basic disturbance" is yet to be clarified. On Minkowsi's account, this concept of "basic disturbance" or "trouble genérateur" has two senses. In one sense, "trouble genérateur" refers to the 'original point' from which a given psychotic condition emerges (Minkowski, 1927/1997, p.5,77f, 83; translated in Sass, 2001, p.256). It has the connotation of causation and, therefore, aetiology.

consciousness and the symptoms of the patients" (p.100; italics added), it should not be so. If the inference involved in structural analysis is *sensu stricto* deduction, any phenomenological research of mental disorder can be, in principle, rendered obsolete. Simply attribute disturbance/alteration/modification to whichever phenomenological concepts that are deemed suitable and deduce every aspect of the given psychopathological phenomenon. If the rules of inferences are followed and the terms in the premises are clear, the provided account will be valid.

As opposed to deductive inference, even in the case where a researcher *seems* to clearly deduce a given psychological phenomenon from a structural claim, there always exists a room of epistemic uncertainty. Why so? Because the structural claim is justified by the researchers' interpretation of the self-reports, and this interpretation can be always otherwise. The above self-reports of Professor Saks alone do not justify the well-rehearsed disturbed temporality claim. *To make it so,* it has to be rendered into a particular kind of temporal experience and its feature has to be conceptualised as the loss of coherence in self and world experience. Without this specification, albeit provisional, the reported experience does not follow from the proposed particular structural claim. Although it seems intuitive to interpret the above reported experience as a kind of temporal experience, there is no principled reason to do so. Other phenomenologists, with respect to their varying research aims, can interpret her experience as a kind of embodied or affective experience. Given this, there is at least one case wherein the reported experience does not follow from the proposed structural claim, that is, the case in which the reported experience is interpreted as a kind of experience that is not temporal experience. *Therefore,* structural claim is not some sort of analytic truth form which one can "deduce the entire content of consciousness or the symptoms of patients" with apodictic certainty. The point here is that structural analysis is intrinsically ambiguous. The lived experience of schizophrenia (its property and feature) just cannot be, once

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In another sense, it is used to mean a sort of "essence" that determines the kind of the psychiatric condition, with no connotation of causation (Minkowski, 1927/1997, p.5,77f, 83; translated in Sass, 2001, p.256). On Blankenberg's account, this basic disturbance or "Grundstörung" or "basic disorder" is used to mean the second sense Minkow's "trouble genérateur", a kind of essence with no etiological connotation (Blankenburg, 1971/1991,p. 27,4; translated original in Sass, 2001, p.258). However, both employs such a concept to denote the common structural perturbation of subjectivity present in schizophrenia (e.g., for the case of Minkowski, "the vital contact with reality" and, for Blankenburg, "the breakdown of common sense"). With such a concept, both researchers understand other cardinal features of schizophrenia. In this chapter, I take the concept of "trouble genérateur", "Grundstörung", or "basic disorder", as a structural claim from which one deduces the target psychopathological phenomenon.

and for all, fully predicated into a set of simple sentences. However, this epistemic uncertainty is not the shortfall of the structural analysis. It is its virtue as it helps resist the reification of phenomenological analysis.

The actual investigation of the structural analysis does not involve a simple attribution of disturbance/modification/alteration to some phenomenological concept. It always involves the analysis of the self-reports, clinical observations, and numerous case histories (Titelman, 1976, p.22). Stanghellini and Rossi call this stage of phenomenological investigation "phenomenological exploration" [..] which is "the gathering of qualitative descriptions of the lived experiences about the individuals" (Stanghellini & Rossi, 2014, p.239). The end product of which is a "rich and detailed collection of the patient's self-descriptions related to each dimension, for example, temporal continuity/discontinuity, space flat/filled with saliences, bodily coherence/fragmentation, self-world demarcation/ permeability, self-other attunement/misattunement, and so on." (Stanghellini & Rossi, 2014, p.239). This investigation is the background condition that enables a researcher to use a particular phenomenological concept over others so as to interpret the target phenomenon as this and that kind of experience.

To schematise this interpretation process, it usually goes through the following: a.) explanation of the phenomenological concept in use, b.) provisional specification of the target phenomenon as a particular kind of experience, c.) clarification of the structural claim, and d.) delimitation of the domain of the structural claim with respect to the specified target phenomenon. If one fails to carry out c.) and d.), then the structural claim will be meaningless. Its scope would be too broad to account for the target phenomenon: nothing *particular* follows from the 'disturbed temporality' claim. If one fails to carry out a.) and b.), then the structural claim will lose its justification: nothing *particular* can lend support to the 'disturbed temporality' claim.

The point here is that though the above interpretation involved in the structural analysis can be always otherwise it is not groundless. Yes, there is no principled reason to interpret the target phenomenon only as this and that kind of experience, and there is no principled reason to believe the interpreted target phenomenon lends support only to this and that particular structural claim. However, if the interpretation involved in the structural analysis goes through the aforementioned process, then there is a reason to believe that the structural claim is justified and the target phenomenon can be reasonably deduced from the structural claim. The implication of

which is that, if it doesn't, if a presented phenomenological account fails to a.) explain the phenomenological concept in use, b.) provisionally specify the target pheromone as a particular kind, c.) clarify the structural claim, or d.) delimit the domain of the structural claim, then there is a reason to believe that the structural claim is not justified and its account is invalid. It is this interpretation process, which follows a certain rule-like pattern, that enables a researcher to constantly revise/refute a given phenomenological account, and thereby help resisting the reification of structural analysis. For instance, focusing on c.) and d.), a researcher may argue that from the pre-established structural claim, say, 'the breakdown in inner time consciousness', it is not the self-fragmentation experience that follows but the impossibility in having any experience. If this kind of argument goes through, it can motivate researchers to, at the very least, clarify the structural claim or, at most, look for other dimensions of experience to better accommodate the target phenomenon[30] . Focusing on a.) and b.) a researcher may argue that the phenomenon denoted by 'delusional mood' is more heterogeneous than it has thus far taken to be and bring attention to its overlooked feature to clearly distinguish such features from each other[31]. If this kind of argument goes through, it can challenge the thus far accepted structural claim and provide a more detailed account of the target phenomenon.

Let me now term the kind of understanding that aims to describe the underlying structure of psychopathological condition by the a.) interpretation of target phenomenon into a structural claim and b.) demonstration of the deductive inference from the structural claim back to the target phenomenon as "structural understanding by deductive interpretation". But, what exactly is being understood by this kind of understanding? And what is the point of identifying and clarifying this structural alteration?

As briefly mentioned above, the structural understanding sheds light on the change in the way one relates to the world and others, to be specific, in the altered mode of experience. Ellenberger describes structural understanding as an attempt to reconstruct the life world of patients "through an analysis of their manner of experiencing time, space, causality, and materiality and other existential 'categories' (in the philosophical sense of the world)" (Ellenberger, 1960, p.101). In a similar vein, Stanghellini et al. write that the project of

[30] I carry out this task in Chapter 4 and 5
[31] I carry out this task in Chapter 6

phenomenological psychopathology is "to articulate the life-world of each person and identify the conditions of possibility for the emergence of pathological phenomena in human existence" (Stanghellini & Rossi, 2014, p. 237, 239). In line with this view, Parnas writes:

> [...] Every anomalous mental state contains therefore an imprint of more basic experiential and existential alterations, comprising, for example, changes in time and space experience, self-experience or alterations in the elementary relatedness to the world. It is such structural alterations that transpire phenomenally in the single symptoms, shaping them, keeping them meaningfully interconnected, and founding the specificity of the overall diagnostic Gestalt (Parnas, 2011, p.1123)

In short, what is made clear by the structural understanding is not only the particular type of experience one undergoes but also its underlying structural alteration. The entire point of the above-described deductive interpretation process is to clearly conceptualise such an alteration and delimit its boundary with as much precision as possible. This "structural emphasis" is the search for "[...] psychopathological organisers connecting single features (e.g., affective depersonalization in melancholic depression or autism in schizophrenia) within a larger experiential gestalt" (McCarthy-Jones, 2013, pg.4; original in Fuchs, 2010, pg.548). In Fuchs' words, this is to "help define mental disorders on the basis of their structural experiential features, linking apparently disconnected phenomena together" (Fuchs, 2010, pg. 549). And this "linking" Fuchs talks of is the deductive interpretation *process*. The process whereby a researcher *demonstrates how* the alteration in one's consciousness and existence, say, the breakdown in inner-time consciousness, *can lead* to the multifarious features found in, for the case of schizophrenia, a.) the loss in the sense of existing as a self-identical subject of one's own experience across time (in contemporary terms, "ipseity disturbance" (Sass & Parnas, 2003), b.) the expansive feeling of grandeur (e.g., that one is a supernatural figure that exists outside time (Minkowski, 1933/1970,p.285)), and c.) the sudden loss of train of thoughts (or "thought-withdrawal", Fuchs, 2002). In short, the point of structural understanding is to provide a coherent account that can articulate conceptual unity among otherwise seemingly disparate individual features of a given disorder. And what is all this for the contemporary empirically oriented researchers of schizophrenia?

§1.3.2.1. Mutual Constraints

In the above, I provided a generic answer to the raised question: if one aims to provide a neurobiological account of schizophrenia or its specific symptoms/signs, one first has to have a good grasp of what it is that one is trying to explain in relation to its neurobiological underpinning or correlates. Phenomenological account due to its subjectivity centred approach can do a good job in clarifying the target phenomenon under neurobiological investigation. Let me add more meat to this claim by focusing on the one of the most contending and enduring neurobiological hypotheses of schizophrenia, namely, the aberrant salience hypothesis (Kapur, 2003, 2005).

This hypothesis postulates that in the early stage of schizophrenia there involves elevated presynaptic striatal and subcortical dopamine synthesis and release capacity (Kapur & Howes, 2009). This dysregulation in dopamine production and transmission has been known to cause "aberrant salience", whereby a person constantly notices every insignificant detail of one's experience and attributes context irrelevant salience to innocuous details (Kapur, 2003; Kapur et al., 2005). The proponents of this model argue that psychosis, specifically, delusions found in the case of schizophrenia, is most likely the result of a person attempting to make sense of the aberrant salience experience over time (Kapur, 2003, p.15).

Although the aberrant salience hypothesis has gained much of an attraction due partly to its intuitive explanation for the prodromal experiential feature of schizophrenia (i.e., delusional mood), in the recent review of the hypothesis, Howes and Nour (2016) claim that "it is less intuitive how anomalous experience leads to positive psychotic symptoms", suggesting the process of how the experience of aberrant salience gives rise to the psychotic symptom of delusion still remains to be clarified. A similar concern has been voiced within the field of phenomenological psychopathology. As pointed out by Mario Maj in the recent review of the hypothesis, the experiences described under the heading of the aberrant salience only share a partial commonality with psychopathologists' descriptions (Maj, 2013, p. 234). The aberrant salience, or as Maj terms it referring to Jasper's coinage "changes in intensity of perception", is not the only experiential abnormality present in the early stage. It is also characterised with, as most extensively studied by Gestalt school psychologists (Conrad, 1958; Mattusek, 1987), the loss of the meaning of an object, the perceptual field fragmentation, and global atmospheric shift in one's lived world (Maj, 2013, p.234). In line with this view, Mishara and Fusar-poli claim: "How do the dopaminergic alterations

affect the creation of a "new (psychotic) world"? There remains an explanatory gap between what we know about the neurobiology of early psychosis and what we understand about its subjective psychopathological experience" (Mishara & Fusar-Poli, 2013, p.284). So, what can this phenomenologically oriented "structural understanding" do here? Something like the following.

If phenomenologically oriented researchers can reasonably demonstrate how a particular modal alteration(s) lead to the manifestation of aberrant salience, the loss of meaning of an object, perceptual field fragmentation, and atmospheric shift in one's lived world, then such alteration(s) can be provisionally used as a conceptual scheme (or psychopathological organiser) to specify the relationship between such features. If this relationship turns out to be mutual implication, such that aberrant salience phenomenon necessarily implies the aforementioned other characteristic features and vice versa, then the identified modal alteration can be used to complement the mind-level explanation of the aberrant salience hypothesis. If, further, the identified modal alteration (s) can be translated into the terms used in the context of neurobiology, e.g, 'disrupted prediction error signalling' (Hemsley & Garety, 1986, Gray et al., 1991, Corlett et al., 2010) or 'disturbed activation of the stored context appropriate material' (Maclean, 1970, Pankow et al., 2012), then the provided structural understanding can ground such experiential disturbance as the target phenomenon. Having the target phenomenon clarified, neurobiologically oriented researchers can zero in on the relationship between the dopaminergic dysfunction and the so-identified disturbance to provide a more robust neurobiological explanation that can accommodate various features present in the early stage of schizophrenia. The empirical findings of which can, in turn, motivate the phenomenologically oriented researchers to revise/refine their structural understanding.

The general point is the following. The structural understanding can be employed to articulate the relationship between otherwise seemingly disparate individual features of a given disorder. If the neurobiological account in question cannot chart out how it is that the phenomenon under investigation (call it P) is present with other aetiologically relevant phenomenon (call this P1), then a structural account can complement it by arguing for this claim: P is present with P1 because of M (M=a modal alteration in one's consciousness and existence). Further, a.) if this M can be translated into the concepts used by neurocognitive scientist, for instance, disturbance in prediction error minimization (call it PEM*), such that the M and the PEM* target the same kind of experience, and b.) if the neurobiological correlate (call this NC) of the PEM* is identified, then

it can be initially hypothesised that the NC underpins both P and P1. This would invite the specification for the neurocognitive explanation of the target phenomenon (specifically, the relationship the PEM* might have with respect to the P1). If a.) is allowed, then the direction of influence should go the other way around too, from neurobiology back to phenomenology. If various neural correlates were found that implicate not only the PEM* but also, say, implicit memory disturbance, then phenomenologists would have a strong reason to revise the structural understanding, to accommodate the experience that initially fell outside the scope of investigation. In such a way, a phenomenologically oriented structural understanding can help complement or motivate the specification of the pre-existing neurobiological hypothesis, and the empirical findings of the neurobiological hypothesis, in turn, can help refine the proposed structural understanding.

In contemporary literature, the above-described interaction between phenomenology and neurobiology has been termed as 'mutual constraint'. Referring to Varlea's well-known article Neurophenomenolgy (1996), Sass and et al (2011) construe such a relationship as a sort of reciprocity between "the phenomenological account of the structure of experience and their counterparts in cognitive science" (1996, p.343). Clarifying the general tenent of such a repciority, Thompson, a colleague of Varela, writes: "By 'reciprocal constraints' [...] mean that phenomenological analysis can help guide and shape the scientific investigation of consciousness, and that scientific findings can in turn help guide and shape the phenomenological investigation" (Thompson, 2007, p.329). To be clear, the point here is not that a well-rehearsed hypothesis from either phenomenology or neurobiology should dictate "in a rigid unilateral fashion" the investigative process of each respective area of research (Sass et al., 2011, pg.5). The claim here is that insofar as phenomenological approach aims to aid neurobiological investigation of schizophrenia, its structural understanding must not be epistemologically immune to the empirical findings offered by neurobiological inquiry. Phenomenologists should be able to interpret the empirical findings, and if the given results suggest that the target phenomenon is incorrectly identified, phenomenologists should revise their original proposal. The same goes for neurobiological explanation. To the extent that the *explandum* of neurobiological research is schizophrenic *experience*, the neurobiological explanation should not be epistemologically immune to phenomenological understanding. Why not, exactly? Because, as put most concisely put by Sass and et al. (2011): "To say that the facts of subjective life "constrian" neurobiological

explanation is simply to say that these facts are among those that an adequate neurobiology *must ultimately take into account*" (Sass et al., 2011, pg.5; italics added). In the contemporary research context wherein the "serious and embarrassing psychological lacuna is becoming glaringly apparent" (Parnas & Handest, 2003, pg.121), a phenomenological structural understanding that details and organises various features of the lived experience of schizophrenia in their coherent unity can help neurobiological approach to realise its purpose, taking into account its explanandum or schizophrenic *experience*.

§1.4. Schizophrenia as a Person Living With Schizophrenia

So far has been a brief rundown of specialised understanding phenomenology can offer to aid the contemporary research of schizophrenia. Let me here raise a critical question and assess it. This will help clarify the object of inquiry in this thesis and delimit its scope. The question is this: is all this *necessary* to understand a person living with schizophrenia? For psychiatrists, counsellors, psychologists, nurses, and therapists, whose object of inquiry is the disordered aspect of their patient's/ service user's subjectivity, then, yes, it is necessary. However, the question was not whether phenomenology is needed to understand the "disordered subjectivity" of a schizophrenic patient/service user. The question was whether it is needed to understand a "person" living with schizophrenia. Then, the answer is: No, phenomenology is not needed to understand a person living with schizophrenia.

To claim otherwise, to claim that phenomenology is *needed* to understand a person living with schizophrenia, would be to make a wrong claim. To make its latent nonsense audible, imagine yourself hearing the following claim from your friend who could not understand why it is that you are infuriated over losing your key: "Sorry, I have to first read Husserl's *Analyses Concerning Active and Passive Synthesis: Lectures on Transcendental Logic* to understand you". In everyday life context, the situation that demands one to say "I simply don't understand you" is when the interpersonal relationship between us (or I) and the other particular person is broken down. Say, the situation where the person you are talking to suddenly leaves a conversation. The best course of action in such a situation would be asking them what happened later on, not opening up Husserl's book.

The same goes for understanding the person living with schizophrenia. The situations that demand one to say "I simply do not understand you" *can be, at times,* the kind of situation when

that person is going through an active psychotic phase, or, to be specific, when the person acts erratically and violates certain social norms. The person in question may cut off all social connections or may actively engage in social interaction to confirm their delusional thinking or carry out ritualistic behaviour. This situation, however, can be just as well not be a psychosis induced kind or has no relation to schizophrenic experience. It can be that the person in question just simply does not want to talk to other people in general because, as life has it, it can sometimes get exhausting to even hold down a simple, everydaylife conversation. This, to other people, may seem as though the person in question is withdrawn into one's own world. To a particular group of people, this withdrawal from social interaction — if persists and if the person in question has the diagnosis of schizophrenia and/or has the history of being put on antipsychotics — may seem as an instance of the negative symptoms of schizophrenia, i.e., avolition. Or it can be that the person in question is in the process of remission and may not want to be caught up in the relationship with a particular group of people who only see them as schizophrenic. This, to other people, may seem as though the person in question lacks an insight into their illness. To a particular group of people, this may seem as a classic instance of anosognosia associated with schizophrenia. Or it can be that the person in question does not want to say anything intelligible to a particular group of people to make a point. This, to other people, *as intended*, will look and sound insane. To a particular group of people, this will be counted as an instance of active psychotic phase. The point here is that when it comes to understanding a person living with schizophrenia what should be brought to attention is not simply their "psyche" but also the *particular* situation the person exists in and the *particular* relationship the person in question has with other *particular* people. Why? Because the situation that demands one to say "I simply do not understand you", or the situation that puts the intelligibility of the behaviour and the utterance of a person living with schizophrenia into question, is when the particular interpersonal relationship one has with other particular people is broken down. A person living with schizophrenia could have intentionally broken down such a relationship to make a point, or could have not. Then, to understand such a person, one should *ask that person in question* what happened and what's been going on in their mind and *ask yourself* who you are to that person and how you have treated them. If the person in question cannot clearly articulate the reason for their behaviour and experience and as such the other person cannot fully understand that person's rationale behind their action, then, so be it. People do not usually understand other people's behaviour or their utterance because they fully

grasp its underlying rationale, or, for the case of phenomenological psychopathology, because an interlocutor excavated the modal alteration involved in the other interlocutor's structure of consciousness and existence that underpins their behaviours and utterance. People simply do, albeit not perfectly, and people come to better understand other people by letting the other person talk, paying attentive regards to the person when speaking, and putting oneself in other's shoes. This takes time and patience on both sides, not philosophical phenomenology.

However, this is not to say that phenomenology has no use whatsoever in understanding a person living with schizophrenia. Phenomenological accounts describe in detail the lived experience of schizophrenia. As such, it can show what it is like to have such an experience to the other who doesn't have schizophrenia. Though one may not be able to completely relate to such an experience, it may, at least, enable one to drop a dismissal attitude, and, at most, take an empathetic attitude towards the person living with schizophrenia. Further, the attentive regards phenomenologically oriented researchers pay to the lived experience of schizophrenia, to be specific, just asking questions of what it is that one experiences and trying to understand such an experience with the person in question, can help alleviate the sense of dreadful isolation a person living with schizophrenia experiences. Consider the following remarks made by the proponents of the minimal self disturbance model.

> One patient was able to recognise himself quite clearly in the distrubed-ipseity model, stating "this does describe what's been going on… I haven't given it a name before… It's amazing how much this (the self-disturbance model) relates to what's been going on for me (Nelson and Sass, 2009, p.496). His therapist noted that the patient was "more enliviend than ever" when relating this model to his own experience ; in this case, the fact that the therapist seemed to be familiar with significant aspect of the patient's experience, even though he himself had not experienced them, seems to strengthen the therapeutic relationship and to enable the patient better to understand the nature of his psychotic vulnerability (Sass & Pienkos, 2012 ,pg.32).

As recounted by the proponents of the minimal self disturbance model, phenomenology can *help* one to understand a person living with schizophrenia. My position here, however, is that it is *not necessary*. Let me cut to the core. To claim that phenomenology is *necessary* to understand

the people living with schizophrenia is to claim that if one does not appeal to philosophical phenomenology then one cannot understand the people living with schizophrenia. . That is to say, it would be to claim that all there is to the people living with schizophrenia is their odd, contradictory, and, sometimes, ineffable experience. To be precise, for the case of phenomenological psychopathology, it would be to claim that all there is to the people living with schizophrenia is just their altered/modified/disturbed structure of consciousness and existence, and, as such, again, phenomenology is needed to understand the people living with schizophrenia. However, it just isn't. There is more to the people living with schizophrenia than simply having schizophrenia. There is more to the people living with schizophrenia than their mode of experience being altered. It should be made clear here that what is at stake in everyday life understanding is a concrete individual who exists in a particular situation with a particular group of people, not a collection of experience abstracted away from other kinds of experience and categorised as a particular kind of experience that lends support to a particular structural claim. What's at stake in everyday life context is not an instance of minimal self disturbance model, or breakdown in the inner time consciousness, or global crisis of common sense, or schizophrenic autism, or false-self system, or disembodied existence but a person: *your friend, your peer, your co-workers, your partner, your family member, your relatives.* Insofar as, as Stanghellini and et al., aptly put it, the aim of phenomenological psychopathology is to understand a "person" living with mental disorder, phenomenologists should not claim that philosophical phenomenology is needed to understand a person living with schizophrenia. This necessity claim entails the reification claim.

The point here is that there is a time and a place for phenomenological research. The specialised understanding phenomenology can offer has its own limitations. Ignoring the particular aim and scope of specialised phenomenological understandings, and conflating the complementary role phenomenology can play in understanding the person living with schizophrenia with that of necessity will help no one. It will lead to dogmatism and wrongfully recast the existence of the people living with schizophrenia as a kind of being whose mystery can be only deciphered by philosophical phenomenologists. So, let me claim that phenomenology is not needed to understand a person living with schizophrenia. Well then, where does this leave us with this thesis?

This thesis stands at the intersection of phenomenology and psychopathology, and I write this thesis as a researcher. The question this thesis asks is this: how does schizophrenic delusion

come about? Its object of inquiry is schizophrenia as a form of subjectivity, or the disordered subjectivity of the people living with schizophrenia. To specify the target experience, it is the self-fragmentation experience and the delusional mood experience. My tactic in answering the thesis question is the following: identify the underlying structure of both experiences and provide a coherent account that demonstrates how such a structural alteration can lead into the development of schizophrenia delusion. Is this thesis necessary to understand a person living with schizophrenia? Let me be exact here. Is it necessary in the sense that if one does not subscribe to or understand the affective centred account I provide then one cannot understand a person living with schizophrenia? No, it is not necessary. It may, at times, help one to understand what it is like to go through a certain experience characteristic of the early stage of schizophrenia. This thesis aims to provide a conceptual scheme that can help one to understand the panoply of experiences implicated in the early stage of schizophrenia in their coherent unity so as to clarify the formative stage of schizophrenic delusion. In so doing, it refines the contending phenomenological models and facilitates a dialogue with the fields other than phenomenological psychopathology, i.e., psychiatry and neurobiology. If, however, this thesis and the experience it highlights while achieving its aim helps one to understand one's experience from the perspective other than one had developed, and if this helped alleviate the sense of isolation one had felt, then that's all I sincerely hope for.

§1.5. Conclusion

In this chapter, I discussed what phenomenology is in relation to the constant interaction it had with psychopathology. I further clarified its value for aiding contemporary research on schizophrenia. I specified two specialised kinds of understanding phenomenology can offer: nosographic understanding and structural understanding. If the nosographic one can be used to chart out the order of schizophrenic experience, the structural approach, I have suggested, can be used to understand how it is that the individual features of schizophrenia are interrelated with each other, contributing towards its systemic understanding. Drawing on contemporary phenomenological research, I have articulated how such an understanding may benefit the nosographic and neurobiological inquiry into schizophrenia. Afterwards, I deflated their value outside the context of psychiatry and psychology. This was to resist the reification of the existence

of people living with schizophrenia into a simple instance of schizophrenic structure of consciousness and existence.

As should be emphasised, I do not here aim to suggest that the above described nosographic and structural understanding is the only type of understanding philosophical phenomenology can offer. I am aware that there can be other types of phenomenological understanding that cannot be counted as an instance of either. I do not believe that the above described types of understanding can capture all the unique features of contemporary phenomenological investigations into schizophrenia. Nor do I believe that the value of phenomenology in the study of schizophrenia (or, "mental disorder" in general, for that matter) has to be articulated only in relation to its psychiatric or psychological investigation. However, by clearly describing the kinds of understanding phenomenology can offer, I hope to have shown exactly how phenomenologically oriented research can aid contemporary research into schizophrenia.

Now that I have discussed the general role of phenomenology, let me turn my attention to two of the most notable methods phenomenologists have proposed, refined, and employed in their analysis of mental disorder: the ideal type approach and the essential type approach. In the following chapter, I chart out a way in which both approaches can complement one another, so as to resolve the difficulty inherent to each approach. In short, I advance a mutual complementarity thesis. This thesis will guide the structural analysis I carry out in Chapter 4, 5, and 6. Let me proceed.

Ch.2 Phenomenology and Psychiatric Classification: Ideal Type Vs. Essential Type

§2. Introduction

In the previous chapter, I discussed the general use and value of phenomenology in the psychological research of schizophrenia. Appealing to phenomenological psychopathological traditions, I first suggested that to study schizophrenia from a phenomenological perspective is to study it as a particular form of subjectivity. Afterwards, I clarified how such a theoretical postulate can be employed to produce two specialised kinds of understanding that may benefit the classificatory and neurobiological study of schizophrenia, i.e., nosographic understanding and structural understanding. Having the general theoretical orientation of current research and its implication clarified, let me now turn my attention to the particular methods employed in a phenomenologically oriented study of mental disorder[32]: ideal type approach (Schwartz et al., 1995, Schwartz and Wiggins, 1987a, Schwartz and Wiggins, 1987b) and essential type approach[33] (Zahavi and Parnas, 2002). In this chapter, I critically assess both approaches and advance a mutual complementarity thesis.

Before I present my argument and render the proposed thesis in the terms relevant to current research, let me here briefly describe the general historical context of psychiatric research in which the ideal type and the essential type approaches are proposed. This will help clarify the

[32]Of note, there is another one: prototypical approach (Parnas and Gallgher, 2015). Briefly, this approach makes categories based on the concrete and exemplar case of a given concept (Livesley, 1985). On this approach, class membership is a matter of degree. An individual is either a "better" or "worse" fit for a given category. I do not discuss this approach in detail as it has little to no relevance to the argument I wish to make here. Interestingly, according to the recent rendition of prototype (Parnas and Gallagher, 2015; Contra. Livesley, 1985 and Schwartz et al., 1995), prototype is supposed to articulate a certain law-like relatedness among various features of a given disorder (or "gestalt" that "is a unity or organisation of phenomenal aspects, a unity that emerges from the relations among the features of experience" (Parnas and Gallagher, 2015, p.74)). This is in line with, at least, one of the aims of the ideal type approach (I discuss this in detail in §3.2. and 4). *If,* however, the construction of a prototype is based on the same method the ideal type approach takes (as shall be discussed in detail in §3.2 and 4), the scope of my argument extends to the prototype approach. In this chapter, I do not entertain this possibility. For a further discussion, please read: Parnas and Gallagher, 2015, especially, p.75. For a succinct summary of the type oriented classificatory approaches proposed by phenomenologists, please read: Fernandez, 2016, 2019.

[33]It should be noted here that Zahavi and Parnas initially titled their classificatory approach as 'ideal type approach' that is in line with Schwartz's and Wiggins' proposal. It is only recently that Ferandnez (2016) helpfully distinguished Zahavi's and Parnas' approach from the ideal type approach and termed it as essential type approach. I discuss this in §4.

general motivation behind their proposal and the intended aim of each approach (which has been often confused among contemporary researchers and only recently identified and corrected by Fernandez (2016)).

Bluntly put, the history of psychiatric diagnosis and classification is a history of crisis. From the early 1960s up to 1980, the reliability of a psychiatric diagnosis made based on the predominant psychiatric guideline, namely, the Diagnostic and Statistical Manual of Mental Disorders II and its 3rd edition, was put into question (Spitzer and Fleiss, 1974; Kirk and Kutchins, 1994). The reliability of psychiatric diagnosis, or the likelihood of two or more clinical practitioners coming to the same diagnosis for the same patient, was significantly low. An influential study conducted by Cooper and Kendell in 1972 showed that the rate at which schizophrenia diagnoses were made in the United States was 5-20 times greater than in the United Kingdom (Cooper et al., 1972). Later studies found that this difference reflected not the alleged actual difference in the prevalence of schizophrenia but the difference in the diagnostic procedures of the two countries. This reliability crisis brought worldwide dissatisfaction with conventional psychiatric classification and led to clinical practitioners standardising their diagnostic procedures by taking the operational approach (Cooper et al., 1969; Allardyce et al., 2007).

As discussed in the previous chapter, under the operational approach, easily observable signs and symptoms that various experts considered characteristic of a particular mental disorder are listed as its clinical features in colloquial English terms (APA, 1987, p.xxiii). Equivocal psychoanalytic terms and speculative causal accounts, which led to heterogeneous interpretations of the same classification among clinical practitioners, were removed during the development of the DSM-III for the issue of diagnostic reliability (APA, 1987, p.xxiii). The majority of the categories of the DSM-III and its later edition are thus defined based on the psychiatrists' consensus of the best descriptor of the mental disorder in question[34] (Owen, 2014, p.564; Pincus and MacQueen, 2002, p.15). In addition to the operationalization of classification, a polythetic

[34]This is not to suggest that the revision of clinical criteria solely relies on clinicians' opinions. The revision process involves empirical considerations regarding the sensitivity and specificity of the criteria in question. Further, in contemporary research, some researchers have employed item response theory analysis to test the specificity of clinical criteria for autism spectrum disorder. The footnoted claim is intended to say that, in response to the reliability crisis psychiatry faced, the DSM classification went under a kind of operationalization process-- whereby clinicians can come to a consensus with respect to, at least, the interpretation of a given diagnostic category and, at most, its application in the field.

approach was introduced to further ensure the reliability of DSM psychiatric diagnoses (Guze, 1978, Kendell, 1983). This approach requires an individual to exhibit a certain number of features for her to count as a member of a particular classification, while none of the individual features, by itself, is sufficient for class membership. In a diagnostic context, this approach requires a psychiatrist to check off a certain number of features she observes from her patient against pre-delineated list of the DSM clinical criterion, thus bypassing often raised diagnostic disagreement among clinical practitioners regarding which individual feature is 'essential' for a certain diagnosis to be made. This operational, polythetic approach has been known to significantly improve the reliability of a DSM psychiatric diagnosis (Matarazzo, 1983; Skre et al., 1991; Hyler et al., 1982; Cf. Parnas and Bovet, 2014)

However, current psychiatric classification finds itself in another crisis, that of validity. The validity of a psychiatric classification, or the degree to which an individual member of a given classification sharing the same underlying etiological and pathogenic process with other members of the same classification, has been known to be significantly low. A recent study conducted by St. Stoyanov and his colleagues found that most DSM categories do not correlate with biological underpinnings, and even less so for distinct neurobiological states (St. Stoyanov et al., 2015). As pointed out by Fernandez (2016), this validity crisis is further exacerbated by the presupposed legitimacy of the DSM. Despite the validity issue, the legitimacy of the DSM is already assumed prior to etiological and pathogenic research. As a result, neurobiologist Steven Hyman wrote: "the modern DSM system, intended to create a shared language, also creates epistemic blinders that impede progress toward valid diagnosis" (Hyman, 2010, p.157).

Although the above listed litany of complaints regarding the DSM classification is raised quite recently within the field of psychiatry, phenomenologists working within the field of psychopathology and psychiatry have been critical of the DSM's operational, polythetic classificatory approach for the past few decades. Schwartz and Wiggins have (1987a, 1987b) argued that the DSM's approach fails to appreciate the psychiatrist's immediate way of seeing a patient as having a certain type of disorder, engendering the so-called "mysteries of psychiatric diagnosis". Furthermore, as pointed out by Sass, Parnas, and Fernandez among other prominent figures, the current operationally defined categories of the DSM-5 still remain to be a list of easily observable symptoms that do not stand together in any meaningful way. The DSM categories do

not provide any information about why it is that the listed clinical features of a given mental illness tend to arise together and in what way those features are interrelated (if they are at all). The information of which is important to carry out an etiological analysis whereby a researcher identifies the underlying psychopathogenic process of the disorder in question. It is against the backdrop of this intellectual environment, phenomenologically oriented researchers have provided an alternative approach to psychiatric classificatory schemes: the ideal type approach and the essential type approach.

In this chapter, I critically assess both approaches. Despite the recent suggestion that those approaches should be understood as "antithetical" to one another (Fernandez, 2016, p.51), I argue that their difference should not be read disjunctively. Their difference has to be maintained; however, they should stand in a complementary relationship such that both approaches constantly inform and constrain each other. In short, I advance a mutual complementarity thesis[35]. By arguing for this thesis, I hope to show how phenomenologically oriented classificatory schemes may enhance one another so as to provide a more systematic understanding of psychiatric conditions. I present my argument in the following order.

First, I begin by reviewing the value of the ideal type approach in psychiatric research and diagnosis — as proposed and popularised by Schwartz, Wiggins, and Norko (1995, 1987a, 1987b). As this approach is largely derived from the critical appraisal of psychiatrist's everyday life "typification", I explain this concept in detail and discuss its role in the context of a diagnostic procedure. Afterwards, in line with Schwartz and Wiggins, I show how the use of such a

[35]I render this thesis in the terms relevant to current research in the conclusion. I only spell this out in the conclusion for the sake of presentation. However, in an anticipatory summary, in the context of current research, the proposed thesis amounts to the following. As an ideal type analysis, this thesis is subscribed to the following claims. First, the subject matter of current research is not the concrete totality of the formative stage of schizophrenic delusion nor its essential features. I focus on the aspects of experience that have been deemed characteristic to the formative stage of schizophrenic delusion: self-fragmentation experience and delusional mood experience. Second, the structural claim I make with respect to those kinds of experiences is a thought-construct. It is a conceptual scheme that helps one to better understand otherwise seemingly disparate features of the pre-delusional experience in their unity. As an ideal type analysis complemented by the essential type approach, I employ the phenomenological concepts, to be specific, Husserl's inner time consciousness and affection that aims to articulate the basic, essential structure of temporality and mood. I make this explicit in the conclusion of this chapter.

phenomenological concept can help demystify the mystery of psychiatric diagnosis and further explain and justify the objective status of psychiatric diagnosis. Second, I critically review the status of the ideal type approach as a psychiatric classification one. I zero in on its aim in making the type that exemplifies the 'unified conceptual whole' through which one can understand various features of a given disorder in their conceptual unity. Following Jasper's adaptation of the ideal type, the proposed method in making such a type is by "synthesising" or "grouping together" individual features into an analytic construct (Schwartz et al., 1995, p.426). I contest this claim with the following rationale: unless one already presupposes a certain relationship between the target features, grouping them together will only produce a cluster-like type that shows they are present in a given disorder, not how they are related to each other. Third, I appeal to the essential type approach. I demonstrate how this approach, with its emphasis on clarifying the necessary, ideal connection between various types of experience, can help construct the unified conceptual whole the ideal type aims to exemplify, and thereby complementing the ideal type approach. Fourth, I argue that complementarity has to go both ways. Essential types, as shall be demonstrated, can very easily grow reluctant to a falsification process. The process of which would be crucial to identify and isolate the features the essential type aims to exemplify: the essential ones that confer a particular type to a given disorder. I argue that the findings of the ideal type complemented by the essential type can help continually revise and refine an essential type in use and push for a mutual complementarity thesis. In doing so, I hope to chart out a possible avenue whereby phenomenologically oriented classificatory schemes can contribute towards a more systematic understanding of psychiatric conditions that can be falsified and refined in light of experiential evidence. I conclude by translating the proposed mutual complementarity thesis in the terms relevant to current research.

§2.1.Everyday Life Typification

In the context of psychiatric diagnosis, Schwartz and Wiggins (1987a) argue that the appreciation of the "typification" operative in a diagnostic procedure can help demystify the mystery of psychiatric diagnosis and help explain and justify the objective status of psychiatric diagnosis can be "explained and justified" (Schwartz and Wiggins, 1987a, p.69). Furthermore,

they see much value in employing psychiatric typification in the construction of a psychiatric classification, and they do so by linking it to the ideal type approach (Schwartz and Wiggins, 1987a, p.69). As this approach is based on the critical appraisal of typification, I detail this concept by highlighting its three[36] central features: 1.) immediate and pre-conceptual, 2.) sedimentation, and 3.) anticipatory. In the subsequent section, I clarify the value of the ideal type in the context of psychiatric research and diagnosis.

Boradly put, phenomenologists have long suggested that perception is not a passive mental state in which a perceived object imprints its image on one's mind by exciting sensory organs. Instead, our perception actively means or intends an object so that, for instance, a cup one perceives does not appear as a meaningless amalgamation of sense data but as a meant, intended object, that is to say, as a cup. This aspect of perception or perceiving an object as belonging to a certain category, or perceiving as, is termed as 'typification'.

Drawing largely on the works of Husserl, Schultz and Hanson, Schwartz and Wiggins (1987a) suggest that the typification process involved in our everyday life perception is *immediate and pre-conceptual*. For example, when I walk into my room, I do not confront an alien space or see a collection of brute things. Instead, I immediately perceive the environment I walked into *as* my room and perceived objects *as* a cup, a book, a table, and so on. To be precise, I immediately perceive the surrounding environment and objects therein as belonging to various categories without having to define such categories. Emphasising this intuitive aspect of our everyday life experience, Schwartz and Wiggins suggest that everyday life typification is 'immediate' and 'pre-conceptual' in the sense that typification is not an explicit, reflective act of categorisation that mediates our perception and the perceived object (Schwartz and Wiggins, 1987a, p.71). To use the example of perceiving a cup, I do not articulate the list of the defining attributes of 'a cup', and assess whether the perceived particular object has those enumerated attributes, and conclude that

[36]Fernandez (2016) lays out six. They are: 1.) tacit, 2.) contextual, 3.) anticipatory, 4.) sedimented, 5.) adaptive, and 6.) fuzzy (p.41-43). Although explaining each feature would be important to provide a detailed account of typification and its relevance to psychiatric diagnosis in general, I specifically focus on its immediate and preconceptual, sedimented, and anticipatory aspects. I do so because the mystery of psychiatric diagnosis Schwartz and Wiggins have in mind can be demystified by appealing to those three. However, for a more in-depth analysis of typification, please read: Fernandez (2016) and also Taipale (2016)

it does, and impose this conclusion on my perception, and then perceive an object as a cup. Instead, the cup just appears to me as a cup. I just see it *as* a cup. To be exact, the perception of a given object directly presents the perceived object *as* a cup, and this presentation, as the authors put it, "does not require explicit acts of thought" (Schwartz and Wiggins, 1987a, p.71). In other words, as opposed to being a mediating term between an otherwise purely non-conceptual perception and the perceived object, typification forms an integral, structural aspect of perception that enables a perceived object to immediately appear as belonging to a certain category or type[37].

In addition to the immediate, pre-conceptual aspect of typification, Schwartz and Wiggins suggest that it is acquired through a direct interaction with the typified object (Schwartz and Wiggins, 1987a, p.73). For instance, by seeing a cup in person and using it as other people do, one acquires the perceptual knowledge that it is an object one can take up to drink from. Importantly, this acquired knowledge is not lost but sedimented and generalised through repetitive interaction with the perceived object, which, in turn, informs the later perception (Husserl, 1973, p.331; Husserl, 2001b, p.46-49; Fernandez, 2016; Taipale, 2016). To put it in Husserl's terms, the past experiences and the perceptual knowledge acquired therein functions as 'passive background' that constantly provides a framework of determinate sense and familiarity to the present perception (Husserl, 2001b, p.46-49). Emphasising this sedimented aspect of typification, Fernandez writes: "our past experiences and social historical milieu structure our lived world, providing us with taken for granted ways of understanding, engaging with, and even perceiving our environment. This personal and social history lives on by shaping our present and future experience" (Fernandez, 2016, pg.42). To stick with the example of a cup, thanks to the years of past experiences whereby

[37] Along this line, Husserl writes: "Apperception is our surplus, which is found in experience itself, in its descriptive content as opposed to the raw existence of sense: it is the act-character which as it were enousls sense, and is in essence such as to make us perceive this or that object, see this tree, e.g., hear this ringing, smell this scent of flowers etc." (Husserl, 2001a, p.105). Apperception, broadly puts, denotes the cognitive aspect of perception, whereby sensations are interpreted "as" a particular object, *as* this scent of flowers, this ringing, etc. I am aware that a certain distinction has to be drawn between apperception in general and typification (Taipale, 2016). However, just as apperception is "found in experience" (Husserl, 2001a,p.105) and is "not seen, heard, or perceived by any sense"(Husserl, 2001a, p.105), typification is not perceived but experienced. What is perceived is the typified object, e.g., a cup. What is immediately experienced and evades my (object-directed) consciousness is the typification, that is, the cognitive aspect of perception through which a given object can appear *as* a cup. In simple terms, I see a cup when I see a cup, and I do not see the typification effective in my perception. I live through it.

I directly interacted with a cup, the given particular cup does not appear to me as an alien object I have to inspect to know what it is for. Instead, it appears to me as a more-or-less familiar object (as an object that belongs to the general category of cup), as a particular cup that will be have in the way a cup in general has been, that is to say, as an object I can just reach my hands towards to drink its content.

Zeroing in on the fallible characteristic of typification, Schwartz and Wiggins highlight its 'openness towards future experience' or its anticipatory aspect. If the sedimented and generalised set of typification enables one to perceive a given object, as a 'cup' with its determinate, familiar meaning, its anticipatory aspect provides the determinate anticipation that the perceived object will behave in the way a cup in general does. If this type of anticipation is violated, that is to say (to stay with the cup example), if one perceives a cup not behaving in the way a cup usually does, the typification in question can be revised and corrected. For instance, thanks to the years of my past experiences, when I see a cup about to fall from my desk I anticipate *that* it will break apart if it hits the floor. However, for the sake of argument, let us assume that the cup does not shatter but bounces off the floor. This experience would direct my attention to the cup that's bouncing off. I may pick up the cup and inspect it closely, only to see that it's made of plastic, not glass. In this case, the typification in question (to word it out) that 'a cup breaks apart if it hits the floor', would be revised and specified into 'a cup does not break apart if it is made of plastic even if it hits the floor'. In other words, the typification sets up a determinate anticipation that the perceived object will behave in a way that conforms to its type. *And* if the anticipated aspects of an object are not directly given, the typification in question can be revised and corrected, thus providing us a more precise understanding of the typified object.

In sum, typification plays a central role in our daily experiences. As an integral aspect of perception, typification first enables one to immediately perceive objects as belonging to type-specific categories. Through this typification, perceived objects can appear as meaningfully different from each other (*as* cups, *as* books, *as* lamps, etc.). Second, once acquired typification is sedimented and generalised, constituting the background context necessary for our everyday life understanding of the perceived objects. Through this aspect of typification, a perceived object can appear with its determinate, familiar meaning. Third, thanks to the anticipatory aspect of

typification, the typification effective in our everyday life perception can be corrected and revised in light of new experience. Through this typification, a perceived object appears as a particular object that will behave in the way that conforms to its type. Now, the main reason Schwartz and Wiggins explains this phenomenological concept in detail is that they believe the above discussed general features of typification are operative in a psychiatric diagnosis procedure. They argue that it is only after one makes explicit such aspects of typification and takes a critical stance to them one can demystify the mystery of psychiatric diagnosis and further help explain and justify the objective status of psychiatric diagnosis (Schwartz and Wiggins,1987a, p.69). What, then, exactly is this 'mystery'? And how does acknowledging the typication involved in psychiatric diagnosis contribute to achieving the objective status of psychiatric diagnosis?

§2.2. Mystery and Psychiatric Typification

The mystery Schwartz and Wiggins have in mind is the rapidity of psychiatric diagnosis. In line with the findings of the influential study conducted by Kendell in 1975, the researchers argue that psychiatrists often form a definite diagnostic impression of their patient simply upon seeing her (some cases, even prior to an actual interview) and that this first impression remains constant to the final step of diagnostic procedure (Kendell, 1975). Furthermore, Schwartz and Wiggins emphasise the evidence that "psychiatrists use criteria different from those which they believed themselves to be using. And moreover, psychiatrists may not be aware of which items of information are crucial for them in making their diagnoses (Gauron and Dickinson, 1966, p.205)" (Schwartz and Wiggins, 1988, p. 221). In other words, the mystery of psychiatric diagnosis lies in that within a few minutes of interacting with a patient (or even by simply seeing the patient), a.) psychiatrists develop a definite diagnostic impression which tends to become the patient's final diagnosis and yet b.) the psychiatrists do not know which items of information they have used to come to the final diagnosis.

The researchers' proposal for the demystification of psychiatric diagnosis is decidedly simple. It is this: acknowledge that psychiatrists are human. Or, to be precise, accept that clinical perception is just as much preconditioned by typifications as everyday life perception is. Their

demystification process goes as follows. First, the immediate and pre-conceptual aspect of typification enables a psychiatrist to immediately perceive her patient as belonging to a certain classification, without having to be explicitly aware of which items of information she uses in seeing the patient as having a certain mental disorder (Schwartz and Wiggins, 1987a, p.65-68). This accounts for the rapidity of the diagnosis. Second, the psychiatrist's past clinical experience and the typification acquired therein constitute the background context necessary for perceiving a certain behaviour, a speech pattern, or a facial expression exhibited by a patient, as signs and symptoms of a type-specific mental disorder (Schwartz and Wiggins, 1987a, p.65-68). This accounts for the rapid development of *definite* diagnostic impressions. Third, the anticipatory aspect of typification sets up a definite anticipation that the perceived patient will behave in a way that conforms to its type. This anticipation further guides psychiatrists to look for the symptoms and signs typical of the classification (Schwartz and Wiggins, 1987a,p.65-68). This accounts for the confirmation of the first diagnostic impression and its constancy to the final stage of diagnosis.

By highlighting the psychiatric typification effective in a diagnostic procedure, Schwartz and Wiggins do not aim to solely explain the psychiatrist's ability to rapidly diagnose a patient. They further aim to provide some ways to safeguard the objective status of a psychiatric diagnosis. Under the current operational approach of the DSM, the objectivity of diagnosis is said to be achieved if a psychiatrist makes a diagnosis based on the observable symptoms and signs exhibited by a patient. Psychiatrists' clinical intuition and subjective feelings are supposed to be ruled out from a diagnostic procedure. To put it in Dawes' words, for a diagnostic judgement to be objective, "the human judge is eliminated and conclusions rest solely on empirically established relations between data and the condition or event of interest" (Dawes et al., 1989, p. 1688). However, as mentioned above, psychiatrists' intuition and subjective feeling already guide their day-to-day diagnostic procedures. Moreover, from a phenomenological perspective, the subjectivity of psychiatrists does not simply amount to their subjective feeling or fleeting intuition. Instead, construed as a set of typification acquired from years of clinical experience and training, it is the necessary condition for a certain feature of the patient's behavioural and speech components to appear *as* signs and symptoms of a mental disorder. Just as a cup would not appear to me as an object to drink from without my past experiences of direct interaction with cups, an utterance such as, for instance, 'cookies jump dogs dodged then kitchen fell into the door then who is the cook'

and its behavioural expression would not be perceived as the word-salad symptom without an adequate amount of clinical experience and direct interaction with the patient. In other words, psychiatric typification is an indispensable aspect of a psychiatric diagnosis without which no behaviour or speech components of a patient can appear as signs or symptoms of a disorder.

Instead of ignoring such a subjective dimension and the integral role it plays in a diagnostic process, Schwartz and Wiggins propose that clinical practitioners must affirm it in a critical manner to secure the objective status of their diagnosis. Detailing this critical stance, Schwartz and Wiggins write:

> Scientific work requires what Husserl (1970, pp. 120- 129) has called "a critical attitude." By critical attitude Husserl means an attitude toward things and people in which we vigilantly doubt or question the meaning they appear to have [...] In prescientific experience we accept appearances at their face value. In everyday experience no distinction is made between appearance and reality until something proves to be merely an appearance and not a reality (Schwartz and Wiggins, 1988, p.218)

To translate such a stance in the context of psychiatric diagnosis, it amounts to a conscious effort wherein a psychiatrist a.) makes explicit a set of typications operating in their diagnostic procedure and b.) actively seeks for disconfirming evidence that runs counter to the initial definite diagnostic impression so constituted by the typification (Schwartz and Wiggins, 1987a, p.75). For instance, upon a brief encounter with a patient, a psychiatrist may initially have an ineffable feeling that the patient may have schizophrenia[38]. As a result of this typification, the psychiatrist may

[38]This feeling has been coined as "praecox feeling" by Henricus Cornelius Rümke (Rümke and Neelman, 1990). It refers to the peculiar atmospheric feeling a psychiatrist experiences when she encounters a person with schizophrenia, sometimes even before verbally engaging with the patient. Rümke describes praecox feeling as the impossibility to "contact with his personality as a whole." (Rümke and Neelman, 1990, p.336). In a little bit more detail, a patient, he writes, does not "draw in other people" and evades the psychiatrist's empathetic understanding, inducing the praecox feeling (Rümke and Neelman, 1990, p.336). Further detailing this feeling, contemporary researchers, Tudi Gozé and his colleagues, write: "one [psychiatrist] "feels" it in his/her body posture, facial expression, the tone of the voice, motor behaviour, and attitude. Taken individually, the changes are insignificant, but as a whole, they present the patient as "definitely un-understandable." (Gozel et al., 2019, p.966).

expect the patient to exhibit symptoms typical of schizophrenia. If the psychiatrist in question is to take the critical stance, she should not let the initial diagnostic impression guide her diagnostic process but vigilantly put it to question. Instead of asking the questions eliciting the psychosocial or historical information conducive to the diagnosis of schizophrenia, the psychiatrist may, firstly, elucidate how it is that she has developed such a feeling. She may identify the lack of rapport and the loss of mutuality as the basis for such a feeling. After making explicit the typification that has thus far remained tacit, the psychiatrist can then seek for evidence that runs counter to this definite diagnostic impression. By taking such a critical stance, the psychiatric typification which tends to operate in the background and remains implicit in a diagnostic procedure can be falsified, confirmed, or revised in light of an ample amount of empirical evidence. As such Schwartz and Wiggins conclude that : "when the workings of typification in the diagnostic process are elucidated [...] Not only do these mysteries disappear but, moreover, the truly *objective* and *scientific* status of psychiatric diagnoses can be explained and justified" (Schwartz and Wiggins, 1987a, p.69; italics added).

Schwartz and Wiggins further see much value in making full use of psychiatric typification for the classification of mental disorders, and they do so by linking it to the ideal type classificatory approach (originally proposed by Max Weber and later adapted by Karl Jaspers in *General Psychopathology*). In the context of psychiatric *diagnosis*, in line with Weber, Schwartz and Wiggins see the value of ideal type for an idiographic study, or a study designed to understand an individual or a particular group of individuals in its uniqueness. In the context of psychological *research*, following Jaspers' adaptation of ideal type approach in *General Psychopathology*, the authors see the value of ideal type in initially articulating a certain 'law-like' relatedness among various features of a given disorder, and thereby hinting at the value of ideal type in nomological study. In what follows, I explain this ideal type approach in detail in both the context of diagnosis and research. Afterwards, I raise a methodological concern, specifically, with respect to the construction of the ideal type for a research purpose. This will be necessary not only to highlight the relevance of the essential type approach in the ideal type analysis but also chart out a possible way to make those approaches stand in a complementary way.

§2.3. Ideal Type

The ideal type approach proposed by Schwartz, Wiggins and Norko (1987b) owes much of its theoretical justification to the method Max Weber employed in his sociological study. Weber claims that when one considers any object in its immediate concrete situations, be it a physical thing, a person, or a social event, we are faced with an "infinite multiplicity of successive and coexistent emerging and disappearing events" (Weber, 1949, p.72). Accepting this position, Schwartz and Wiggins suggest that one faces a similar problem in the context of psychiatry. They write: "The task of comprehending any individual patient, however, presents an initial problem: the facts pertaining to any person, when considered in their concrete fullness, are virtually infinite" (Schwartz and Wiggins, 1987b, p.281). The researchers take Weber's value-relevant abstract method for resolving such a problem. Weber's method for reducing the complexity of a concrete phenomenon into manageable parts is to posit a pre-established value of a researcher as a guiding principle — according to which researchers select certain features of an object as worthy of an investigation while excluding other features (Weber, 1949, p.78, p.90). In other words, the researcher's value, or what they deem worthy of knowing, initially furnishes the criterion of relevance, and this criterion, in turn, guides researchers to focus only on those features relevant to the research. In the initial stage of inquiry, a researcher is to take those selected features as typical, distinctive, or characteristic of the object thus inquired, in order to clearly draw its conceptual boundary. The type defined through this abstraction is called the ideal type. Weber writes:

> An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more or less present and occasionally absent *concrete individual* phenomena, which are arranged according to those one-sidedly emphasized viewpoints into a unified analytical construct. In its conceptual purity, this mental construct cannot be found empirically anywhere in reality. It is a utopia (Weber, 1949, p.90).

As a mental construct, or a "utopia" (Weber, 1949, p.90), the ideal type depicts the idealised case in which an object it exemplifies has all of its characteristic features. As an ideal, the defining criterion of an ideal type may not be fully present in every instance of the type. However, in the

initial stage of inquiry where one has to clearly define the object under inquiry, one *provisionally* supposes that it does, so that it can *initially orient and guide the research*. As such, the value of an ideal type lies not in its factual accuracy but in its utility. In the context of psychiatry, if the defined ideal type helps a psychiatrist (or a group of psychiatrists working under the same aim of a research program) to arrive at an empirically verifiable diagnostic belief or helps a researcher develop a general hypothesis of a given disorder, it is valuable. Characterising the use of such an ideal type in research and diagnostic context, Fernandez most succinctly writes: "Psychiatrists might rally around a proposed ideal type in order to have a starting point for research -- seeking out, for example, distinct neurobiological substrates or testing treatment response across a population with common psychopathological conditions. In the case of idiographic inquiry [in this context, diagnostic study], by contrast, psychiatrists can employ a shared set of diagnostic categories to initially characterise their patients, while admitting that this is only a starting point for more personalised therapeutic intervention" (Fernandez, 2016, p.46). But, how does one make a type like that?

§2.3.1. Ideal Type and Psychiatric Diagnosis

Schwartz and Wiggins argue for the use of psychiatric typifications in constructing an ideal type (Schwartz and Wiggins, 1987, p.6). They write:

> Psychiatrists who have acquired these skills are able to see patients as displaying certain kinds of mental disorders. On the basis of their preconceptual seeing, psychiatrists are then able to conceptualize these different sorts of disorders. The ideal types that provide the explicit categories of nosology thus presuppose these more fundamental psychiatric skills for identifying mental distress [...] *In defining an ideal type we try to set aside this indistinctness, ambiguity, and extreme variation and imagine a pure case in which the relevant features are distinct, unambiguous, and invariant. Ideal types are thus idealized definitions of typifications.* To some extent at least, ideal types overcome the fuzziness and ambiguity that permeates preconceptual typifications. Although based on typifications, ideal types reshape them by being more specific and definite in meaning (Schwartz and Wiggins, 1987b, p.286-287)

As discussed in the previous section, the typifications that psychiatrists have acquired from years of their clinical experience and training enables them to immediately perceive certain aspects of their patient as more typical clinical features of a specific mental disorder than that of other disorders. In other words, psychiatric typification pre-delineates the basic discrimination among various features of mental disorders necessary for their explicit categorisation. By taking a critical stance towards psychiatric classification, Schwartz and Wiggins argue, one can explicitly articulate the list of the clinical features of a given disorder and enumerate them as a list of defining criterion for its provisional categorisation. This explicitly-defined ideal type, which outlines the typical features of the mental disorder in question, could then be initially used as a shared set of diagnostic categories that inform and guide the initial process of diagnostic investigation.

As the ideal type only depicts the ideal case in which its characteristic features are fully present, an actual instance of the type will lack some of its features or exhibit a feature not specified by the ideal type. As opposed to being a shortfall, Schawrtz and Wiggins argue (1987b), such a deviation is what makes the ideal type approach valuable. It is this deviation that leads to the concrete, personalised understanding of the patient necessary for an effective treatment and a further specification of the ideal type. Let me unpack this claim. For instance, assume a clinical practitioner takes flat affect, perceptual aberration, and delusional ideation as characteristic features of the prodromal stage of schizophrenia. Let us further assume that a patient experiences delusional ideations and perceptual aberrations. However, the patient does not display any lack of emotional expression. Furthermore, the patient exhibits the signs of self-harm not specified by the defined ideal type. Although the patient does not exhibit all the characteristic features of the prodromal stage of schizophrenia, a clinical practitioner may provisionally suppose that the patient is an instance that deviates from the idealised case. Upon this consideration, the clinical practitioner can inquire into the cause of the absence of the characteristic feature and the presence of atypical features. In attempting to understand such a deviation, the clinical practitioner can ask a set of questions guided by the ideal type: Why does she not display any signs of flat affect all the while having all other characteristic features of the prodromal stage of schizophrenia? Why is she exhibiting the signs of self-harm? Answering these questions will require a psychiatrist to have a more accurate and detailed knowledge about her. She would have to determine the severity of self-

harm and ask the patient if the self-harm is, in some way, related to other experiential anomalies she has been having. Through this inquiry, the psychiatrist's general diagnostic intuition of the patient can grow more and more concrete, specific, and personalised. Upon this understanding, the psychiatrist can then tailor an individualised treatment effective for her patient. Furthermore, if the deviation of an actual instance from its ideal type turns out to be a general phenomenon, it would force one to further specify the type by constructing a subtype or reject the type being used and construct an entirely new type.

§2.3.2. Ideal Type and Psychiatric Research

In contrast to Weber's proposal that the ideal type is suitable for studying an individual (or a particular group of individuals) in their uniqueness, following Jaspers' adaptation of ideal type in *General Psychopathology*, Schwartz, Wiggins, and Norko (1995) see its value in research context as well. To be precise, Schwartz et al. see its value in its ability to initially articulate a certain order held among various features of mental disorders. As mentioned above, the current operationally defined categories of mental disorders provide us no information about why it is that the listed clinical features of a given mental illness tend to arise together and in what way those features relate to each other (if they do at all). The ideal type contrasts with the operationally defined categories, the researchers argue, in that it can be used to initially articulate a law-like relatedness among various features of a mental disorder. Accordingly, the researchers suggest that in defining an ideal type, one not simply enumerate the characteristic features of a mental disorder but also "try to 'synthesise' or group these features together into a 'unified thought construct or concept'" (Schwartz et al., 1995, p.426). In an effort to emphasis the value of ideal type as a kind of unified conceptual scheme, the researchers contrast ideal type with 'prototype'[39]. They write:

[39]In a little bit more detail, similar to ideal type, prototype does not stipulate class membership on essential criteria. An individual can have more or less features than the ones listed in the prototype. If an individual has more features, then it is a "better" fit for the category. If it has less, then it is a "worse" fit (Livesley, 1985; Schwartz et al., 1989, p.3). In short, class membership is a matter of degree on the prototypical approach, as it is for the ideal type approach. In contrast to the ideal type approach, however, prototypes are made based on a real life, exemplar case (or the best example of a concept). Hence, their boundary tends to be 'fuzzy' (Schwartz et al., 1989, p.3). Further, at least on Schwartz et al.'s proposal, a prototype only lists out the attributes of a given disorder. It does not provide any conceptual scheme to understand those features in their relationship. However, this construal of prototype has been recently challenged by Parnas

> At least as portrayed so far, prototypes consist of a list of attributes. A list exhibits no conceptual unity; it consists rather of discrete and separate items. Some of the items on the list may appear to resemble one another. But this resemblance is merely apparent because the list leaves them separate and posits no connection among them. A prototype provides, to borrow Jaspers' words, "a disjointed enumeration" of features (Jaspers, 1963, p. 561). For Jaspers, *ideal types unify and relate the attributes of the disorder. An ideal type defines a unified whole of which the various attributes are the parts* (Schwartz et al., 1995, p.426; italics added)

Schwartz and Wiggins further appeal to Jaspers' account of 'hysterical personality' to better elucidate this "unified whole" the ideal type aims to capture. Briefly, Jaspers argues that to understand seemingly multifarious features of hysterical personality, "we have to fall back on one basic trait". This basic trait, according to Jaspers, is the following: "Far from accepting their given dispositions and life opportunities, hysterical personalities crave to appear, both to themselves and others, as more than they are and to experience more than they are ever capable of" (Jaspers, 1963, p. 443; quoted from Schwartz et al., 1995, p.426). Put otherwise, the characteristic features of hysterical personality (or "histrionic personality" in the current DSM-5 guideline), such as a.) "rapidly shifting and shallow expression of emotions", b.) "consistent use of physical appearance to draw attention to oneself", c.) "a style of speech that is excessively impressionistic and lacking in detail", etc (APA, 2013), on Jaspers account, can be understood as derived from or "understandably deduced" (Jaspers, 1963, p.443) from the aforementioned basic trait. To put it exactly in the terms of Schwartz et al.: "the various other traits of hysterical personality, such as those listed in prototypes (Livesley, 1986) or DSM-III-R (American Psychiatric Association, 1987), Jaspers would try to understand as meaningfully derived from this one. And only such an understanding of the connections of meaning among the manifold traits "unifies" them." (Schwartz et al., 1995, p.426)

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and Gallgher (2015). I do not detail their argument in this chapter. For a further discussion, please read: Parnas and Gallagher, 2015, p.75

In other words, in the hands of Schwartz et al., the ideal type approach is supposed to group together or synthesise various features of a given disorder into a unified conceptual whole with which one can understand individual features in their meaningful relationships. To be precise, the individual features of a given disorder are considered as "understandably deduced" (Jaspers, 1963, p.443) or "meaningfully derived" from (Schwartz et al., 1995, p.426) the unified conceptual whole. The researchers further suggest that the relationship initially clarified by the ideal type is then to be tested using a statistical analysis to determine whether the relationship in question is accidental, probable, or universal for the purposes of constructing a nomological account of a given mental disorder. They accordingly conclude that "ideal types furnish the initial conceptual guidelines for the postulation of law-like regularities and the design of experiments to test such postulates" (Schwartz and Wiggins, 1987b, p.286). To schematize the value of ideal type in research context, if the ideal type constructed in the initial stage of research could reasonably articulate that the feature of a given disorder (call it P) is closely related with another features (call it P1,2,3,..), then the P can be initially considered as the target phenomenon. And, if through clinical studies, it is shown that the target phenomenon aggregates into a particular type of disorder, the P can be initially posited as a particular phenotype to isolate its correlating neurobiological state.

§2.4. Ideal Type and Unified Conceptual Whole

So far I have discussed the ideal type approach as proposed by Schwartz, Wiggins and Norko. This approach has gained widespread popularity among contemporary phenomenological psychopathologists, praised as the "seminal" work (Parnas and Gallagher, 2015, p.75). It has been further employed and clarified in the works of various figures (Ghaemi, 2007; Fernandez, 2016, 2019; Ratcliffe, 2015). In the current literature, the ideal type approach has been often contrasted with another ideal type approach [henceforth essential type approach] proposed by Zahavi and Parnas (Broome, 2006; Fernandez, 2016, 2019). The usual point of such a contrast has been that Zahavi and Parnas conflate Weber's ideal types with Husserlian essences and, as such, their approach points to a completely different classificatory approach (Broome, 2006; Fernandez, 2016, 2019). Construing Zahavi's and Parnas' approach as 'monothetic approach', Fernandez writes:

> Monothetic approaches classify phenomena by appealing to a set of essential features that is, those features that must hold for the phenomenon to count as the kind of phenomenon that it is [...] The criteria that define an ideal type consist in only those features that are *typical* or *representative*-- not *essential.* [...] Despite Schwartz and Wiggins' distinction between ideal types and monothetic classifications, the two approaches have still been confused in the phenomenological literature. Parnas and Zahavi, for example, have argued that phenomenological psychopathologists aim to uncover the essential features of a disorder. In at least one case, they align this approach with the ideal types developed by Weber and popularized by Schwartz and Wiggins. They conflate ideal types with essences or sets of essential features claiming that the "ideal type exemplifies the ideal and necessary connections between its composing features" (Parnas and Zahavi, 2002, p.157) (Fernandez, 2016, p.52).

The identified main difference between the ideal type and the essential type is this: the essential type stipulates class membership on the necessary criteria and does not leave a room for deviation, whereas the ideal type doesn't and allows deviations. Accordingly, to the extent that Zahavi and Parnas claim that their approach aligns with the ideal type approach, the conflation charge stands. Although it is true that the essential type approach differs from the ideal type approach with respect to its class membership, this difference should not be read disjunctively. Those approaches should not be construed as "antithetical" to each other (Fernandez, 2016, p.52), for the ideal type approach *requires* the essential type to make the type it aims to construct. Consider the following argument.

As mentioned, one of the core values of the ideal type is that it aims to articulate a law-like relatedness among various features of a given disorder. As Fernandez aptly puts it, unlike the DSM categories, "the ideal type articulates what phenomenologists refer to as "motivational relations" among the various component features of a disorder, examining how one feature might bring about another, or why certain features tend to arise together" (Fernandez, 2016, p.49). And, Schwartz's, Wiggins', and Norko's method for constructing such an ideal type, following Jasper's adaptation,

was by “synthesising” or “grouping together” various features of a mental disorder into an analytic construct. However, it is at least unclear how exactly it is that this grouping together of individual features can give us something like a unified conceptual whole (or in Jaspers’ terms, “basic trait”) from which one can ‘understandably deduce’ or ‘meaningfully derive’ other features of the disorder in question. Let us take an example. Consider the disarticulation of time experience known to be present particular to schizophrenia.

As defined by Stanghellini, the core phenomenon of the disarticulation of time experience is that “patients live the external world as a series of snapshots” (Stanghellini, 2016, p.50). A patient of Bin Kimura describes such an experience as follows: “Even time is also running strangely. It falls apart and no longer progresses. There arise only innumerable separate now, now, now-- quite crazy and without rules or order” (Kimura, 1979, p.18; as quoted in Fuchs, 2013, p.85). The fragmentation of self experience refers to the co-occurring anomalous experience in which a person can no longer experience herself existing as a self-identical, coherent subject. The same patient of Kimura reports: “From moment to moment, various selves arise and disappear entirely at random. There is no connection between my present ego and the one before” (Kimura, 1979, p.18; as quoted in Fuchs, 2013, p.85). If one were to take the ideal type approach, one would have to group together such anomalous temporal and self-experience together to construct their unified conceptual whole. However, unless one *already presupposes* a certain assumption with regards to the relationship between those anomalous experience and posits each experience as the individual relata of such a presupposed relationship, grouping them together will only give us a cluster-like type whose individual member is the disarticulation of time experience and the fragmentation of self-experience. This type will simply tell us that its individual members are present in schizophrenia, not how it is that they arise together, nor in what they are related to each other. In contrast to the ideal type approach, the essential type approach makes full use of the phenomenological account of human experience and existence. To be specific, in its psychopathological analysis, it makes explicit the presupposed assumption between the types of experiences under investigation and aims to clarify their necessary, ideal connection. In what follows, I explain the essential type approach and demonstrate how this approach can complement the ideal type approach. I then argue that this complementarity has to go both ways, that is: the essential type *requires* the ideal type approach so as to resist its reification.

§2.5. Essential Type

If the ideal type approach owes much of its theoretical justification to Weber's value relevant abstract method, the essential type approach appeals to Husserl's phenomenological method, or 'eidetic reduction' (Zahavi and Parnas, 2002, p.156). This method amounts to a conceptual analysis whereby a researcher imagines variations on many aspects of the phenomenon in question so as to reveal those aspects whose alteration leads to a change in the type of phenomenon (Zahavi and Parnas, 2002, p.157; Husserl, 1925/1977, p.53-57). The core value of the essential type approach, however, does not solely lie in its specific methodological procedure but in its theory-laden nature. In constructing a type, the essential type approach makes full use of the phenomenological understanding of human existence and consciousness to identify the structure of a given disorder (Zahavi and Parnas, 2002, p.143).

A short detour is necessary. In Husserl's phenomenology, eidetic reduction is employed to articulate various structural aspects of our consciousness such as temporality, affection, intersubjectivity, intentionality, and embodiment. Relevant for the current purposes of the argument, one of the core claims that Husserl makes regarding such structural aspects of consciousness is that they are closely connected with each other. To put it in Zahavi's and Parnas' words:

> Rather, the phenomenological concept of consciousness implies a meaningful network of interdependent *moments* (i.e., non-independent parts), a network founded on intertwining, motivation and mutual implication, encompassing and framed by an intersubjective matrix (Zahavi and Parnas, 2002, p.157).

In other words, the structural moments of consciousness are connected in a mutually constitutive and implicative manner. Accordingly, a certain alteration in one of those moments is to, in principle, necessarily implicate alterations in other aspects. Applying this understanding in the domain of psychopathology, Sass (2014), has clarified such an implication as

"phenomenological implication" and categorised it into various forms of implicatory relationships[40]. With this in mind, let us here re-consider the disarticulation of time experience. This will show how the essential type approach can complement the ideal type. In full detail, the patient of Bin Kimura reports:

> When I watch television, it is even stranger. Even time is also running strangely. It falls apart and no longer progresses. There arise only innumerable separate now, now, now-- quite crazy and without rules or order. It is the same with myself. From moment to moment, various selves arise and disappear entirely at random. There is no connection between my present ego and the one before. (Kimura, 1978, p.18, as quoted in Fuchs, 2013, p.85).

In constructing a type on the essential type approach, a researcher can make full use of the phenomenological account of the temporal mode of experience, or 'how' one experiences time. Husserl argues that the way we experience time is pre-conditioned by 'temporal synthesis[41]'. Temporal synthesis essentially refers to the automatic, self-intending feature of the present consciousness whereby the present consciousness automatically intends (or retains) its own just-elapsed phase and anticipates (or protends) its yet-to-come phase. Let me unpack this claim first and then go on to articulate its relevance to the ideal type approach.

To take the example of the current perceptual experience, this laptop I have used to write this chapter appears to me as the same laptop that has been existing for some time, that is to say, as an object whose identity extends across time. The same goes for myself. Although I have been

[40] Sass (2014) has categorised such implicatory relationships into two general types: synchronic and diachronic. These two general categories are further specified into three different categories. For synchronic type, there belong constitutive, equiprimordial, and expressive relationships. For diachronic type, there belong primary/basic, consequential, and compensatory relationships. Put it broadly, synchronic relationship concerns the implicatory relationship held between the types of experiences that are co-present (Sass, 2014, p.369). Diachronic relationship concerns with the development of the underlying structure of anomalous experience over time, developing into apparent signs and symptoms (Sass, 2014, p.369). As I do not detail these concepts any further, I do not use these terms in this thesis. However, the relationship I describe between the disarticulation of time experience and the fragmentation of self-experience can be termed as the 'equiprimordial relationship'.

[41] I discuss this concept in full detail in Chapter 4.

hungry, my mood has been fluctuating, and my attention has been disturbed, I still experience myself as the same subject who has been looking at this chapter for some time, that is to say, as an experiential subject whose identity persists across time. The limit condition that has to be the case for such an experience to be possible, according to Husserl, is that a.) our present consciousness has to extend beyond the punctual now point and b.) it has to intend its own temporal phases. To detail, in the present moment where I perceive this laptop, this perceptual consciousness has to retain the just-past phase of the previous perceptual consciousness in the present moment. If not, if the present perceptual experience is not connected to the just-past perceptual experience, this laptop would not appear to me as an object whose identity persists across time, or as the *same* laptop I have been looking at. Further, my present perceptual consciousness has to anticipate or protends the succession of the current now perceptual experience by the new now consciousness. If not, if the present perceptual experience is not connected to the new now perceptual experience, the laptop I perceive in the next now moment would appear to me as an object that has no temporal connection to the laptop that I perceived just before. It will appear to me as a new laptop. In short, the self-intending feature of the present consciousness enables one to experience the now, just-past, yet-to-come consciousness in their coherence, and in so doing, it constitutes the temporal identity of the perceived object as well. Further, since this temporal coherence is constituted nothing but by the present consciousness intending *its own* just-past and yet-to-come phases of consciousness, Husserl argues, one can be immediately experience oneself as the very subject of *one's own experience*, that is to say, the experiential sense that it is obviously me who has been looking at this laptop for some time. Put it otherwise, the temporal unity of an experience and its first-personal givness is constituted by the synthetic, self-intending feature of the present consciousness, or temporal synthesis. (Husserl, 1991, p.361-363; Husserl, 2001b, p.607).

Given that temporal synthesis constitutes the coherent unity of temporal and self experience, its alteration necessarily implicates disturbance in *both* the way one experiences time and one's self in their unity. One can then initially articulate the relationship between the disarticulation of time experience and the fragmentation of self experience in terms of mutual implication. In that, the presence of one of those anomalous experiences necessarily implicates the presence of the other for they are simply two different sides of the same disturbance. Important for our analysis, on the ideal type approach, the identified structural alteration, or disturbed temporal

synthesis, can be, in turn, taken as a unified conceptual whole from which a researcher can "reasonably deduce" the disarticulation of time experience and the fragmentation of self experience and further clarify their relationship as that of mutual implication.

The above is a very brief rundown on how the essential type approach can complement the ideal type. Although I have specifically focused on the temporal mode of experience, researchers may focus on other modes, such as the way one experiences one's own body, one's self, the world, and others. This essential type investigation, with the use of phenomenological concepts, can initially describe and identify the structural alteration involved in the different types of experience. And, on the ideal type approach, the identified alteration can subsequently function as an analytic construct with which a researcher can understand the target features in their conceptual unity and clarify their relationship. If the identified modal alteration and its correlating experience turned out to be present particular to a given disorder via a comparative analysis, it can be initially employed to cleanly circumscribe its boundary. To stay with the above example, if it turns out to be that the time fragmentation experience is present particular to schizophrenia, then the identified modal alterations (i.e., altered temporal synthesis) can be posited as a 'core phenomenon'-- with which one can draw a conceptual boundary of schizophrenia from other types of disorder. If the identified modal alteration is different within the individual members of the same diagnostic category, to be precise, different with respect to its intensity, duration, or kind, this may indicate the presence of heterogeneous conditions lumped under the same category. This finding can help motivate the reclassification of the category in question, and the identified modal alteration can initially provide a conceptual distinction to carry out such a task. In short, the essential type can complement the idea type approach by supplying it with the structural account of a target phenomenon.

As should be emphasised here, to say that the essential type approach complements the ideal type approach is not to say that it will change the kindhood assumption of the ideal type. I am not here proposing a new classificatory scheme. My claim is much more modest. To say that the essential type can complement the ideal type is to simply say that the essential type approach can help construct the type the ideal type approach aims to make. Further, to be clear, the above proposal is not that the essential type approach should subsume or replace the ideal type approach.

Although the essential type can complement the ideal type approach, it will not lead to changing the nature of the ideal type. There still lies a fundamental difference between those approaches. On the essential type approach, the identified structural alteration is taken as a real disturbance or as "trouble générateur" (i.e., core disturbance) that underpins various features of the disorder in question and confers its type (Zahavi and Parnas, 2002,p.157). As Parnas explicitly claims:

> *Here, it is important to emphasize that the core is not merely a construct but possesses phenomenological reality* [...] *It is such structural alterations that transpire phenomenally in the single symptoms, shaping them, keeping them meaningfully interconnected, and founding the specificity of the overall diagnostic Gestalt* (Parnas, 2011, p.1121-1122; italics added)

To put it generally, the essential type approach identifies the structural underpinning of a given disorder and posits various features of the disorder in question as particular manifestations of the identified structure. Construed as the distinctive manifestations of the structural underpinning essential to the type of the disorder in question, the essential type lists a set of features as necessary for class membership. In contrast, on the ideal type approach, the structural alteration initially identified by the essential type will not be posited as a real disturbance but as a heuristic mental construct. Clarifying the reality standing of such a construct, Schwartz, Wiggins, and Norko claim, it "*does not unify the other traits by functioning as some kind of "ultimate cause or "source of them"* and that it "*is not an underlying reality that which produce other traits as its effects*" (Schwartz et al., 1995, p.427; italics added). Accordingly, the ideal type *will not* posit the structural alteration exemplified by the essential type is a real disturbance that underpins and confers the type to the disorder in question. It will be taken as a useful concept. Hence, in contrast to the essential type, the ideal type will not list a set of features of the disorder in question as necessary for class membership on the grounds that those are the particular manifestations of the underlying structural alteration essential to the type of the disorder in question. Instead, the defined ideal type will list a set of features as characteristic to the disorder. Thus, an individual that fails to possess certain individual features or has atypical features will be considered as a less characteristic instance of the predefined type, as a deviation from the perfect, ideal case. In sum, the ideal type complemented by the essential type (for the sake of brevity, 'IcE') remains an ideal type. Not only

is the IcE still an ideal type, it must remain so, for its use, *as an ideal type,* is crucial to resist the reification of the essential type.

§2.5.1. Essential type and Deviation

After explaining the essential type approach, Zahavi and Parnas emphasise that the essential type is a fallible type (Zahavi and Parnas, 2003, p.157): the features the type outlines can later turn out to be contingent or accidental by later phenomenological analyses. This falsification process would necessarily involve a process whereby a researcher has to accommodate everyday life fuzzy cases -- the cases that either lack predefined features or have atypical features not outlined in the type. An inquiry into the presence of the types of experience other than the listed feature would motivate a researcher to revise the claim that the disturbed structural alteration implicates *only* the target features under investigation. In the case of revision, a subtype would have to be defined by revising the implicatory relationship from a necessary one to a contingent one. Nevertheless, as the essential type stipulates a class membership on the necessary criteria, those fuzzy cases will not even be counted as an instance of the essential type in use. Deviating cases that can potentially falsify the essential type will be counted out from the type. Essential type approach accounts for deviations by explaining them away.

In contrast, the IcE can accommodate deviations because it is still a heuristic device. Following this approach, researchers would simply take the identified structural alteration as a useful concept with which one can organise heterogeneous components of target phenomenon in their conceptual unity, and the case that lacks predefined features or has atypical features will be counted as a deviation from the perfect, ideal case. A clinical practitioner can then inquire into such a deviation through a semi-structured interview with the patient in question. By accommodating this deviation, the ideal type analysis can produce concrete findings that suggest the predefined features are neither essential nor necessary but simply contingent or typical to the disorder in question. In light of this finding, the proponents of the essential type can, subsequently revise and specify or reject and reconstruct the type in use. Through such a process of revision and refinement, the essential type may pindown the essential features that are shared among the

concrete individual members of the particular type of disorder. If the essential type can identify such features, it would, in turn, provide clinical practitioners with a clear way of differentiating the disorder in question from other types of disorder. And if the identified features turn out to be a trait-like feature present from the early stage of the disorder, clinical practitioners can aim for an effective early therapeutic intervention. In the context of neurobiological research, those features can be used as a constant phenotypic vulnerability particular to the disorder in question. Researchers can initially use such a constant phenotype to isolate its distinct biomarkers for the neurobiological explanation of the disorder in question. Nevertheless, identifying such features would be a demanding process. At the very least this process would involve, as Zahavi and Parnas claim, the falsification of the initially constructed type and its constant modification in light of new evidence. However, as argued above, the use of the essential type alone can make the type very easily grow reluctant to a revision as it does not allow a deviation. I have accordingly argued that the use of the IcE, as an ideal type that accommodates deviations, is crucial to resist such a reification.

§2.6. Conclusion

In this chapter, I critically discussed two contending phenomenological approaches in studying psychiatric conditions, i.e., the ideal type approach and the essential type approach. In contrast to the contemporary views that construe them as antithetical approaches, I advanced a mutual complementary thesis. That is, each approach needs the other to construct the type it aims to construct. To argue for this thesis, I first raised a general methodological concern with respect to the ideal type approach, that is, 'grouping together' various features of a given mental disorder cannot make the 'unified conceptual whole' the ideal type approach aims to construct. I have argued that the essential type approach can help resolve such a problem by supplying it with the structural account of the disorder in question. After establishing this point, I have argued that complementarity has to go both ways. I suggested that the use of the ideal type complemented by the essential type is crucial to resolve the reification problem inherent to the essential type approach.

To put the proposed mutual complementarity thesis in the terms relevant to the current research, it translates to the following claims. First, the subject matter of current research is not

the concrete totality of the formative stage of schizophrenic delusion nor its essential features. I focus on the aspects of experience that have been deemed characteristic to the formative stage of schizophrenic delusion: self-fragmentation experience and delusional mood experience. Second, the concepts I employ to investigate their structural underpinning are phenomenological concepts that aim to articulate the basic, necessary structure of temporality and mood, i.e., inner time consciousness and affection. Third, the proposed structural underpinning I identify, as shall be articulated and demonstrated in full detail soon (Ch.4,5,6), is an analytic construct that can help one to understand otherwise seemingly disparate features of phenomena in their conceptual unity. The understanding of which may benefit, as detailed in the previous chapter (in §1.2.2.1. and 1.2.2.2), its classificatory and neurobiological study. Having specified the general methodological orientation of the current research, let me now turn my attention to the subject matter of this thesis and the enduring challenge that one faces in carrying out its phenomenological investigation: schizophrenic delusion and its incomprehensibility. The challenge is the following. Schizophrenic delusion is, in principle, incomprehensible, and it indicates the end of a phenomenological inquiry. Given that current research aims to provide a phenomenological account of schizophrenic delusion and that the aforementioned point was rendered by none other than one of the founders of phenomenological psychopathology, namely, Karl Jaspers, this challenge carries some weight. Let me stand up to it.

Ch.3 Primary Delusion and Incomprehensibility Thesis

§3. Introduction

In the previous chapter, I laid out two competing methods employed in contemporary phenomenological psychopathological research: the essential and ideal type approaches. I argued for a mutual complementarity thesis, that both approaches need one another to construct the type they aim to construct. To translate this thesis in the context of current research, it amounts to the claim that the structural underpinning[42] I identify with respect to the formative stage of schizophrenic delusion formation is an analytic construct that enables one to understand its characteristic, typical features in their conceptual unity. Having this general methodological orientation clarified, let me turn my attention to the subject matter of this thesis: schizophrenic delusion. One of the most enduring challenges one faces in providing a phenomenological analysis of schizophrenic delusion is raised by none other than one of the founders of phenomenological psychopathology, namely, Karl Jaspers. The challenge is this: schizophrenic delusion, or in his terms, "primary delusion" is, *in principle*, un-understandable. Primary delusion is a radically alien mental state such that it is recalcitrant to other's empathetic understanding, or "closed to empathy" (Jaspers, 1913/1963, p.578). As such, he claims that "any theoretical formulations of them [primary delusions] only try to make us understand what in its essence cannot be understood" (Jaspers, 1913/1963, p.105). It is not then too surprising Jasper places schizophrenic delusion on the other side of "a gulf which defies description" (Jaspers, 1913/1963, p. 447) which resists any kind of legitimate phenomenological inquiry. Let me term Jaspers' point regarding the un-understandability of schizophrenic delusion as "incomprehensibility thesis".

In this chapter, I critically assess the incomprehensibility thesis in light of the enduring debate concerning the nature of delusion raised in the philosophy of mind and recent phenomenological accounts of empathy. In an anticipatory summary, I reject Jasper's incomprehensibility thesis and provide a nuanced account of understanding that is more conducive to providing a phenomenological account of schizophrenic delusion. I advance my argument in the following order.

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[42] I carry out this task in chapter 4, 5, and 6.

First, I begin by reviewing the recent debates concerning the nature of delusion raised in the field of philosophy of mind; namely, the infamous doxa vs. anti-doxa debate. From this debate, I glean the following two important lessons that phenomenologically oriented research into schizophrenic delusion must appreciate. The first lesson is that delusion resists a simple definition. The second lesson is that phenomenologists should remain suspicious of an approach that defines schizophrenic delusion by presupposing an exclusive disjunction between schizophrenic delusional mental states and other (pathological/non-pathological) mental states. Simply put, phenomenologists should be suspicious of a strand of argument that purports to have identified the essential features of schizophrenic delusions. I then interlace these lessons in the context of phenomenological psychopathology and proceed into presenting Jasper's account of primary delusion. Second, I systematise the argument Jaspers provides for the incomprehensibility thesis into two strands: 1.) closed-to-empathy argument and 2.) psychological irreducibility argument. I critically assess each strand and reject both. I argue that Jaspers raises the requirement for satisfying the understandability inclusion criterion too high such that even most ordinary mental states fail to satisfy such a requirement. The implication of which is that, as shall be demonstrated in detail, if the incomprehensibility thesis is correct we must rule that most mental states are un-understandable and that, therefore, almost everyone is having schizophrenic delusion. Third, after having rejected the incomprehensibility thesis, I venture into the recent phenomenological account of empathetic understanding and provide a more nuanced account of understanding ideal for comprehending the primary delusional experience.

§3.1. Doxa Vs. Anti-doxa Debate

Delusion is a belief, so goes the common understanding and the current DSM-5 psychiatric guideline. The DSM -5 defines delusion as follows: “delusions are fixed beliefs based on incorrect inference about external reality that persist despite the evidence to the contrary; these beliefs are not ordinarily accepted by other members of the person's culture or subculture” (American Psychiatric Association, 2013). Considering delusion as a type of belief does not seem to be too problematic and have some intuitive appeal too. Indeed, what is odd about delusion is that a person

claims that they believe in something that is implausible (or impossible) as representing the actual status of reality. One does not report that one is imagining that one is dead, loved by celebrity or high status figures that they have no connection with, persecuted by certain institutions or a group of people, or had their significant others/close relatives replaced by identical imposters. One reports that one *believes* so, contrary to the counter evidence and with certitude.

The doxastic approach (Doxa: opinion or belief in greek) hones in on this intuitive appeal and argues that delusion is a *belief* (Bayne & Pacherie, 2005; Bortolotti, 2010; 2012; Bayne,2010). Not only does the doxastic approach have intuitive appeal, its proponents argue that it has a number of other advantages. Lopez-Silva (2015) lists out the following three advantages. The first advantage is that the doxastic view can explain one of the epistemic features of delusion, specifically, its high degree of subjective certainty. As per the reasoning of Lopez-Silva goes, a high degree of certitude is characteristic of beliefs. Therefore, if one accepts that delusion is a belief, one can easily explain why it is that an afflicted individual holds their delusion with a great degree of certainty. It is so because delusion is a belief. The second advantage is that if one accepts the view that delusion is a belief, one can easily distinguish delusion from other psychopathological mental states, such as hallucination. This is helpful in making a precise diagnosis necessary for an effective therapeutic treatment (Lopez-Silva, 2015, p.13). Closely related to the second advantage, the third advantage is that if one accepts that delusion is a belief, it helpfully narrows down the scope of psychogenic analysis of delusion to the formation of belief (Lopez-Silva, 2015, p.13). Meaning, in the analysis of delusion formation, psychologists can focus on the mechanisms involved in the production of normal beliefs and identify certain malfunctions or breakdown in such mechanisms to explain the formation of delusion. Although the doxastic view is the most commonly held one among clinical practitioners,[43] and empirical researches based on this view have provided valuable insight regarding the cognitive mechanisms very likely involved in the production of delusion, it is not without its opponents.

Anti-doxa approach is the view that claims that delusion is not a belief (Currie & Jureidini, 2001, Currie & Ravenscroft 2002, Currie, 2000, Hohwy & Rosenborg, 2005). Simply put, their argument usually goes as follows: (1) for a mental state to be counted as a belief it has to be rational

[43] This should not come across as a surprise given that the DSM had this view since its inception.

(2) delusion is irrational (3) therefore, delusion is not a belief. In a little bit more detail, in accordance with the Davidsonian-Denett belief ascription theory, the first general premise of the anti-doxa argument is that all beliefs presuppose a background rationality or rationality constraints. This means that if a mental state violates the rationality constraint, it cannot be counted as a belief. There are three norms that consist of the rationality constraint: (a) responsive to evidence, (b) good-integration with other beliefs of the subject, and (c) action guidance (Lopez-Silva, 2015, p.14). Meaning, if a mental state is a belief, it must be (a) amenable to the relevant evidence, (b) hang together well with other beliefs of the subject, or (c) motivate one to act in accordance with the content of the belief. The second premise of the anti-doxa argument is that delusion violates one or all of those norms of rationality (Berrios, 1998, Currie & Jureidini, 2001, Currie, 2000, and Hohwy & Rosenborg, 2005). Its conclusion being that delusion is irrational, therefore, not a belief. The specific argumentation goes as follows.

Firstly, if a mental state is a belief, it has to be responsive to evidence. As the common understanding and the DSM guidelines go, delusion is not. To take the 'Capgras delusion' as an example, a person believes that one's spouse is replaced by an identical imposter despite the overwhelming counter evidence. Given that a mental state has to be responsive to evidence to be counted as a belief, insofar as delusion is not, it follows that delusion cannot be counted as a belief (Berrios, 1991, p.8)[44]. The second part of the argument concerns integration violation. If a mental state is a belief, it has to be well integrated with other beliefs of the subject. Delusion is not (Currie & Ravenscroft, 2002, p. 176; Currie & Jureidini, 2001, p.161). For instance, a patient considered by Breen et al claims that her husband died four years ago, all the while insisting that he is living in the same hospital with her (Breen et al., 2000, p.91). Gallagher mentions a patient who believes

[44] In a little bit more detail, German Berrios (1991) lists out the following four belief ascription criteria Henry Price (1934) proposed. They are: "a) Entertaining P, together with one or more alternative propositions Q and R; b) Knowing a fact or set of facts (F), which is relevant to P,Q,R; c) Knowing that F makes P more likely than Q or R; d) Assenting to P; which in turn includes (i) the preferring of P to Q and R; (ii) the feeling a certain degree of confidence with regard to P" (Berrios, 1991, p.8). Applying this understanding, Berrios argues that in the case of delusion, an individual does not entertain their delusion with rival proposition Q and R (violation of A). Further, delusional content is simply too bizarre for there to be a relevant fact or a set of facts to revise, maintain, confirm, or falsify the delusion (violation of B). He goes on to argue that even if there is a fact or set of facts relevant for the delusional content, a subject who has delusion assigns higher probability to her delusional claim than other plausible explanations of their delusional experience (violation of D) despite knowing that the delusional claim is less likely than other plausible explanations (violation of C). As such, he concludes that delusion is not a belief.

that the doctors and nurses poison her food but happily eats the food they give her (Gallgher, 2009, p. 259-260). As such, Currie and Jureidini (2001) suggests that delusions "[fail] to be spectacularly integrated with what the subject really does believe" (p.161), concluding that delusion is irrational; therefore, it cannot be counted as a belief. The final part of the argument concerns action guidance violation. If a mental state is a belief, one must act in accordance with the content of the belief. A person who has delusion does not. The well-known self-reports used to justify this point is the following: "I could even say with Jesus Christ: '*My Kingdom is not of this world*,' my so-called delusions are concerned solely with *God and the beyond*, they can therefore never in any way influence my behavior in any worldly matter" (Schreber, 1988, p.301). Eugene Bleueler writes that his patients "rarely follow up the logic to act accordingly, as, for instance, to bark like a dog when they profess to be a dog" (Bleuler, 1916/1924, p. 144) and that "Kings and emperors, popes and redeemers engage, for the most part, in quite banal work [...] None of our generals has ever attempted to act in accordance with his imaginary rank and station" (Bleuler 1911/1950, p. 129).

Rejoinders have been made by the proponents of the doxastic approach. Their rejoinders come in the two strands. The first strand argues that most delusions are belief. Its argument proceeds as follows: (1) accept the norms of rationality so proposed by the advocates of anti-doxastic view, (2) find out as many as delusions that are either (a) responsive to evidence, (b) well integrated with other beliefs, or (c) action guiding, and (3) conclude that most delusion is a belief (Bayne & Pacherie, 2005; Bortolotti, 2012, Bayne, 2012). To counter the responsiveness to evidence violation objection[45], Bortolotti (2009) and Lopez-Silva (2015) appeal to empirical findings concerning the recent success of the CBT therapy. The findings of which suggest that some individuals do change the certitude of their delusion in light of counter evidence and plausible explanation *if* these epistemic resources are collaboratively explored and presented in a non-confrontational manner (Wykes et al., 2008; Cf. Durham et al., 2005 and Horsfall et al., 2010). In response to the integration violation objection[46], Bortolotti and Lopez-Silva argue that in many cases they are well integrated with other beliefs. For instance, a patient considered by Ames (1984) believed that he had two heads. He believed that the second head belongs to the gynaecologist of

[45] That is, delusion does not respond to counter evidence; therefore, delusion is not a belief.
[46] That is, delusion does not hang together well with other beliefs of the subject; therefore, delusion is not a belief.

his wife. In an attempt to decapitate his second head, he attacked it with an axe. In this case, as concisely put by Lopez-Silva, he was able to integrate the belief that <I have two heads> with the belief that <I can use an axe> and the belief that <an axe is an object usable for decapitation> (Lopez-Silva, 2015, p.16). As such, he wielded an axe to decapitate his second head. In response to the action guidance violation[47], Bortoloti claim that, in many cases, delusions motivate one to act in accordance with its content. When the aforementioned patient considered by Ames (1984) failed to decapitate his second head with an axe, he used a gun to shoot it off, leading to his hospitalisation. A patient of Blout (1986) who believed that his stepfather was replaced by an identical imposter (for his case, an identical robot) decapitated him to find the batteries in his head. People who believe that one is dead often do not eat or bathe oneself and remain mute (Young and Leafhead 1996). People who have persecutory delusions often change their name, cut all connection with their close relatives and friends and disappear. In short, the gist of the first strand of the doxastic rejoinder is that a careful consideration of actual instances of delusion reveals that a non-trivial amount of delusions do behave like a belief.

The second strand of the doxasticism rejoinder directly challenges the idealised status of the rationality contrast on belief ascription— the understanding that the violation of the norms of rationality warrants the inhibition of a belief ascription to a given mental state. The gist of this argument is that if delusion is not a belief because it is not: (a) responsive to evidence, (b) well integrated with other beliefs of the subject, or (c) action guiding, then some ordinary beliefs (hypocritical beliefs[48] and superstitious beliefs[49]) and all non-pathological irrational beliefs (such as sexist, racist, and extreme religious and political beliefs[50]) must be also counted out from the belief category, for the reason that they violate those norms. However, they are still counted as a belief — albeit irrational and prejudiced but still as a belief. Meaning, the mere violation of the norms of rationality, i.e., irrationality, is not a good enough marker to differentiate delusion from non-delusional beliefs. As such, Bortolotti argues that "what makes delusions pathological is not their being irrational because the irrationality of delusion is not different *in kind* from the irrationality of everyday beliefs." (Bortolotti, 2010 p.260) In other words, delusion and non-

[47] That is, delusions do not guide one's action; therefore, delusion is not a belief.
[48] They violate the action guidance norm.
[49] They violate the integration norm.
[50] These beliefs violate the responsiveness to the evidence norm.

delusional irrational beliefs both violate the norms of rationality, therefore, their irrationality is not different in kind. Instead, delusions, Brotolotti argues, differ from non-delusional irrational beliefs in that delusion tends to violate *more* norms of rationality and the degree to which it violates such norms tends to be *more* severe than non-delusional irrational beliefs. In short, delusion and irrational everyday life are on a continuum.

§3.2. What's It To Phenomenology?: Two Lessons To be Learned

There are two lessons to be learned from the above debate. Firstly, delusion is a *heterogeneous* class of phenomenon whose formal definition cannot be solely based on its epistemic features (i.e., incorrigibility, imperviousness, and logical incoherence). As seen above, some delusions may be responsive to evidence, but some may not. In the right context, some individuals may be responsive to counter evidence and entertain more plausible alternatives, leading to a temporary suspension of their judgement. In a different context, those same individuals may turn completely indifferent to the alternative epistemic resources. Some delusions may hang together well with the other beliefs of the subject. As such, if prompted in the right manner, some individuals may articulate the exact steps they took to come to believe their delusion. In a different context, the same individuals who were once explicating their delusion in a rational manner may repeatedly assert that their delusion is true. Some delusions may be action guiding, some may not. Even in the case whereby some delusions are action guiding, the individuals who are acting in accordance with their delusion may be fully well aware of the irrationality of their behaviour and yet still carry out their action. Given this heterogeneous and conflicting nature of delusions, providing a satisfactory one-fit-for-all formal definition based on their epistemic features alone seems implausible.

The second lesson, closely related to the first, is that an approach that proposes a criterion or a set of criteria whose violation implicates, in essence, a discontinuity between a pathological delusional state and a non-pathological state, and thereby attempts to define delusion as a state that is qualitatively different from other non-pathological mental states may not be ideal for understanding the complex nature of delusion. In attempting to cleanly circumscribe non-

pathological states from delusional states, such an approach may set the requirement for meeting an inclusion criterion too high, such that even most ordinary normal states fail to meet such a requirement. To take the anti-doxa argument as an example, the rationality constraint on belief ascription (recall their first premise) is idealised to the point that even some ordinary beliefs and all non-pathological irrational beliefs fail to satisfy such constraints. As seen above, if the belief-ascription theory stands, then it should be ruled that, as opposed to its intended conclusion, there is no difference between delusion and non-pathological irrational beliefs and some ordinary. All of them are irrational; therefore, all of them are not beliefs. Meaning, the difference and the continuity between delusional state and non-pathological states, whose analysis may be crucial for understanding the nature of delusion, are decimated from the beginning by the idealised inclusion criterion, for this case, by the rationality constraint. Hence, an analysis, especially a phenomenological one that zeros in on the lived experience of delusion to do justice to its complex nature, must be cautious of a strand of argument that aims to define delusion by presupposing an exclusive disjunction between schizophrenic delusion and other mental states.

In the context of phenomenological psychopathology, the first lesson is no news. Delusion is a heterogeneous phenomenon, and providing its formal definition based solely on its epistemic features is implausible. This point has been already rendered by Jaspers at the beginning of the 20th century in *General Psychopathology* (1913/1963). Jaspers lists out the following three epistemic features that "vaguely applies to all false judgments [including overvalued ideas, delusion-like ideas, and pathological delusions]" (Jaspers, 1913/ 1963 163, p. p.95). They are: (1) extraordinary conviction, (2) imperviousness to other experiences and to compelling counter-argument and (3) impossible content (Jaspers, 1913/1963, p.95-96). However, he goes on to claim that:

> To say simply that a delusion is a mistaken idea which is firmly held by the patient and which cannot be corrected gives only a superficial and incorrect answer to the problem. *Definition will not dispose of the matter. Delusion is a primary phenomenon and the first thing we have to do is to get it into a proper focus*. If we want to get behind these mere external characteristics of delusion [extraordinary conviction, imperviousness, and impossible content]into the psychological nature

> of delusion, we must distinguish the original experience from the *judgement based* on it, i.e, the delusional content as presented data from the fixed judgement which is then merely reproduced, disputed, dissimulated as occasion demands (Jaspers, 1913/1963, p.93; italics added)

The essential feature that differentiates schizophrenia delusion from other false judgments is not epistemic, such as having extraordinary conviction, imperviousness, or impossible content. Instead, he argues that it lies in the *original experience* from which schizophrenic delusions arise. Jaspers continues that such an original experience is, in principle, "un-understandable" (Jaspers, 1913/1963, p.95) and proposes the concept of understandability as an essential criterion for distinguishing ordinary overvalued ideas and non-schizophrenic delusion (i.e., delusion-like ideas) from schizophrenic delusion (Jaspers, 1913/1963, p.95-96). In other words, the 'understandability' functions as an inclusion criterion for ordinary beliefs (overvalued ideas) and non-schizophrenic delusions (delusion-like ideas) whose fulfilment implies their instance and, violation, that of schizophrenic delusion. In the following, I first present Jaspers' account of primary delusion with respect to his concept of understandability. I systematise the argument he provides for the un-understandability in schizophrenic delusion into two strands: 1) a closed-to-empathy argument and 2) a psychological irreducibility argument. I critically assess each strand and reject both. In line with the above discussed second lesson, I argue that Jaspers raises the requirement for satisfying the understandability criterion too high, such that even most ordinary mental states fail to satisfy such a requirement. The implication being that, if the incomprehensibility thesis stands, then we must rule that most mental states are un-understandable and that, therefore, almost everyone is having schizophrenic delusion. After having rejected his incomprehensibility thesis, I venture into the recent phenomenological account of empathy and provide a more nuanced account of understanding that is more fruitful in clarifying the complex nature of schizophrenic delusion.

§3.3. The Incomprehensibility Thesis

As briefly mentioned above, Jaspers argues that to grasp the psychological nature of schizophrenic delusion we must shift our attention from its epistemic features to its lived

experience, or the "original experience" or "primary experience traceable to illness" (Jaspers, 1913/1963, p.96). Jaspers terms such original experience or primary experience as "primary delusion". Jaspers specifically characterises primary delusion as the experience of direct delusional meaning. He writes:

> Perceptions are never mechanical responses to sense stimuli; there is always at the same time a perception of meaning. A house is there for people to inhabit. If I see a knife, I see directly, immediately a tool for cutting. Now, the primary delusional experience is analogous to this seeing of meanings [...] *The direct or immediate, intrusive knowledge of meaning is the primary delusional experience.* These are not considered interpretations but direct experiences of meaning while perception itself remains normal and unchanged. All primary delusional experience is an experience of meanings (Jaspers, 1913/1963, p.99)

He proceeds to provide two of his patients' experience as an example for the primary delusional experience. One day, one of his patients was looking at people in the streets. Among them were Spanish and Turkish soldiers. They were in their uniforms, and then "a man in a brown jacket is seen a few steps away" from the soldiers (Jaspers, 1913/1963, p.99). The patient then immediately perceived the man in the brown jacket as "the dead Archduke who has resurrected", and two other people in raincoats as "Schiller and Goethe" (Jaspers, 1913/1963, p.99). Recounting on the day he ran away from his family, another patient writes: "as I went across the square the clock was suddenly upside down; it had stopped upside down". From this he thought that "the world was going to end; on the last day everything stops" (Jaspers, 1913/1963,p.101). Jaspers goes on to claim that in the case of schizophrenia "the awareness of meaning undergoes a radical transformation" (Jaspers, 1913/163,p. 101), and that such a radical transformation results in the unmediated, direct experience of delusional meaning or primary delusion. Jaspers argues that such an alteration is a radically alien state such that it can be "in principle never seen by us [he means himself and other clinical practitioners] which we always have to circumscribe negatively and indirectly by saying what they are not." He continues: "Such elements which are in principle psychologically inaccessible we term ''*statically ununderstandable"* or closed to empathy" (Jaspers, 1913/1963, p.578, emphasis original). In other words, primary delusional experience is

a radically alien mental state to the others who do not have schizophrenia such that is recalcitrant to other's empathy and therefore un-understandable.

Based on the understanding that primary delusion is un-understandable, Jaspers distinguishes two classes of delusion: one is primary delusion particular to schizophrenia and the other is delusion-like ideas. As opposed to primary delusion, which is a direct, immediate perception of meaning, delusion-like ideas are essentially a judgement mediated by thoughts. They are "developed, evolved, based on thinking and working through" of certain life events and motivated by exaggerated and/or diminished emotional states." He writes: "Delusions-like ideas emerge *understandably* from preceding affects, from shattering, mortifying, guilt-provoking or other experiences, from false-perception or from the experience of derealisation in states of altered consciousness, etc." (Jaspers, 1913/1963, p.96). Meaning, delusion-like ideas are understandable when considered with respect to the person's preceding mental states (Jaspers, 1913/1963, p.589). Whereas the primary delusion cannot be understood in such a manner. It has no traceable preceding mental state from which the primary delusion arises. In his terms, primary delusion is "psychologically irreducible". Accordingly, he writes: "Pathological life of the first kind [delusion-like ideas] we can comprehend as an exaggeration or diminution of known phenomena" (Jaspers, 1913/1963, p.577). Whereas, "Pathological psychic life of the second kind [primary delusion] we cannot adequately comprehend in this way. Instead we find changes for which we have no empathy" (Jaspers, 1913/1963, p. 577). In short, Jasper's incomprehensibility thesis amounts to the following. Primary delusion is, in principle, un-understandable because it is closed to empathy and psychologically irreducible, and this un-understandability is the essential feature that characterises primary delusion.

§3.3.1. The Incomprehensibility Thesis: Closed to Empathy Argument

Prior to systematising Jasper's argument, let me present his account of empathy in detail as it is this account that underlies his incomprehensibility thesis. In a clinical context, Jaspers argues that empathy plays the same role sense perception plays in empirical science. If, in the context of empirical science, the sense perception of a researcher directly (or indirectly via

experimental tools) presents the object of their empirical inquiry (be it a piece of rock, larva, chemical bonds between molecules, a DNA strand in some cell, etc.), in the context of psychiatry, it is through the empathy of a clinical practitioner the object of its study becomes perceptible, that is, the subjective experience of a given mental disorder. In Jaspers' terms: "Subjective symptoms cannot be perceived by the sense organs but have to be grasped by transferring oneself, so to say, into the other individual's psyche, that is by empathy" (Jaspers, 1912/1968, p.314). Further detailing this empathy, he continues: "They [subjective symptoms] can only become an inner reality for the observer by his participating in the other person's experiences ('through co-*experience*), not by any intellectual effort" (Jaspers, 1912/1968, p. 314). Through this non-intellectual form of empathy, Jaspers argues that the clinical practitioner "can share the patient's experience [...] and gain an essentially personal, indefinable and direct understanding" (Jaspers, 1912/1968, p.316)[51]. Although, as Sass has noted (2013), it is true that Jaspers tends to describe empathy as a "merger or total identification with the other" (Sass, 2013, p.98) and thus on his account empathy does seem to involve a "rather mysterious or even magical" (Sass, 2013, p.98) self-transposal process whereby a clinical practitioner becomes one with the patient, a plausible interpretation can be drawn. We can attribute the kind of identification with the other supposedly achieved by empathy not to the empathised subject herself but to the mental state the empathised subject is having. Meaning, to empathise with the other is not to actually become the empathised subject. It is to have the same mental state the empathised subject is having. We have everything we need. Let us systematise his argument. Call it "close to empathy argument". p= premise; c= conclusion.

> (P1) Empathy is the precondition for understanding the other subject's mental state
>
> (P2) To empathise with the other subject is to have the same mental state the other subject has, such that if an empathising subject, S, does not have the same

[51] Empathy "leads directly into the psychic connection' and involves seeing 'how certain thoughts rise from moods, wishes or fears'" (Jaspers, 1912/1968, p.304). Through empathy, "we sink ourselves into the psychic situation and understand genetically by empathy how one psychic event emerges from another" (Jaspers, 1912/1968, p.301).

mental state, M, of an empathised subject, S*, S does not empathise with the M.

(P3) Primary delusion is a mental state, M*, particular to schizophrenia, such that if a person has M*, then one has schizophrenia

(P4) The other is a subject who does not have schizophrenia

(C1) Therefore, the other does not have M* (P3,P4, MT)

(C2) Therefore, the other does not empathise with M* (P2,C1, MP)

(C3) Therefore, the other cannot understand M* (P1, C2, MT)

(C4) Therefore, the other cannot understand primary delusion (P3,C3, Sub.)

In short, primary delusion is un-understandable to others (Jaspers himself and others who do not have schizophrenia) because the others do not have the same primary delusional experience. Given (1) one empathises with the mental state of other subject if the empathising subject has the same mental state the other is having and that (2) it is through such an empathy the empathising subject can understand the empathised subject's mental state, it follows that primary delusion is un-understandable to the others who do not have such an experience. However, here we must question if having the same mental state with the other can be counted as an instance of empathy. Consider the following.

A friend tells me that he lost his pet. He starts to cry. I stop writing this chapter. I turn my face toward him. I am emotionally (and quite immediately) pulled towards his grieving body, such that what has so far preoccupied my mind, i.e., finishing this chapter, disappears from my daily concern. Instead, I start to concern myself with ways to comfort him. I think to myself if I should hug him or pat his shoulders. I think to myself if I am required to say something or not, and if so, what it is that I should say to comfort him. However, in this state, I am not having the same mental state he is having. I am not crying. I never had a pet so I do not even know what it is like to be distressed over the loss of a pet. Even if I lost a pet and thus know what it is like to experience the distress he is having now, I cannot experience his distress as he does. I am not him. Due to this asymmetry in the first-personal giveness of an experience (that is, his experience is given to him

as his and not to me as mine and vice versa), I can be aware of his distress as his and not as mine, i.e., as the other's experience. For the sake of argument, however, let us assume that I am having the same mental state he is having. I am crying just exactly as he is crying. I am distressed just exactly as he is distressed. I experience his distress just exactly as he experiences it. Meaning, his experience is given to me as my own distress just exactly as it is given to himself as his own distress. My experience and his experience are then qualitatively identical. As Jaspers would have put it, I rendered the inner psyche of my friend as *my* inner reality. Only then, on Jasper's account, can I say that I have the same mental state with him and thus empathise with it, and only then can I say that I understand his mental state. However, this is not empathy. I am not empathising at all. In this case, there is no object of empathy to begin with: the other's experience. His distress *is* my distress. I am understanding my own mental state. This is a self-understanding[52].

To cut to the core of the problem in Jaspers' account of empathy, the otherness in other's experience is not something to be negated for empathy to occur. One can empathise with the other's mental state not *despite of* its otherness via the special act of self-transposal process whereby "the observer" (the empathising subject) "transfers oneself into" the empathised subject's "inner psyche" and renders such an inner psyche as the "inner reality" *of* the empathising subject. Instead, one can empathise with the other's mental state *in virtue of* its otherness. I can see that he is in distress, and I am moved towards him precisely because his mental state is given to him as his, not mine. In a little bit more detail, I turn my face towards my *friend* and try to recall what *he* likes to eat and think to myself what I should say/do to comfort *him because* I immediately perceive *his distress.* Without this otherness, I would not be able to be aware of his distress as *his*, so I would not be able to empathise with *his* mental state. Hence, to demand the total identification or the merger of identity between the mental state of an empathising subject and that of an empathised subject as the condition of empathy is to demand conceptual impossibility. It is to negate the very object of empathy without which no empathy as such can be talked of in any rational sense: the otherness in other's experience.

[52]On this point, Zahavi writes: "It is precisely because of this difference, precisely because of this asymmetry, that we can claim that the minds we experience are *other* minds. As Husserl points out, had I had the same access to the consciousness of the other as I have to my own, the other would cease being an other and would instead become a part of myself." (Zahavi, 2012, p.549; italics added).

To preempt some confusion, this is not to say that empathy has nothing to do with 'understanding and sharing the feeling of another', as its everyday life meaning has it[53]. I can grieve with my friend, and this can be achieved through empathy. However, the point here is that this grieving together or emotional sharing needs not be the necessary condition of empathy, such that if the empthaiser does not share the emotional state the empathisee has, then the empathiser does not empathise with the empathisee. How so? Because I can empathise with my friend and understand that he is in distress, without having to experience his grief myself. Without having to live through his grief as he does, I can understand and see that he is grieving. His grieving body immediately shows that he is in distress, and I immediately turn toward him and understand and see it as such. This does not take the sharing of his grief. Against the backdrop of this empathetic seeing whereby his grief is given to me as the object of my experience, I may begin to set out ways to establish an affective bond with him or grieve together with him. Say, by attentively listening to his recount on how much the pet meant to him, I may recall the similar experience whereby I lost someone. In doing so, I may come to understand that the loss of a pet can mean something very much like losing a person. In that, it is not that he lost the possession of an animal but lost all possibilities to be together with his pet. With it I can better comprehend the object of my experience, i.e., his grief, and experience a feeling of oneness with him, as subjects who share the predicament underpinned by the loss. In such a way, I may feel a sense of oneness with him. However, to stay with the dialectic of the argument, this is not to say that I have done so by rendering his "inner psyche" into "my own reality", or by rendering his grief as my own. The

[53]Svenaeus argues that empathy construed simply as the other mind directed intentionality should be distinguished from everyday life understanding of empathy (Svenaeus, 2016). The former does not posit emotional sharing as the success condition for empathy. The latter does. Appealing to Edith Stein's account of empathy, he argues that empathy, in its proper sense, should incorporate not only the other mind directed intentionality (which offers us the minimal understanding of the other mind) but also a sense of investigative attitude, wherein an empathizer attempts to "investigate the experiences of other person in their own right" (Svenaeus, 2016, p.237). Relevant to the current discussion, he does not consider emotional sharing as the necessary condition of empathy; the investigative attitude is (Svenaeus, 2016, p.237). Further, as he highlights, the feeling of togetherness or emotional sharing achieved by empathy is to "follow in the footsteps of the other, *not in the sense of merging with her,* but in the sense of appreciating what it *could be* like for her, and also what aspects of her experience I am not likely to get any hold of because of the limitations inherent in human imagination and the differences between us that cannot be dissolved" (Svenaeus, 2016, p.173; italics added). In other words, the feeling of togetherness involved with 'empathy' (in its proper sense) presupposes the appreciation of the otherness in other's experience, not its negation. The footnoted paragraph details how this feeling of togetherness might be achieved. For a further discussion, please read: Svenaeus, 2016.

affective bond between *him* and *I*, first and foremost, presuppose that I empathetically perceive and understand his grief *as* his. Had I not encountered his grief as his, I wouldn't have been pulled towards *his* grieving body, nor would I have attentively listened to *his* recounts of his pet, nor would I have bothered to recall *my* experience to better understand *his* grief. Therefore, I wouldn't have been able to sense the feeling of oneness with him. In other words, even in the case where I sense the feeling of oneness with my friend, the basic asymmetry in the first-personal giveness of the empathised (my friend's) and the empathising experience (mine) has to be maintained. The intrinsic otherness in the empathised experience is not something to be negated for a certain mental state to count as empathy. Instead, this otherness and its careful appreciation (e.g., paying attentive regards to the person, listening carefully, not making the whole situation about oneself (empthaiser), etc.) is conducive towards a more fine grained, detailed empathetic understanding of the other.

As Jaspers notes, the primary delusional experience is an alien experience to the people who do not have schizophrenia. I do not dispute this claim. However, it is one thing to make such a claim and it is another thing to argue that the others, in principle, cannot empathise with primary delusion and therefore cannot understand it on the grounds that the others do not have the same primary delusional experience. As objected above, to demand such a condition for empathy-- the merger of identity between my mental state and the other's mental state, such that to have the same mental state with the other is to render the inner psyche of the other as *my own* inner reality, is to demand conceptual impossibility. It is to negate the object of empathy. Even if we accept his account of empathy despite the raised objection, the situation will be no better. Given 1.) to empathise with the other's mental state is to have the same mental state the other has and 2.) empathy is the precondition of understanding the other's mental state, we must rule that not only primary delusional experience but also other's everyday life mental states are closed to empathy. Insofar as I am not the other, I cannot experience the mental state of the other in the same way the other does. I am not the other. Therefore, given 1.), we must rule that all others' mental states are closed empathy. Therefore, given 2.), we must rule that all others' mental states are un-understandable. Given that the psychological nature of primary delusion, or its essential characteristic that differentiates itself from other mental states, is its un-understandability, we must further rule that all others' mental states are primary delusions. Given primary delusion is

particular to schizophrenia, then we are liable to conclude that all others are having schizophrenia. Meaning, even if Jasper's account of empathy stands, it not only leads to the conclusion that primary delusion is un-understandable but also that others' ordinary everyday life mental states are un-understandable, leading to the conclusion that every other person one encounters has schizophrenia.

§3.3.2. The Incomprehensibility Thesis: Psychological Irreducibility Argument

Another interpretation of Jaspers' account of empathy can be drawn in support of Jaspers' thesis. As discussed above, Jaspers argues that delusion-like ideas are understandable because they are psychologically reducible, or because clinical practitioners can find the preceding mental state from which the delusion-like ideas arise. In a little bit more detail, delusion-like ideas arise "comprehensively from other psychic events and which can be traced back psychologically to certain affects, drives, desires and fears" (Jaspers, 1913/1963, p. 106–107), whereas primary delusion appears out of nowhere. Given that empathy is the precondition of understanding the other's mental state, it follows that, by transitivity, a given mental state is open to empathy (and therefore understandable) if it can be reducible into the preceding mental state. The implication being that: insofar as a mental state is psychologically irreducible, it is closed to empathy and therefore un-understandable. Given the essential feature of primary delusion is its un-understandability, such a mental state is an instance of primary delusion. Let us systematise this strand of argument. Call it a "psychological irreducibility argument". P=premise; C= conclusion

(P1) If a mental state is open to empathy, it is understandable
(P2) A mental state at tn is open to empathy if the other can find a mental state M at tn-1 from which M at tn arises
(P3) Primary delusion is a mental state M* at t1 such that the other cannot find the M at tn1-1 from which M* arises
(C1) therefore, primary delusion is not open to empathy (P2,P3, MP)
(C2) therefore, primary delusion is un-understandable (C1, P2, MP)

Given to empathise with the mental state of the other is to understand it with respect to its preceding mental state, on this account of empathy, it follows that primary delusion, which seems to appear out of nowhere, is un-understandable. However, here, we must question if Jaspers does not raise the bar of empathy too high. Consider the following argument.

I walk towards a bus stop. As I get closer, I see a woman sitting on the ground. She is clutching her face and sobbing. I do not know who she is. I did not even know this particular person existed in the world prior to this encounter. Despite not knowing who she is and why she is crying, I stop looking at my phone and take my headphones off and turn my face towards her. I think to myself if I should ask her if everything is okay or just leave her be. In short, I see and understand that she is in distress, and I am moved towards her. However, on Jasper's account of empathy, this is no empathy. I did not find the preceding mental state from which her current mental state emerges. Therefore, I must rule that her mental state is closed to empathy and thus un-understandable. Given, again, the essential feature that differentiates primary delusion from other mental states is its un-understandability, I must rule that she is having primary delusion. Given that primary delusion is particular to schizophrenia, I must also rule that she has schizophrenia.

One may object that it stands to reason that in the suggested case, I can go ask her why she is crying, and that, *in principle*, I can find the preceding mental state from which her current state arises. As Jaspers wrote: "[…] in an individual of a wish, a feeling, a judgement of something, an attitude, or alternatively when he acts, we usually 'understand' the content in terms of his previous traits, his basic nature and the presenting situation" (Jaspers, 1913/1963, p.376) Whereas, for primary delusion, *in principle*, such a way of understanding is impossible. Call it an "in-principle" objection.

Let us go back to the above example. She may have been assaulted by a man who looks just like me on her way to the bus stop. So, she may run away or shut down completely or scream at me if I approach her. In this case, (if Jasper's account is correct), I would not be able to empathise with her mental state. I cannot find the preceding mental state from which her current mental state arises if she runs away, screams at me, or remains silent. She must talk to me, at least. Therefore,

in this case, I would not be able to understand her mental state. Or, she may, on a happenstance, have a close friend whose look, tone of voice, mannerism etc., are similar to mine. So, she may feel comfortable talking about her situation with me. I linger around for a while and wait until she is ready to talk to me. She tells me that she lost her mother. In this case, (if Jaspers' account of empathy is correct), I would be able to empathise with (and thereby understand) her mental state. I found the preceding mental state from which her crying arises: the grief over the loss of her mother. *Therefore*, it is not the case that some mental state (i.e., a mental state that is not, at the very least, primary delusion) is, in principle, understandable. *Sometimes it is, sometimes it is not.* To be specific, the possibility of understanding the other's mental state hinges not on its type but on the interpersonal interaction which is always open to variance. In the suggested case, the way I approach her, the way I sound and look to her, the way I open up a conversation, etc., which may or may not have been conducive to start a conversation with her *and* always could have been otherwise, underpins the possibility of understanding her mental state.

The same goes for the primary delusional experience. Assume a person no longer perceives the flickering of a lightbulb in her room as an indication that its fuse is about to run out. She perceives it to mean that it is a sign sent by her deceased friend, warning her that the intelligence service is back on its surveillance and that she should be on guard. If she refuses to discuss this experience with others and repeatedly asserts nothing but that her delusional experience is true, her primary delusion will be un-understandable to others. For the reason that, given Jaspers' account of empathy is true, in this case, the others *cannot* find the preceding mental state from which her primary delusion arises. If she discusses her delusional experience with the other in an attempt to make them better understand her situation but the other rules out the possibility of such an experience being understandable in any sense and therefore refuses to listen to her, her primary delusional experience will be un-understandable to others. For the reason that, given Jaspers' account of empathy is true, in this case, the other *does not* find the preceding mental state from which primary delusion arises. If the other is open to the possibility that primary delusion is understandable but she refuses to discuss her delusional experience any further than that her delusional experience is true, her primary delusion will be un-understandable to others. For the reason that, given Jaspers' account of empathy is true, in this case, the others *cannot* find the preceding mental state from which primary delusion arises. If the other is not open to the

possibility of understanding her delusional experience and she refuses to discuss her experience, her primary delusion will remain un-understandable to others. For the reason that, given Jaspers' account of empathy is true, in this case, the other *does not and cannot* find the preceding mental state from which primary delusion arises. In all of these cases, even if Jaspers' account of empathy is true, primary delusion will be un-understandable not because it is *io epso* primary delusion. It is so because the interpersonal interaction between her and the other is broken down by her failure to invite and accept the other's attempt to understand her experience and/or the other's refusal to understand her experience from the beginning. Insofar as 1) primary delusion is a mental state a subject has and 2) it is its understandability that is at question, the understandability of primary delusion depends on the interpersonal interaction between the subject who has primary delusion and the other who assesses its understandability, which is always open to variance. Therefore, it is not the case that primary delusion is, in principle, un-understandable

To cut to the core of the issue in the in-principle objection, Jasper attributes the "un-understandability" to a mental state as its intrinsic feature and defines such a mental state as primary delusion. However, for the sake of making a point, we have to remind ourselves that a mental state does not come with the name tag that goes "un-understandable-mental-state", while others come with "understandable-mental-state". When it is the understandability of a mental state that is at question, we must be aware that (1) there is always a particular other (e.g., friend, therapists, psychiatrists, etc.) who assess the understandability of a mental state and a particular subject whose mental state is being assessed in a particular social context and that (2) it is through the interpersonal interaction between those two particular subjects (which is always open to break down and always can be otherwise) the particular other can assess and judge if a given mental state is understandable or not. Meaning, 'un-understandability' is not a feature instinct to a mental state. Attributed to a mental state, "understandability" is a variable interpersonal kind. With this point in mind, let me return to the initial objection I raised.

Recall: on Jaspers' account of empathy, to empathise with the other's mental state is to understand it in relation to a preceding mental state from which it emerges. Primary delusion appears out of nowhere. Therefore, the other cannot find the preceding mental state from which primary delusion emerges. Therefore, the other cannot empathise with primary delusion and

cannot understand it. Simply put, primary delusion is psychologically irreducible and therefore un-understandable. If I am correct in suggesting that the understandability (or un-understandability) is not a feature intrinsic to a mental state, it follows that neither primary delusion nor ordinary mental states are intrinsically understandable or un-understandable. To put it otherwise, the understandability of a given mental state does not hinge on whether it is a primary-delusion type or not-primary-delusion type. Instead, it hinges on whether or not *the particular other existing in a particular social context can find* the preceding mental state from which the current empathised mental state emerges. Therefore, if the particular other (be this friend, therapist or psychiatrist, etc.) cannot find the preceding mental state from which the current empathised mental state comes about (be this primary delusion or other ordinary mental states, e.g., grief, sorrow, happiness, anger, joy, etc.[54]) the particular other must rule that such a mental state is un-understandable and therefore an instance of primary delusion. Given primary delusion is particular to schizophrenia, the particular other must rule that everyone, who cannot explain how it is that their current mental state has emerged from their preceding mental state to the particular other who assesses its understandability, has schizophrenia.

§3.3.3. This is (possibly) The Only Way Out: Let Us Not be So Literal About Jaspers' Incomprehensibility Thesis

Let me summarise. Jaspers argues that primary delusion is un-understandable because it is closed to empathy and psychologically irreducible. His account of empathy underlies his rationale. It is as follows: 1.) To empathise with the other's mental state is to have the same mental state the other is having and 2.) To empathise with the other's mental state is to understand it with respect to its preceding mental state. The first is the general premise for the closed-to-empathy argument. Empathy is the precondition of understanding the other's mental state. Others cannot have the same primary delusion the people with schizophrenia have. Therefore, others cannot understand primary delusion. The second is the general premise for the psychological irreducibility argument. Empathy is the precondition of understanding other's mental state. Others cannot find the

[54]Given the understandability of a mental state depends on the interpersonal interaction between the empathiser and the empathised subject, not on its type.

preceding mental state from which primary delusion emerges. Therefore, others cannot understand primary delusion. In short, Jaspers' account of empathy necessitates the conclusion that primary delusion is un-understandable. However, I have shown that, *even if* Jaspers' account of empathy is true, it leads to the conclusion that not only primary delusion but also other's everyday life mental state is un-understandable. This is because, I argued, in an attempt to cleanly separate off primary delusion from other pathological (delusion-like ideas) and ordinary mental states, Jaspers raises the bar of empathy too high. Such that not only does primary delusion (easily) fail to satisfy such a requirement but so do all (or most) ordinary mental states, leading to the conclusion that everyone (or almost everyone) one encounters has schizophrenia.

However, Jaspers' incomprehensibility thesis is not without its value. Primary delusion is indeed odd and alien to the others who do not have schizophrenia. Further, a person who has schizophrenia is well aware that their experience is unique and different from others' experience. Hence, a clinician who attempts to do away with such uniqueness and alien-ness by the use of the analogy of their own experience or by appealing to whatever psychological models she deemed fit may seem as though she is missing the point and stepping the boundary. As such, in a clinical context, the failure to acknowledge the alien-ness and the uniqueness of schizophrenic experience may endanger the relationship between a patient and a clinician. Along this line, Stanghellini (2013) argues that Jasper's incomprehensibility thesis can be taken as a useful, *ethical* precept for clinicians to follow. He writes:

> A better way to see Jaspers' incomprehensibility as a clinically useful concept is to link it with ethics. In this light, it sets the agenda for a kind of clinical care based on *the practice of approximation*. This applies to understanding schizophrenic existence, as well as to human existence as a whole. Crucial to this practice is the clinician's attitude to the inevitable failure of grasping the totality of his patient's existence; and to the failure of reducing the otherness of the other to the same, that is, understanding the other by analogy to myself. The other is not like me; rather he calls *me* into question (Stanghellini, 2013, p.180; emphasis added).

The incomprehensibility thesis, Stanghellini seems to argue, amounts to the claim that there is always an aspect of the other's experience that evades a clinician's complete empathetic understanding in virtue of the other's experience being just that, other's experience. In light of this awareness, clinicians must remain open to the possibility that, simply put, their understanding of the patient can be wrong. In concrete terms, the kind of therapeutic strategy and the type of medications they prescribe and the diagnosis they make should not be considered as an absolute one that cannot be revised once it is enshrined in the medical records section of their patient's profile. Instead, it should be considered an amenable one that can be, in principle, maintained, falsified, and corrected by further interaction with the patient.

Although I agree with Stanghellini's interpretation, accepting it would come into direct conflict with Jasper's account of empathy. Specifically, the one that claims that to empathise with the other is to render the inner psyche of the other as the inner reality of the empathising subject. Yet, as shown above, accepting this claim leads to the absurd conclusion that every other person one encounters has schizophrenia. Further, as Stanghellini argues, taking Jaspers' incomprehensibility thesis as an absolute methodological principle that establishes "the boundaries of what can be grasped and made sense of in another persons' existence" (Stanghellini, 2013,p.181), may come at the cost of missing the bigger picture. That is, the other cannot be grasped in their totality and thus clinicians must remain humble about the interpretation and the judgement they make of the other's experience. Let us not miss this bigger picture. So, let us reject Jasper's account of empathy that underlies the use of his thesis as a methodological principle and replaces it with a better account of empathy. To be specific, the account of empathy that appreciates the otherness in others' experience and, in doing so, in virtue of such an appreciation, enables one to understand the kind of primary delusional experience. What is this empathy? Radical empathy.

§3.4. Radical Empathy and the Otherness

As proposed originally by Matthew Ratcliffe (2012), radical empathy is a distinctive kind of attitude one takes towards the other's experience for its comprehension. This attitude, or as he calls it, "phenomenological stance" essentially amounts to appreciating two different aspects of the otherness in the empathised subject's experience. First is the otherness concerning the

ownership of the empathised experience, or, as discussed above, the asymmetry in the first-personal giveness of an experience between an empathising subject's experience and the empathised subject's experience. The appreciation of this otherness roughly translates to that having the same experience the empathised subject is having is not the condition of empathy, instead, this otherness is the precondition of empathy. To go back to the above example, when I empathise with my friend's grief over the loss of his pet, I do not experience his grief as my own grief. Yet I *can* still empathise with his grief and see that he is clearly upset. To better understand his emotional state, I might recall the past experience where I lost a close friend and re-live the grief I experienced. To put it in terms of the enduring psychological theory of empathy, I "simulate" my friend's mental state (grief) by employing cognitive resources available to me in my mind (Davies and Stone, 1995, Goldman, 2006, p. 4-10). Although this way of empathising may enhance my understanding of the friend's current emotional state, it does not do so by replicating the same copy of his experience in my mind. When I simulate my friend's grief, I am not experiencing his grief. I am (re) experiencing *my own grief* and then attributing a similar mental state to him. Meaning, even in the case in which an empathising subject deploys cognitive resources to simulate the more-or-less similar empathised experience in her mind, the basic asymmetry in the first-personal givenness between the empathised other's experience and the empathising subject's experience is maintained. And it should be so, for without such an asymmetry, to be precise, for if the grief my friend has over the loss of his pet is not given to him as his but to me as mine, then the simulation I construct, no matter how fine grained it is, will be conducive to self-understanding, not to empathetic understanding of my friend. As such, Ratcliffe writes: "in the absence of that attitude [taking other's experience as such, as *other's*], simulation would not amount to empathy, as the experience would not be other directed" (Ratcliffe, 2012,p. 475).

However, appreciating that the empathised experience first-personally manifests to the empathised subject and not to the empathising subject does not make radical empathy as a distinctive type of empathy. In everyday life basic empathy, we *already* take it as such. When I empathise with my friend, I take it for granted that obviously it is him who is grieving not me. As such, I see that he (not me) is clearly upset and try to come up with some way to comfort him (not

me). The appreciation of the second aspect of otherness in other's experience is what makes radical empathy distinctive and "radical". What is this otherness?

Second otherness concerns the structure of the empathised experience. The appreciation of this otherness amounts to that the way the empathised subject experiences the world can be different from the empathising subject. The reason radical empathy bears the term "radical" and Ratcliffe calls it a "phenomenological stance" is because, much the similar way Husserl's phenomenological method of epoché suspends an implicit, natural (or naive) belief in the mind-independent existence of the world to get a clearer view of the object of phenomenological investigation, radical empathy suspends a certain naivety that is always at work in everydaylife empathy. What exactly is this naivety? What is its suspension for? Let us go back to the example.

When I empathise with my friend who lost his pet-- very simply put-- much is taken for granted by both of us. I take it for granted that it is him who is grieving not me, and so does he. As such, if I ask him "Is it me who is grieving or you?", he will be baffled. I take it for granted that he exists in the world, so does he. As such, if I ask him, amid his distress, "Do you exist?", he will be baffled. I take it for granted that he will not disappear into thin air in the next moment but will be there as he has been, so does he. As such, if I ask him, when he starts to cry, "Are you going to disappear in the very next moment?", he will be baffled. I take it for granted that he has a similar grasp of the social norm as I do, so does he. As such, if I ask him "Do you not think that crying in a public place is weird?", he will be baffled and most likely fire back with "Do you genuinely think that I do not know that?". I take it for granted that he is sad when he talks to me about how much the pet meant to him in a shaking voice, so does he. He takes it for granted that although I may not fully understand the relationship he had with his pet, I will, at the very least, see that he is sad. As such, if I ask him, after listening to him, "Are you sad?", he will be baffled and, most likely, leave the conversation at this point.

In technical terms, the questions that I raised are the ones regarding the first-personal giveness of experience, the sense of reality, temporality, (co-)inhabitation of the social world, and basic empathy. In everyday life interaction with the world, these aspects of experience are taken for granted. We rarely question them because they are too plainly obvious: Obviously, he is the

one who is grieving, not me. Obviously, he exists. Obviously, he is not going to disappear into thin air in the succeeding moment. Obviously, he is sad, etc. Not only do we rarely question such aspects of our experience but also naively assume that the other person we encounter experiences the world in much the same way we do. In the above example, the bafflement arises precisely because my friend presumptively assumes, without a doubt, that I experience the world in much the same way he does. It is such a naivety—or the taken for granted implicit belief that the empathised subject experiences the self, other, time, space, object, and event in the same way the empathising subject does[55]—radical empathy aims to put it out of action. In Ratcliffe's terms, "Radical empathy, I propose, is a way of engaging with others' experience that involves suspending the usual assumption that both parties share the same modal space[56]" (Ratcliffe, 2012, p.483). Why does it do so?

To render the seemingly un-understandable experience associated with a given psychiatric disorder, which immediately strikes one's ears as odd or causes bafflement on the side of empathising the subject, intelligible. If one can accept that the way the other (empathised subject) experiences the world can be different from that of the empathising subject, the empathising subject, at the very least, cannot rule that the empathised experience is closed to empathy because it is radically different from her own experience. The appreciation of this difference *is* the starting point of radical empathy. Against the backdrop of such an appreciation, a seemingly nonsensical, too-alien-to-empathise experience can then be made amenable to an empathic understanding by identifying its altered structural underpinnings. Claims such as "Is it me who is grieving or you?" can be understood as genuinely reflecting the altered aspect of experience people take for granted

[55]Schutz terms such a taken for granted other belief as "a general thesis of the other-self. This thesis denotes the fundamental conviction that the other exists, endures, and consciously undergoes subjective experience much the same way the empathising subject does" (Schutz, 1967, p.145-146)

[56] Although Stanghellini does not make an explicit reference to radical empathy, he summarises the importance of appreciating the otherness in the empathised experience as follows: "The lifeworld inhabited by the other person is not like my own. The supposition that the other person lives in a world like my own - that he experiences time, space, his own body, others, the materiality of objects, etc. just like I do - is often the source of serious misunderstanding. In order to empathise, I must acknowledge the radical difference that separates me from the way of being in the world that characterises the other. Any forgetting of this difference, paradigmatically between my own world and that of a schizophrenic patient (but I would say, also, mutatis mutandis between my own and an adolescent's or an old man's world), will be an obstacle to empathic understanding." (Stanghellini, 2013, p. 169)

and do not heed any attention in their daily life,that is, in the first-personal givenness of experience. Claims such as "I was simply sectioned again, detached from my real self, observing what was being done to me in a third-person perspective" (Kean 2009, p.1034) can be understood as genuinely reflecting the altered state of the pre-reflective basic self-experience-- and not simply dismissed, for her case, by her psychiatrist with "You certainly communicate your distress clearly" (Kean, 2009,p.1034). Claims such as "One's center gives way. The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal" (Saks, 2003, p.13) can then be understood as genuinely reflecting the disturbed structure of basic temporal-self experience and further postulated as the core disturbance that transpires through her symptoms-- and not simply discounted as a mere talk of insanity. The gist of radical empathy is the following. In order to understand psychopathological phenomena, the empathising subject has to suspend the belief in the uniformity of the structure of experience. Why? *To hold back* the empathising subject from immediately ruling a given anomalous experience as un-understandable on the grounds that it is too radically different from her own experience. So that the alienness and radical difference present in psychopathological phenomena can be brought into a proper focus— as the legitimate object of phenomenological investigation wherein the alienness and difference of a given experience can be made intelligible with respect to its structural underpinnings.

§3.4.1. Beginning

What is immediately striking about Ratcliffe's project of empathy is that in the face of the otherness present in psychopathological phenomena, it runs into the complete opposite direction that Jaspers took. On Jaspers' account, the otherness in a psychopathological phenomenon, specifically, the radical alienness of primary delusion, indicates the end of phenomenological inquiry. To recall, on Jasper's account, primary delusion is, in principle, un-understandable. Therefore, it defies any legitimate phenomenological investigations. It is the end of phenomenological investigation. Whereas, on Ratcliffe's account, the alienness of psychopathological phenomenon indicates only the beginning of a phenomenological inquiry. As should be expected by now, this difference originates from two different accounts of empathy. Jaspers construes empathy as a self-transposal process whereby the empathising subject comes to

have the same experience the empathised subject is having. Empathy is to achieve the feeling of oneness with the other. Therefore, primary delusion, which seems too alien for an empathising subject to feel the oneness with, is closed to empathy and therefore un-understandable. Whereas on Ratcliffe's account of empathy, empathy is intrinsically other mind directed. On his account of empathy, the fact that an empathising subject cannot have the same psychopathological phenomenon, or, for our case, primary delusion, as the empathised subject has does not imply that the empathising subject cannot empathise with primary delusion. Instead, it is thanks to that the empathising subject cannot have the same empathised primary delusional experience as the empathised subject does, the primary delusion can be given to the empathising subject as the very object of empathy, as the other's experience. As shown above, by effectuating the suspension in the belief in the uniformity of the structure of experience, radical empathy aims to further render the radical alienness and the difference present in primary delusion, as the legitimate object of the phenomenological inquiry. The inquiry, to be exact, in which an empathising subject begins to examine the underlying structure of primary delusion and understands its aliens and difference with respect to the identified structure— and thereby supplying concrete content to the phenomenological understanding of primary delusion.

So, does primary delusion indicate the end of phenomenological inquiry? Short answer: No. Accepting that it does entails an endorsement to Jaspers' account of empathy. As argued above (in §3.2.1 and §3.2.2.), Jaspers' account of empathy not only necessitates that primary delusion is un-understandable but also that almost all or all others' mental states are un-understandable, leading to the conclusion that almost all or all others one encounter has schizophrenia. As further explained in the above (in §3.2.3.), accepting his account of empathy comes into direct conflict with the ethical version of the incomprehensibility thesis. Let us then do not accept the claim that primary delusion indicates the end of phenomenological inquiry. Its acceptance will not only commit us to the absurd conclusion that almost everyone or all one encounters has schizophrenia but also come at the cost of missing the bigger picture the incomprehensibility thesis aims to sketch out. Let us thus replace Jaspers' account of empathy with radical empathy in support of the ethical version of the incomprehensibility thesis. This means the following. An empathising subject must be aware that one cannot grasp the totality of the empathised subject's experience in virtue of the empathised experience belonging to the other. Applied in the domain of clinical psychiatry, this

means that a clinician must resist "body of didactic principles purporting to be definitive and complete" (Jaspers, 2003, p.12) and must remain open to the possibility of their understanding of their patient (be this motivated and guided by neurobiological hypothesis, psychoanalytic theory, phenomenological hypothesis or outright prejudices) amenable to falsification, revision, and correction by further interaction with the patient-- and thereby leading to a more concrete and personalised understanding of the patient[57]. Applied in the context of phenomenological psychopathology, the acceptance of the ethical version of incomprehensibility thesis roughly amounts to the following. No matter how well a given psychopathological phenomenon seems to be made intelligible by identifying its correlating structure and no matter how closely such an understanding seems to get at the core gestalten alteration that transpires through a given phenomenon, one must be aware that there will be some aspect of the investigated phenomenon that goes beyond the scope of so proposed phenomenological understanding. Claiming that a phenomenological account grasps the essence of schizophrenia once and for all would be to disregard the otherness in schizophrenic experience. The otherness[58] of which is the source of constant falsification, correction, and revision of a given phenomenological understanding. Disregarding such an otherness would amount to dogmatism or, in Jaspers' terms, would be "the most devastating threat to the truth" (Jaspers, 2003, 70). In the succeeding chapters (Chapter 4, 5, and 6), I provide a phenomenological account of primary delusion, focusing specifically on its temporal and affective dimensions. The objects of my inquiry are as follows: self-fragmentation experience and delusional mood experience. As with traditional and contemporary phenomenologists working in the field of psychopathology, I appeal to Husserl's phenomenology to chart out their structure so as to render them amenable to comprehension. The conclusion is the following. The functional disturbance in temporal synthesis and that of the affective dimension of experience underpins, respectively, the self-fragmentation experience and the delusional mood experience. Do I intend to claim that my account grasps the totality of such phenomena? No, I argue that it is somewhere along the right lines, but it is not quite there and should never be: it can be falsified and corrected, and must be so.

[57] In Jaspers' terms, "all practice on the basis of knowledge must rely on the unseen encompassing: medical treatment must rely on un-understood life" (Jaspers, 1971, p.24).

[58] To be exact, the aspect of the investigated phenomenon that goes over the scope of the logical construction of its structure.

§3.5. Conclusion

In this chapter, I critically assessed Jaspers' incomprehensibility thesis in light of the enduring debate concerning the nature of delusion (doxa vs. anti-doxa debate) raised in the philosophy of mind and the recent phenomenological account of empathy. I systematised Jaspers' thesis into two strands of arguments and rejected both. After having done so, I replaced his account of empathy-- which underlies his incomprehensibility thesis-- with that of radical empathy in support of the ethical version of the incomprehensibility thesis. This was to open up the possibility to provide a phenomenological understanding of primary delusion. However, there remains another challenge. The challenge is that primary delusion is intimately related with an equally odd experience, termed as 'the loss of cogito' by Jaspers, or 'self-fragmentation experience' by contemporary researchers. In the following chapter, I zero in on such an experience and chart out a possible way to understand it. Let me now kick it up a notch and fill in the specific content of such a phenomenological understanding.

Ch.4 Schizophrenia, Temporality, and Affection[59]

§4.Introduction

In the previous chapter, I addressed one of the enduring challenges in providing a phenomenological account of primary delusion, that is, primary delusion is incomprehensible. I argued that Jaspers' incomprehensibility thesis -- if taken as an a priori methodological principle for differentiating which mental state is understandable and which is not-- leads to the conclusion that almost all or all people one encounters has schizophrenia. This is because, in an attempt to cleanly circumscribe primary delusion, Jaspers raises the bar of empathetic understanding way too high, such that not only does primary delusion (easily) fail to satisfy the postulated requirement but so does almost all or all mental states of others. I then replaced Jaspers' account of empathy with radical empathy in support of the contemporary view that takes Jasper' incomprehensibility thesis as an ethical precept. Taken in such a manner, the incomprehensibility thesis amounts to that the radical otherness one finds in primary delusion indicates not the end but only the beginning of its phenomenological inquiry. The inquiry in which a researcher, I have argued, firstly, clarifies the altered structure of primary delusion to render it understandable and, secondly, refines, develops, or rejects the proposed structural account with respect to the lived experience of primary delusion. Nevertheless, there remains another challenge.

The challenge is this: primary delusion is intimately related with another kind of experience that is equally difficult to understand or, in Jaspers words, "elementary experiences [that are] entirely inaccessible to us", namely, the loss of cogito experience (Jaspers, 1913/1963, p.580). Jaspers characterises such an experience as the loss of the basic sense of existing as the self-identical subject of one's own experience across time[60] (Jaspers, 1913/1963, p.578-580).

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[59] This chapter is published in *Phenomenology and the Cognitive Sciences*. It is reproduced with permission from Springer Nature. Please refer to the published article for its citation: Sul, JR. (2022). Schizophrenia, Temporality, and Affection. *Phenom Cogn Sci* 21 (4), 927–947, DOI: https://doi.org/10.1007/s11097-021-09757-8.

[60] Jaspers argues that this basic sense of self usually "accompanies all perceptions, ideas and thought" and further describes such a sense as "*this particular aspect of "being mine"* of having an "I" quality, of

Emphasising the presence of such a radical self-disturbance, he argues that the persisting sense of miness of an experience, which "emanates from our actual, momentary self", is altogether lost or severely attenuated in the case of schizophrenia (Jaspers, 1913/1963, p.578). This self disturbance is not only documented by Jaspers but also by his predecessors and contemporary researchers. Consider the following self-reports that have been deemed as its prototypical instance:

> But explaining what I've come to call 'disorganization' is a different challenge altogether. Consciousness gradually loses its coherence. One's center gives way. The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal (...) No core holds things together, providing the lenses through which to see the world, to make judgements and comprehend risk. Random moments of time follow one another. No organising principle takes successive moments in time and puts them together in a coherent way from which senses can be made (Saks, 2007, p.13).

Questions ensue. What exactly is this "me" that loses its coherence? How does it lose its coherence? Is the loss of the coherence in this "me" related to primary delusion? Or is it an isolated phenomenon? This kind of questions have occupied the minds of phenomenological psychopathologists since the days of Karl Jaspers. As such, the loss of cogito experience, or to put it more loosely, self fragmentation experience, has taken the centre stage of phenomenological investigation[61] (Minkowski, 1922, 1933, Fuchs, 2003, 2007, 2013, Fuchs and Dupen 2017,

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"personally belonging", of it [the psychic event] being one's own doing" (Jaspers, 1913/1963, p.121). It is this sense of self that Jaspers argues to be lost in the instance of primary delusion and deems it incomprehensible. Eugene Minkowski (1923,1933) provides a detailed description of schizophrenic anomalous temporal experience. He documents that a person with schizophrenia experiences time as an *immobile now moment* that no longer progresses towards the future (Minkowski, 1933, p.294). With this loss of the temporal progression, he suggests that a person with schizophrenia can no longer experience time in its coherent unity but as "isolated fragments" moments (Minkowski, 1923, p.132).

[61]Although Paul Eugune Bleuer (1911) -- the predecessor of Minkowski and Binswagner-- does not specifically analyse schizophrenic anomalous temporal experience as such, he argues that the essential feature of schizophrenia is the breakdown or "splitting" in the seamless integration of experiences and thoughts, whose development leads to the crystallisation of its psychotic symptoms (Moskowitz and Hein, 2011, p.473). One of the common threads that runs through the traditional psychopathological analyses is that schizophrenia involves a certain disruption in one's consciousness that disintegrates the usual unity and coherence of one's experience.

Gallagher 2005, Vogley and Kupke, 2007, Stanghellini, 2013, Stanghellini et al., 2015, Sass and Pienkos, 2013).

In contemporary phenomenological psychopathological research, such anomalous self-experience has been termed as "time fragmentation experience", further specified into the disarticulation of time experience and the fragmentation of self experience (Fuchs and Dupen, 2017, Stanghellini et al., 2015). Following the tradition of their predecessors, contemporary phenomenological psychopathologists have aimed to clarify the nature of time fragmentation experience and its role in precipitating the psychotic symptoms of schizophrenia, such as delusions and thought insertions. Most notably, Thomas Fuchs (2007, 2013, 2017) and Giovanni Stanghellini and his colleagues (2015) have provided one of the most systematic accounts of time fragmentation experience. Employing Husserl's account of inner time consciousness, both authors have argued that schizophrenia involves the "fragmentation" or "disintegration" (Fuchs, 2013) or "breakdown" (Stanghellini, 2016), or "collapse" (Sass and Peinkos, 2016) in the tripartite structure of inner time consciousness-- the structure of which, as shall be explained in detail soon, normally establishes the unity and coherence of temporal and self experience. Paying particular attention to self-disturbance involved in time fragmentation experience, Louis A. Sass and Elizabeth Peinkos have proposed that in the case whereby the structure of inner time consciousness is fundamentally disturbed, the fragmented temporal experience and its content (be it a thought, a sensation, or a bodily movement) can be no longer experienced as one's own, leading to the delusional ideation that external sources control or influence their mind, bodily movements, and sensations.

In this chapter, I hope to further the development of such a phenomenological inquiry by highlighting a much neglected aspect of schizophrenic temporal experience in contemporary research, that is, its non-emotional affective characteristic. To be clear, by such a characteristic, I specifically mean the kind of an experience wherein an afflicted individual experiences a strong and pervasive *attraction* or *pull* coming from the temporal modes of experience. I do not mean the often discussed emotional state, such as guilt, regrets, or shame, one has about a particular past experience. This non-emotional affective characteristic of temporal experience has been

described by people with schizophrenia as follows[62]: “something of the past had renturend, so to speak *toward* me” (Minkowski, 1933/1970, p.287), “I could *be sucked up* into the past or that the past would *overcome me* and flow over me” (Minkowski, 1933/1970, p.287), or “It goes back into the past [...] “the past arose before me in a *particularly vehement way*, but not the way I usually see it” (Minkowski, 1933/1970, p.287). In contemporary phenomenological research, such an affectively prominent temporal experience has been often broadly described as ““the already-happened” *prevails*”” and ““the about-to-happen” *prevails*”” (Stanghellini et al., 2015, p.50; italics added), or as a change in the “relative *weighting* of past, present and future” (Sass and Pienkos,2013, p.10; italics original). In this chapter, I argue that this affectively prominent temporal experience is not yet another notable experiential characteristic but indicative of the core disturbance that underpins the schizophrenic temporal mode of experience. This analysis will be necessary to further illuminate the nature of the “delusional mood” that has been known to precipitate primary delusion, which will be the object of investigation for the next chapter (Ch.5 Delusional Mood and Affection). I advance my argument in the following manner.

First, I begin by presenting one of the major conceptual tools thus far employed by phenomenologists, psychologists, and psychiatrists to understand schizophrenic temporal experience since the days of Eugene Minkowski (1933) and Ludwig Binswagner (1943), namely, Husserl’s account of inner time consciousness. Second, I detail the contemporary phenomenological accounts according to which the structural disturbance in the inner time consciousness underpins schizophrenia temporal experience. Afterwards, I reject them. In an anticipatory summary, its rationale is the following. The structure of inner time consciousness

[62] Fuchs construes affection as the "basic energetic momentum of mental life which can be expressed by concepts such as drive, striving, urge [...] and termed it as "conation" (Fuchs, 2013,p.77). Conation, he suggests, is the "root of spontaneity, affective directedness, attention and the pursuit of a goal, which are characteristics of living beings generally" (Fuchs, 2013,p.77). Although I am sympathetic towards Fuchs’ rendering of affection as conation and appreciate its value especially in the analysis of affective disorder (e.g., depression, major depressive disorder, bipolar disorder, etc.), I do not use this concept in this chapter. Affection construed as conation or a kind of a motivational state (e.g., "drive, striving, urge") cannot adequately accommodate the basic affective characteristic of schizophrenic temporal experience, i.e., the intense attraction, or literally, a "pull" a person with schizophrenia experiences with regards to one's temporal experience. This experience goes over the scope of drive, striving, or urge. This may be the reason that schizophrenic temporal experience has been thus far explained as the manifestation of disturbed "cognitive protential-retentional structure" (Fuchs, 2013, p.77; also Stanghellini et al., 2015 and Sass and Pienkos, 2013), while its basic affective characteristic has remained largely overlooked.

constitutes the temporal unity of an experience *and*, in so doing, in that very moment of constitution, its first-personal givenness as well. Put it otherwise, it is the condition of possibility or the very dimension of subjectivity without which no experience can first-personally manifest across time. Therefore, the "breakdown", "total collapse", or "fundamental disintegration" does not only imply anomalous temporal experience. It also implies the impossibility in having anomalous temporal *experience* as such. Third, I appeal to the much neglected aspect of inner time consciousness, i.e., its *affective* dimension, and establish a conceptual distinction between temporal modification and affective modification. This is to chart out an alternative way to provide a phenomenological account of schizophrenic temporal experience while appreciating the basic experiential fact that such an experience is possible. Fourth, I propose a provisional account that details the structure of schizophrenia temporal experience with respect to its affective dimension. The central claim of the account I provide is the following. The structure of inner time consciousness, or the synthetic self-intending feature of the present consciousness, remains operative-- and thereby enabling the first-personal givenness of anomalous temporal experience. In contemporary terms, the structural integrity of the inner time consciousness remains intact. In the case of schizophrenia, I argue, however, the structure of time consciousness no longer modulates the affective intensity of temporal experience. I term this malfunction as the "affective modification dysfunction" and employ it as a core concept[63] with which I organise and synthesise heterogeneous components of schizophrenic anomalous temporal experience in their conceptual unity. For the sake of clear description, I organise schizophrenic temporal experience into the following four categories: 1.) Time Stop 2.) Ante-festum 3.) Dejavu/vecu and 4.) Time fragmentation. I then identify the particular underlying affective modification dysfunction for the

[63]As discussed in detail in Chapter 1, a psychopathological concept can be designed for two distinctive purposes. First, it can be constructed for nosographic purposes. A concept designed for this purpose details either formal or highly characteristic features of psychopathological phenomena. It operates as a general category with which one can determine whether or not a given experience can be counted as its particular instance. Concepts of this kind play an essential role in a diagnostic procedure. Second, a concept can be designed for articulating the meaning-structure of a psychopathological phenomenon. In this usage, a designed concept aims to organise and synthesise different types of experience into a meaningful whole so as to lay bare a certain regularity, pattern, or relationships held among them. Concepts of this kind have been termed as "pathological organizer" (Monti and Stanghellini, 1996, p.201-202) or "*trouble générateur*" (Minkowski, 1933/1970, p. 276). In this chapter, by "core concept" I mean the concept of this kind and use it as such. Meaning, I employ "affective modification dysfunction" as a scheme of comprehension to organise and synthesise seemingly disparate components of schizophrenic temporal experience into a unified, meaningful whole.

individual members of each category and demonstrate how such a dysfunction can underpin schizophrenic temporal mode of experience. I conclude by demonstrating how approaching schizophrenic anomalous temporal experience from its affective dimension can further help us luminate the nature of the pre-psychotic phase known to precipitate primary delusion, which will be the object of investigation in the next chapter, i.e., delusional mood.

§4.1. Husserl on Time

Despite its notorious difficulty, Husserl's account of temporality has been constantly employed in the psychopathological analysis of schizophrenia experience. This is partly due to Husserl's systematic description of the structure of temporal experience (or what he calls 'inner time consciousness') and its categorisation into three distinctive concepts (namely, primal impression, retention, and protention) have proven useful for understanding the fragmentation experience present in schizophrenia. In what follows, I first provide Husserl's account of time consciousness in detail. The following presentation may seem pedantic to phenomenologically oriented readers and, for non-phenomenologically oriented readers, too technical. However, a careful presentation of Husserl's understanding will be necessary not only for presenting the prevailing structural accounts of schizophrenia in their conceptual intricacy and, further, identifying their problem and providing a resolution to it. In anticipatory summary, the take home lesson of this section is simply this: the structure of inner time consciousness constitutes the temporal unity of an experience and, in so doing, its first-personal givenness as well.

As is well known, Husserl's analysis of temporality starts from challenging the view that our present perceptual consciousness can be only aware of what is given in the present moment (Husserl, 1991, p.13-23, p.161-162). If our consciousness was only aware of that which is actually present in the now moment, Husserl believes that we would not be able to perceive an object whose identity extends beyond the now moment or endures across time, i.e., a temporal object. Accordingly, he argues for the tripartite structure of consciousness whereby the intentional moments of the present consciousness are articulated with regards to not only the actual now but also the immediate past and the immediate future (Husserl, 1991, p.226). Husserl terms the present

consciousness of the now as primal impression, while retention and protention respectively denote the present consciousness's direct awareness of the just-past and the yet-to-come conscious experience of a given object (Husserl, 1991, p. 226-232). As a 'synthetic unified whole', Husserl argues, primal impression retention and protention belong to every actual now consciousness (Husserl, 2001b, p.346) and associates the manifold temporal phases of conscious experience in their unity. Let us unpack this claim with the popular example of hearing the C-D-E melody[64].

Assuming that the current note in play is the note D, the present consciousness intends the D note via primal impression, providing the awareness that the D note is given in "the original mode of intuitability" or in the mode of now (Husserl, 1991, p.89). In this moment, the retentional moment of the present consciousness retains the just-past consciousness—the consciousness of which intended the C note in the previous now moment through its own primal impression (Husserl, 1991, p.81-89, p.388). In virtue of this retention of previous primal impression, one can be aware of the current now conscious experience of the D note in connection to the previous conscious experience of the C note. To put it otherwise, the present consciousness at tn +1 retains the previous primal impression at tn and the previous now phase of the object correlated to it as well, thus constituting the temporal duration of an object[65]. Similarly, the present consciousness at

[64]For the sake of expediency, I do not follow Husserl's exact order of presentation here. *The Phenomenology of Inner Time Consciousness*, where he expounds his account of time consciousness, is a collection of essays and lectures he prepared for the winter semester at University of Göttingen from 1904-1905 and 1905-1910. The essays and lectures given during the first period (1904-1905) constitute the first part of the book, the latter (1905-1910) its second. During the later period, Husserl significantly revised his understanding of time consciousness, especially his concept of 'retentional intentionality'. Charting out the development of his understanding and explaining the reason for such a development simply goes over the current scope of analysis. In this section, I present Husserl's account of inner time consciousness in the reverse order, specifically, from <No.54 The double Intentionality of the Flow of Consciousness>, where his understanding of retention is reasonably settled and later forms the basis of his genetic phenomenology (Husserl, 2001b, p.186). One more exegetical remark. I do not make the distinction between objective time, subjective time, and pre-subjective or absolute time Husserl establishes. This is due to the nature of this chapter. It is not an exegetical one. Explicitly introducing such a distinction will require a set of justifications that has little to no relevance to the argument I wish to make. However, the first paragraph that immediately succeeds the footnoted sentence concerns the objective time constitution, the second the subjective time constitution, and the succeeding paragraphs the pre-subjective or absolute time (self-)constitution.

[65] However, this does not mean that retention does (re) actualise the just past note. It does not bring the just-past consciousness and the object correlated to it into actuality in the present. Had this been the case, I would have heard the just past note, or the C note, correlated to the retained just past consciousness twice: once when it was actually played, and twice, as an actual now note, when it is retained in the present when the D note is played. In the present, I only hear the D note as the now note, as the only actual note, while

tn+1 protends the yet-to-come phase of the current now conscious experience of the D note, or anticipates its succession by the new now conscious experience in the next moment. In the succeeding moment, the new present consciousness at tn +2 retains the previous present consciousness or the currently just-past consciousness tn+1 and the tripartite structural moments therein as well (Husserl, 1991, p. 81-89, p.388). By retaining the previous protention of the just-past consciousness, in the new now moment whereby the E note is in play, for our case, I can be aware of the new now conscious experience of the E note as fulfilling the previous protention, or as succeeding the previous now experience of D note[66] (Husserl, 1991, p. 52; Ms. L I 15, 24 a-b as translated in Rodemeyer 2003, p.131). In turn, by retaining the previous primal impression, which intended the D note at tn+1, I can hear the D note as a note that came just before the E note, as a just-past note. And through the retention of the previous retention, which retained the primal impression tn whose object was the C note at tn+1, I can hear the C note as a farther past note—as a note that came before the D note. In other words, if the retention of previous protention and its fulfilment enables one to hear the E note as a new now note that succeeds the previous notes, the retention of previous primal impression and previous retention fixes those previous notes in their temporal order, i.e., C as a just-past note and D as a farther-past note. As the temporal location of each past notes is preserved and since each new now note is perceived as succeeding the coherently ordered past notes, I can hear the past notes as part of the same melody that I have been hearing and the newly given note as a part of the same melody that I anticipated to hear. In this way, the tripartite structure of time consciousness enables one to hear the individual notes as a temporally coherent part of the same melody, thereby constituting the persisting identity of melody through its successive phases.

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the C note is heard *as* a just-past note that fades away into the past. As such, Husserl writes: "Retention, instead, presents *the intuition of the past note as just-past*, retention is not a modification in which impressional data are really [reell] preserved, only in modified form: on the contrary, it is an intentionality—indeed, an intentionality with a specific character of its own" (Husserl, 1991, p. 118) "only in primary memory[retention] do we see what is past, only in it does the past become constituted – and constituted *presentatively, not representatively*" (Husserl, 1991,p.43, italics added). I detail this role of retention in 4.2.1. Temporal Modification and Affective Modification

[66]In Husserl's words: "that which came before as such is retained in a new retentional consciousness and this consciousness is, on the one hand, characterized in itself as fulfillment of what was earlier, and on the other, as retention of what was earlier [...] the earlier consciousness is protention (i.e., an intention directed at what comes later) and the following retention would then be retention of the earlier retention that is characterized at the same time as [its] protention" (Ms. L I 15, 24 a-b; as translated in Rodemeyer 2003, p.131).

The basic idea here is that present consciousness retains and protends its own just-past and yet-to-come consciousness. By retaining the just-past consciousness which was actual in the previous now moment thus had its own tripartite structure, the present consciousness retains previous protention, primal impression, and retention as well. Retention of previous protention—or the anticipation that the new now consciousness will replace the current now consciousness—is fulfilled by the very presence of the new consciousness in every succeeding moment. Thanks to this retention of previous protention and its fulfilment, the new now experience can be experienced as succeeding the previous now. And if the experience in question intended an object, say a melody, one can be aware of the succession in its temporal phases as well. In turn, the retention of previous primal impression and previous retention enables one to be aware of the new now conscious experience in connection with the just-past and farther past experiences, so that one can be aware of the temporal duration of a conscious experience and perceive the enduring identity of its intended correlating object as well[67]. Simply put, one can be continually aware of the duration of conscious experience through its successive phases and that of its correlating object, for, in every now moment, the present consciousness retains and protends its own just-past and yet-to-come phases. And by virtue of that same self-intending, Husserl further argues, the temporally unified conscious experience or the flow of consciousness 'constitutes' itself, that is to say, it brings itself to its own appearance or self-manifests. He writes:

> The flow of the consciousness that constitutes immanent time not only exists but is so remarkably and yet intelligibly fashioned that a self appearance of the flow necessarily exists in it, and therefore the flow itself must necessarily apprehensible in the flowing. The self appearance of the flow does not require a second flow; on the contrary, it constitutes itself as a phenomenon in itself. The constituting and the constituted coincide (Husserl, 1991, p.393).

[67]To detail, the retention of previous protention and its fulfilment modifies the temporal form of the incoming phase of consciousness as the new now phase. In turn, the retention of previous primal impression and previous retention modifies the previous now phases into the order in which they came into existence just-past, farther past, farther than farther past phases. In short, this retentional intentionality (or longitudinal retentional intentionality) which retains the tripartite moments of the just-past consciousness constitutes the temporal unity of an experience. And through such a temporally unified conscious experience, a temporal object as such can be given as well, as an object whose identity persists across time.

The flow of consciousness constitutes itself or does not require a second flow or another constitutive dimension for its appearance because its very 'flow'-- its unity of duration and succession-- is constituted nothing but by its own present consciousness retaining and protending its own temporal phases. Meaning, without a mediating higher-order consciousness whereby the flow of consciousness is apprehended as the object of such a consciousness, or in layman's terms, without having to "think" that my consciousness is flowing in its unity, one can be aware of the temporal unity of the flow of consciousness, that is immediately and pre-reflectively. And, correlatively, as the flow of consciousness first-personally manifests, one can be immediately and pre-reflectively aware of oneself as the subject to whom such a flow appears, as the very subject of one's own experience. To paraphrase Husserl's self-constitution claim, the flow of consciousness makes itself appear to one self as such, or manifesting at a first-person level, as a flowing unity thanks to its own synthetic,self-intending feature of the present consciousness. In essence, the tripartite structure of time consciousness constitutes the temporal unity of a conscious experience and, *in so doing, in that very moment of constitution,* its first-personal givenness as well, thereby enabling the pre-reflective form of self-awareness that I am the subject of my own experience. In Husserl's terms: "For the latter [the life of consciousness] is not only a lived-experiencing continually streaming along*; at the same time, as it streams along it is also immediately the consciousness of this streaming.* This consciousness is *self-perceiving* [...] that *presents* all lived-experiencing to consciousness is the so-called inner consciousness or inner perceiving" (Husserl, 2001, p.320; italics added).

§4.2. Psychopathology: Structural Account

In contemporary phenomenological psychopathology, Fuchs, Stanghellini, Sass and Peinkos have taken up Husserl's account of inner time consciousness in their phenomenological analysis of schizophrenia. In line with Husserl, Fuchs claims that the present consciousness retains and protends its own just past and yet-to-come phases so that one can be aware of the duration of one's conscious experience and its coherent succession across time (Fuchs, 2013; Fuchs and Dupen 2017). Acknowledging the intimate connection between the unity of conscious experience and the pre-reflective form of self-awareness, Fuchs writes:

> Inner time-consciousness includes a pre-reflective form of self-awareness as well. When speaking a sentence, I retain what I have just said and am anticipating what I will say, but additionally, I am aware that I am the one who has spoken and who will continue speaking. This is a pre-reflective process: I do not need to reflect in order to become self-aware [...] Prereflective self-awareness, or what has been called the "minimal self", can therefore be considered to be inherent to inner time consciousness (Fuchs, 2013, p.3).

As with Husserl, Fuchs argues that this immediate pre-reflective form of self-awareness or minimal self is underpinned by the synthetic self-intending feature of the present consciousness, or as he puts it, the "spontaneous linking of the primal impression with protention and retention" (Fuchs, 2010, p.87). Zeroing in on the relationship between this minimal self and the first-personal givenness of an experience, Sass and Peinkos, the proponents of the minimal self, suggest that "the microstructure of minimal self [pre-reflective form of self-awareness] or first personal givenness *just* is the structure of inner time consciousness" (Sass and Pienkos, 2013, p.140). In other words, the minimal self and the first-personal givenness of an experience have the same structure of the inner time consciousness, for the tripartite structure of inner time consciousness constitutes the first-personal givenness of an experience, and in so doing, it also enables one to be immediately, pre-reflectively aware of one self existing as the very subject of one's own experience, *viz.* minimal self. In line with the views, Stanghellini et al. write: "Also the feel we have of ourselves as unitary subjects of experience permanent through time is due to the integrity of time consciousness. If we have the feel of our mental life as a streaming self-awareness, this is a consequence of the continuity of inner time consciousness as the innermost structure of our acts of perception" (Stanghellini et al., 2016, p.46).

Employing the above understanding of inner time consciousness, the aforementioned researchers have unanimously argued that schizophrenia involves a fundamental disturbance in the structure of inner time consciousness, engendering the 'time fragmentation experience' present in schizophrenia. As mentioned in the introduction, this experience refers to the anomalous temporal and self experience whereby a person can no longer experience time and self in their unity but in fragmentation. Time fragmentation experience has been accordingly specified into the disarticulation of time experience and the fragmentation of self experience. As defined by

Stanghellini, the disarticulation of time experience refers to the anomalous temporal experience whose usual coherence and unity is lost and split into fragmented individual "now" moments (Stanghellini et al., 2016, p.49). The fragmentation of self experience refers to the co-occurring anomalous experience whereby a person can no longer experience one self existing as a self-identical subject of one's own experience (Stanghellini et al., 2016; Fuchs, 2017). The following self-report has been considered as a paradigmatic case for such experiences.

> The one speaking now is the wrong ego [...] Time is also running strangely. It falls apart and no longer progresses. There arises only innumerable separate now, now, now-- quite crazy and without rules or order. It is the same with myself. From moment to moment, various 'selves' arise and disappear entirely at random. There is no connection between my present ego and the one before (Kimura, 1979, p.18).

As the tripartite structure of inner time consciousness establishes not only the unity of experience but also that of one self, Fuchs argues, its structural disturbance, or "fragmentation" or "disintegration", underpins the disarticulation of time experience and the fragmentation of self-experience (Fuchs, 2013, p.84-85). Stanghellini and his colleagues have carried out an empirical analysis where they compared anomalous temporal experience present in schizophrenia with the ones present in major depression. The research finds that in the case of major depression, a person experiences time as "slowing down" whilst the unity and coherence of one's temporal experience remain intact, whereas, in the case of schizophrenia, there occurs "the collapse of the very vector-like nature of the present moment occurs; as a result [...] life itself can turn into a series of stills as time turns wholly strange and unpredictable." (Stanghellini et al., 2016, p.46). In support of Fuchs' claims, Stanghellini wrote: "Our data partly support his [Fuchs'] hypothesis that a core feature of temporality in schizophrenia is the fragmentation of passive synthesis, that is of the reflexive synthesis of impression retention protention." (Stanghellini et al., 2016, p.52). Another comparative analysis carried out by Sass and Pienkos conclude that "in schizophrenia, a mode of temporality (perhaps better, of a-temporality) that, together with collapse of protention and retention, loses all organization and meaning; in melancholia, a foundering of drive and associated projection of the self into the future, that leaves one dominated by the past, futility, and fatigue" (Sass and Pienkos, 2013, p.10).

Given that the structure of inner time consciousness constitutes the temporal unity of experience and that of one self, it is intuitive that its structural disturbance implicates the disarticulation of time experience and the fragmentation of self experience. However, for the present purpose of argument, let us here remind ourselves that this "self" the authors argue to be fragmented by the structural disturbance in the inner time consciousness is not a self that exists outside its ever flowing experience and maintains its identity as such. Instead, it is the minimal self, as the authors would agree, that exists *within* its experiential flow and whose identity *can* persist only because its experiential flow constantly brings itself to its own appearance or first-personally manifests (Zahavi, 2005, p.65, p.54, Zahavi, 2014 p.64-65, Zahavi, 2007, p. 462, Zahavi and Gallgher, 2005)[68]. And, as mentioned above, since it is the structure of inner time consciousness that enables such a first-personal manifestation and thereby constituting the enduring identity of minimal self, Sass and Peinkos correctly *identified* the structure of minimal self *with* the structure of the inner time consciousness. Recall: "the microstructure of minimal self or first-personal givenness *just is* the structure of inner time consciousness" (Sass and Pienkos, 2013, p.10; italics original). In other words, the structure of the inner time consciousness is the constitutive dimension or the condition of possibility[69] for the first personal givenness of an experience and therefore for minimal self. *Therefore*, the structural disturbance in the inner time consciousness *is not* the minimal self disturbance. The structural disturbance in the inner time consciousness *just is* "fragmentation", "disintegration", "breakdown", or "collapse" in the *very precondition* of minimal self-- the most basic and essential condition of subjectivity without which no experience can first-personally manifest. Had schizophrenia involved such a radical structural disturbance, no experience should have first personally manifest. The disarticulation of time *experience* and the fragmentation of self-*experience* should have been impossible. Given 1) "the structure of inner time consciousness", as Sass and Peinkos aptly wrote, "just is the structure of the first-personal giveness" and 2) the disarticulation of time experience and the fragmentation of

[68]In line with this view, Fuchs writes: "The continuous intertwining of succeeding moments by 'retentions' and 'protentions' includes an intrinsic awareness of my ongoing experience as mine [...] Thus, the phenomenological analysis of the temporal structure of consciousness is capable of accounting for "… self-identity through time, without actually having to posit the self as a separate entity over and above the stream of consciousness (Gallagher and Zahavi 2005)"

[69]This exactly is the reason that Sass and Pienkos correctly claims: "the minimal self can only exist as a temporal flux, yet this flux also *depends* on the minimal self as the medium through which it is manifested" (Sass and Pienkos, 2013, p.8; italics original)

self-experience are first personally given, we are liable to say that the structure of inner time consciousness is not, at the very least, fragmented, disintegrated, collapsed, or broken down.

To be absolutely clear, I do not disagree with the aforementioned authors' interpretation of Husserl's account. Nor do I dispute the phenomenal (or experiential) claim that the time fragmentation experience is present in schizophrenia. My objection targets the transcendental claim regarding the structural breakdown in inner time consciousness. To be specific, what I dispute here is the claim that the structural integrity of inner time-consciousness is fundamentally compromised, as it leads to the conclusion the time fragmentation experience is impossible. Since this conclusion follows if one employs Husserl's account of inner time-consciousness, the quick fix seems evident: do not use it anymore. The verdict seems simple. After several decades of its use, it has finally exhausted its value. Or, has it? The short answer: it has not. In the following, I first take a closer look at the synthetic, self-intending feature of the present consciousness and pull apart its two distinctive yet complementary aspects: temporal modification and affective modification. There are two reasons for establishing this distinction. First is to provide a phenomenological account that can appreciate the basic experiential fact that the time fragmentation experience is possible. Second is to do justice to the often-overlooked experiences in the contemporary research of schizophrenic temporal experience, i.e., non-emotional affectively prominent temporal experience. As mentioned, it denotes the kind of an experience wherein a person with schizophrenia experiences an intense pull from the different temporal modes of experience, described as being "sucked up" by the past, something of the past "returning towards" oneself (Minkowski, 1933/1970, p.287-290; Stanghellini et a., 2016; Fuchs & Van Duppen, 2017) and as being constantly pulled into the alluring immediate future, that "something" is impending (Minkowski, 1933/1970, p.287-290; Stanghellini et al., 2016; Fuchs & Van Duppen 2017). In the contemporary research, this affectively prominent temporal experience has been either considered as another manifestation in the structural disturbance in the inner time-consciousness (Stanghellini et al., 2016, p.13) or regarded a notable change involved in schizophrenic temporal experience but not its "most fundamental change" (Sass & Pienkos, 2013, p.140). By employing Husserl's account of affection, I identify the structural underpinning of such an experience as 'affective modification dysfunction' and use it as a core concept to better reconstruct the structure of schizophrenic temporal experience while retaining its basic subjective dimension. What then is

this temporal modification and affective modification? How exactly is making this distinction helpful?

§4.3. Temporal Modification and Affective Modification

Temporal modification refers nothing but to the above discussed self-intending feature of the present consciousness. Recall: the retention *of* the previous primal impression and previous retention modifies the previous now phases as the just-past and farther past, and the retention *of* the previous protention and its fulfilment in the present modifies the current now as the new now. This self-intending retentional intentionality of the present consciousness is the necessary constitutive dimension or the condition of possibility for the temporal unity of experience and its first-personal givenness. It is this aspect of time consciousness that the proponents of the structural accounts exclusively focus on in their analysis of schizophrenic temporal experience. However, it is one thing to say that A is the condition of possibility for B and it is another thing to say that A is the necessary *and* sufficient condition for B. Grant that the present consciousness intends its own just-past consciousness via retention and that through such a self-intending the temporal unity of an experience is constituted. However, what exactly is the nature of retention such that when it intends the just-past consciousness it retains it *as* just-past? Even if retention grabs hold of the just-past consciousness in the present, insofar as it does not hold it *as* just-past, the now will not be experienced as such, as having arisen from the just-past. There would be no sense of just-past in connection to which one can experience the now as now. Meaning, if retention does not modify the just-elapsed consciousness *as* just past, the temporal unity of experience would be lost. The question that has to be addressed for the constitution of the temporary unity of experience then is: How is it that retentional intentionality retains the just-past consciousness *as* just past? Affective modification comes in here.

To obviate some confusion, on Husserl's account, affection does not strictly refer to emotions nor does it refer to immanent self-affection (or the sense of vitality or aliveness) (Cf. Sass & Parnas, 2003). It is a technical term coined to designate a priori correlation between the consciousness and something that is not in the consciousness and thus intrinsically foreign to itself, i.e., the world (Husserl, 2001b, p. 196). In a little bit more detail, affection designates the constant attraction, "pull" or "allure" the world always-already exercises on our consciousness and our

consciousness, in turn, being always "turned towards" and grasping such a pull (Husserl, 2001b, p.196). As such, Husserl often describes the phenomenon of affection with respect to its 'intensity' or 'vivacity'. Detailing the nature of affection with respect to the themes of investigation other than temporality (i.e., unity formation of immanent sense data, object constitution, perceptual field organisation, implicit and explicit recollection, habitual expectation, sedimentation, and unconsciousness) goes over the scope of the current analysis. What is important in the current analysis is, however, simply the following. To say that A is affective is that it allures or attracts one's attention.

In the analysis of the affective nature of temporal experience, Husserl argues that the present has the strongest affective intensity and that such an intensity gradually loses its force as it slips away into the past. In his terms, "the primordial source of all affection lies and can only lie in the primordial impression and its own greater or lesser affectivity" (Husserl, 2001b, p.217). He continues: "what is given in the mode of original intuitability of having a self in the flesh, givenness in the flesh, [in the now] undergoes the *modal transformation* of the more and more past" (Husserl, 2001b, p.217; italics added). Say, when I listen to my friend talking about how his day went, what he is saying now attracts my attention more so than what he said in the immediate past. I am still aware of what he just said but its affective intensity is not as strong as what he is saying now. I experience what he just said in the mode of "more and more past", slipping away into the past. Yet, again, how is this experience of past possible? To be exact, what is this "modal transformation" involved in constituting the sense of past?

Husserl's answer is roughly this: retention enables such an experience by diminishing the affective intensity of the just-past consciousness. Explaining the affective modification carried out by retention, Husserl writes: "Rather, it [retentional modification] produces a new dimension of blurred distinctions, a growing cloudiness, a murkiness that essentially decreases the affective force" (Husserl, 2001b, p.204). He further construes "the continuation modification of primordial impression [carried out by retention]" as a process of "clouding over" (Husserl, 2001b, p. 217). Bluntly put, the retention of the present consciousness does not simply grab hold of the just-past consciousness (viz. temporal modification). Instead, in the moment it does so, it also diminishes the affective intensity of the retained just-past consciousness (viz. affective modification). Given that the retention of just-past consciousness is the retention of previous protention, retention, and

primal impression, the affective modification of retention entails the following. Retention of previous primal impression and previous retention decreases the affective intensity of the previous now phases so that they can be experienced *as* the just-past and farther-past — as a chain of past phases that gradually fades away into the past. Simultaneously, retention of previous protention decreases the affective intensity of the previous implicit anticipation that the current now will be replaced by the new now in the succeeding moment. So that, in the succeeding moment in which such an anticipation is fulfilled, one can, without having to be surprised by every moment of its fulfillment, experience the current now as the new now — as seamlessly succeeding the previous now. In sum, if temporal modification carried out by retention retains the just-past consciousness and the previous tripartite moments therein, affective modification, in that moment of self-intending, diminishes the affective intensity of the retained previous intentional moments and constitutes the temporal unity of an experience. And what is this all to psychopathology?

§4.3.1. A Way Out

As mentioned above, what the aforementioned researchers have exclusively focused on is the temporal modification of retentional intentionality, *viz.* the self-intending feature of the present consciousness. The "spontaneous linking of the primal impression with protention and retention" or "pre-reflexive, passive temporal synthesis of retention, protention, and primal impression", or simply "the structure of inner time-consciousness"—in virtue of which one can experience time and oneself in their unity of identity— *just is* the self-intending retentional intentionality of the present consciousness. The objection I raised was the following: given that the structure of inner time-consciousness (or the temporal modification of retentional intentionality) constitutes the temporal unity of consciousness *and* its first-personal givenness as well, its disturbance implies the impossibility in having any subjective experience. Having the conceptual distinction between temporal and affective modification in mind, we can now make this move: attribute disturbance to affective modification not to temporal modification. This entails the following two claims. First, the present consciousness *still intends its own* just-past consciousness and yet-to-come consciousness. Thus, no matter how much one experiences oneself and one's experience in its fragmentation and disunity, one can be *still aware* that it is oneself who is having such a fragmentation experience. In accepted terms, the structural integrity of inner time-consciousness remains intact. Second, attributing disturbance to affective modification translates to the following

provisional hypothesis. Retention is not doing the job that it is supposed to do, that is, it no longer diminishes the affective intensity of the retained just past consciousness. This *functional disturbance*, I shall argue, underpins the affectively prominent temporal experience present in schizophrenia and globally alters the way one experiences time and one self. Consider the following.

§4.4. Functional Account

Given that the retention of the just-past consciousness is the retention of previous tripartite intentional moments, the functional disturbance in the affective modification carries the following specific implications. First is the functional disturbance in the retention of previous primal impression. Second is the functional disturbance in the retention of previous protention. Third is the functional disturbance in the retention of previous retention. In the following, I clarify each implication with respect to anomalous temporal experience discussed both in the traditional and contemporary field of psychopathy: 1) Time Stop, 2.) Ante-festum, 3.) Déjà vu/vécu and 4.) Time Fragmentation. Of note, although these experiences have been historically documented and interpreted in various ways, it is only recently that those experiences have been organized as a set of categories for both research and clinical purpose by Stanghellini et al (2016)[70] and Sass et al (2017). Each category has a set of members particular to an individual category and the 'core-phenomenon' without which the set of individual members of a given category cannot be the type they are, i.e., the particular type of structural disturbance in inner time-consciousness. Given that I aim to provide an alternative account to the prevailing structural account, what is at stake in this section is this: provide a set of phenomenological underpinning — or core-phenomenon — for each category.

[70]In their analysis of schizophrenic temporal experience, Stanghellini and et al., (2016) propose two broad general categories for nosographic purpose. First is the "Disturbed Experience of Time Speed". To this general category, there belongs the "decelerated time experience". Second is the "Disarticulation of Time experience". To this category, there belong three sub-categories: 1.) Disruption of time flowing, 2.) Déjà vu/vécu, 3.) Premonitions about oneself. In the main body, with the exception of Dejavu/vecu category, I use "time stop experience", "time fragmentation experience", and "ante-festum" to mean the "decelerated time experience", "disruption of time flowing" and "premonitions about one self" categories.

§4.4.1. Time Stop

First implication: the functional disturbance in the retention of previous primal impression. If it is the case that retention does not diminish the affective intensity of the retained previous primal impression, then the affective intensity of the previous now should remain equal to that of the actual now. Meaning, the previous now which usually loses its affective intensity and thus experienced in the mode of 'running off' will no longer be experienced as such. Further, if it is the case that retention *still* retains the previous primal impression, then the previous now, which lacks the sense of just-past, will *be experienced in connection to* the actual now. Therefore, the actual now will no longer be experienced as an ephemeral point that immediately slips away into the past but as somehow enduring more so than usual. Although Wiggins et al (1990) opt for the term of art "severe attenuation of syntheses of inner time consciousness", they write:

> The present awareness will be experienced as simply *enduring* -- and as enduring without being bounded by a receding past or an approaching future. This extreme attenuation of the syntheses of inner time accounts for the experience of a "*prolonged*" or "*distended present*" which many schizophrenic individuals report (Wiggins et al., 1990, p.31; italics added).

This experience of prolonged or distended present wherein one feels stuck in the now moment is often described by people with schizophrenia as "time stand still" , "immobility, but not calm", "time going back to the same moment", "frozen moment" (Stanghellini and Rosfort, 2013, p.241), "I *continue to live now* in eternity; there are no more hours or days or nights [...] the others walk to and fro in the room, but time does not flow for me. My watch runs just as before" (Minkowski, p.287), "there is only immobility around me [...] Everything around me is motionless and congealed (Fuchs, 2013, p. 91). Describing this immobility experience in detail, a patient of Minkowski (henceforth B) writes

> [...] yes, everything was immobile, as if time did not exist anymore. I seemed to myself to be a timeless being, perfectly clear and limpid as far as the relations of the soul are concerned, as if it could see its own deptlis. Like a mathematical formula. This is also perfectly clear and is outside of time. On the whole, it encompassed only immobility (Minkowski, 1933/1970, p.287)

Another patient (henceforth A) reports a similar sort of experience and describes the experience of "non-disappearability" of time:

> Time is immobile [...] In the morning when I wake up, yes, how can I say it, *the "disappearable" is there again; this torments me terribly*. Do I know where I am? As far as that's concerned, yes. But the *"disappearable" of time is not there*, and how can you take hold of time, when it was yesterday! There it goes on inside of me, always farther behind, but where? Time breaks (Minkowski, 1933/1970, p.287; italics added).

Describing the sense of being pulled back in during the time immobility experience, another patient (henceforth C):

> I am stopped; I am projected from *behind into the past*, by the words that people are speaking in the room [...] There is no more present, there is only a *going-backwards; it is more than a feeling, it extends over everything* (Minkowski, 1933/1970, p.287; italics added).

The above self-reports indicate the presence of a significant alteration in the way one experiences the past. If, in everyday life, the just-past moment fades away into the past and gradually loses its affective intensity, in the instance of time stop experience, it remains present as a non-disappearable moment and constantly pulls oneself into it, hence the claims "the *"disappearable" of time is not there*" there is only a *going-backwards; it is more than a feeling, it extends over everything."* Put otherwise, the retention of the present consciousness does not diminish the affective intensity of the retained previous primal impression, prolonging the ephemeral now point to the immobile now moment and thereby eliciting the time stop experience. In other terms, this disturbance in the retentional affective modification of primal impression is the core phenomenon of time stop experience. With this in mind, let me proceed into clarifying the second implication in the disturbance of the retentional affective modification.

§4.4.2. Ante-festum

Second implication: the functional disturbance in the retention of previous protention. If it is the case that retention does not diminish the affective intensity of previous protention, then the

implicit anticipation towards the future will be exaggerated. Further, if it is the case that 1) retention of the present consciousness still retains the previous protention and 2) the condition of its fulfillment is the presence of the present consciousness, then protention will be *still fulfilled* and thereby enabling one to experience the succeeding moment as another "now" moment[71]. This exaggerated or the affectively prominent protention, however, will anticipate the immediate future as an alluring and pulling phase that for some unknown reason constantly attracts one's attention. Therefore, even after the previous protention is fulfilled by the new present consciousness in the succeeding moment, there will constantly remain the sense of something being unfulfilled, the sense of something significant about to happen will prevail in every moment of succession. In psychopathological context, this exaggerated anticipation, or the sense of foreboding and premonition, has been coined as "ante-festum" (Latin: before-the-feast) (Kimura, 1992). Stanghellini and Rosfort (2013) characterise such an experience as "[...] an eternally pregnant now in which what is most important is not present, what is really relevant is not already there, but is forever about to happen" (p.240). If the above first analysis is somewhere along the right line, then the now moment should be not only characterized by its immobility but also by its incipient movement towards fulfilling the indeterminate, unfulfilling anticipation. Describing such a paradoxical nature of time experience, C writes:

> I am like a machine *that runs* but *does not move from its place*. It goes at full speed, but it remains in place. I am like a burning arrow that *you hurl before you*; *then it stops, falls back, and is finally extinguished as if in a space empty of air* (Minkowski, 1933/1970, p.287; italics added)

In the moment of time immobility experience, B writes:

> All of this occurred in an *incessant flux* and *continuity of movement*, which was contrasted in a particularly gripping way with my own state of mind, *like the frame in relation to a picture*. These movements were a kind of madness in relation to my own state (Minkowski, 1933/1970, p.287; italics added)

[71] Even in the time fragmentation case, a person *still* experiences time as the series of *now, now, now* moment. I will discuss this shortly.

Reporting both the mobility and immobility of time experience, A writes:

> I continue to live now in eternity; there are no more hours or days or nights. *Outside things still go on, the fruits on trees move this way and that. The others walk to and fro in the room, but time does not flow for me.* My watch runs just as before. But I do not wish to look at it; it makes me sad (Minkowski, 1933/1970, p.285; italics added).

As the self-reports indicate, such a temporal experience is not only characterised with immobility but also, paradoxically, constant 'movement'. As most concisely described by Stanghellini and Rosfort, "it [time in schizophrenia] is a paradoxical mixture of immobility *and* protention, a knot of stillness *and* frenzy, ecstatic astonishment, the zero hour *between* hesitancy and solution, calm *and* tension, emptiness *and* pressure, rest *and* unrest, stop *and* incipient movement" (Stanghellini & Rosfort, 2013, p. 241; italics added). This paradoxical nature of time experience may be best understood as the synchronous manifestation of the retentional affective modification dysfunction. For the time stop experience, as the previous primal impression is no longer retained in the mode of running off or as just-past but as a non-disappearable now moment, one feels as though one is stuck in the enduring now moment, eliciting the time stop experience. In turn, as the previous protention anticipates the immediate future as though something is on the verge to happen, the new now moment (anticipated by the previous protention) wherein nothing significant happens cannot resolve that sense of exaggerated anticipation, and thus underpinning the feeling that one is like a "burning arrow" that is hurled only to be "extinguished in a space of empty of air" or like "a machine that runs in the same place". However, even in such a case, the basic sense of anticipation towards the immediate future, or the protention of the yet-to-come phase of consciousness, is still fulfilled, constituting the basic sense of the temporal movement towards the future. Meaning, the time stop experience and ante-festum co-occur as they share the same modal alteration: i.e., the retentional affective modification dysfunction. To specify, the core phenomenon for the time stop experience is the functional disturbance in the retention of previous primal impression, wherein the just-past is experienced as a non-disappearable now in connection to the actual now. For ante-festum, it is the functional disturbance in the retention of previous protention, wherein the exaggerated previous anticipation cannot be entirely fulfilled by the new now phase of consciousness, eliciting the feeling that "something" is about to happen.

§4.4.3. Déjà vu/vecu

Third implication: the functional disturbance in the retention of previous retention. If it is the case that the retention does not diminish the affective intensity of the previous retention, then the further past than the previous now moment, call it the distant-past moment, will no longer lose its affective intensity. Further, if it is the case that retention still retains the previous retention, it follows that the actual now *will still be experienced* with the retained distant past moment that for some unknown reason constantly attracts one's attention and pulls one into it. This kind of an experience wherein the distant past attracts one's attention and "the already-happened prevails" has been coined as "dejavu/vecu" experience (Stanghellini et al., 2016, p.50; Fuchs & Van Duppen, 2017, p.69). B details such an experience as follows: "I don't know whether these are memories from the past which I see or whether I have been led there to them against my will. *In any case, the past arose before me in a particularly vehement way, but not the way I usually see it*" (Minkowski, 1933/1970, p.288; italics added). Describing a certain force coming from the "far-away", A writes: "it takes me backwards, but where? There where it comes from or where it was before. It goes back into the past. You have the feeling that you are going to fall behind [...] It is as if it is right at hand, as if you ought to draw It here again; is it time? It comes from far away!" (Minkowski, 19333/1970, p.286). C similarly reports: "The past is so bothersome; it drowns me; it draws me backwards [...] It is hurled backwards. I mean by that that there is no more future and that I am projected backwards" (Minkowski, 1933/1970, p.287). Put otherwise, the retention of the present consciousness does not diminish the affective intensity of the retained previous retention, eliciting the sense of the distant past exercising a strong affective pull to one's present awareness and, correlatively, drawing one self back into it. In short, the dysfunction in the affective modification of previous retention is the core phenomenon for déjà vu/vecu experience.

If the above analysis is somewhere along the right lines, then one can understand how it is that the time stop, ante-festum, anid déjà vu/vecu experience co-occur in the above mentioned three different individuals. They co-occur because those experiences share the same underlying structural alteration, viz. the affective modification dysfunction. Of note, in all of the above analyses, I have maintained the structural integrity of the inner time-consciousness. I have assumed that the present consciousness still retains and protends its own temporal phases. I did so for the following two reasons. First, without the structural integrity in the inner time-consciousness, the

anomalous experience as such would have been impossible. Second, without the structural integrity of inner time-consciousness, one would have not been able to experience the sense of constant movement *towards* alluring future, the actual now *with* the non-disappearable now, and the affective distant past moment *with* the current now. Therefore, as opposed to its breakdown, total collapse, fragmentation, or disarticulation, the structural integrity of inner time-consciousness is absolutely necessary to provide a phenomenological account that accords with the lived *anomalous-temporal-experience* of schizophrenia. Let me now proceed into the last analysis of the experience that has been taken as the prime manifestation of the structural breakdown in the inner time-consciousness: Time Fragmentation.

§4.4.4. Time Fragmentation

If it is the case that the temporal modification is still operative, then the present consciousness will still intend its own just-past and yet-to-come consciousness. If the retention of the present consciousness, however, no longer diminishes the affective intensity of the retained just-past consciousness (and that of previous primal impression, retention and protention therein), then the previous now tn-1 and its preceding now tn-2 will be no longer experienced in the mode of running off. Instead, they will be experienced as non-fading-away or 'non-disappearable' now moments. Since the present consciousness still retains the previous protention, its anticipation (that the current now consciousness will be replaced by the new now consciousness) will be still fulfilled — and thereby enabling one to experience the succeeding moment as another actual now. Given the present consciousness still intends its own temporal phases, it follows that the previous actual now (tn-1) and the previous non-disappearable now (tn-2) *will be carried over* to the present at tn. Given the affective disturbance claim is correct, it follows that in every moment of succession, the retained previous actual now (tn-1) will be modified into another non-disappearable now. Therefore, in every now, the actual now will be experienced in connection with the series of previous non-disappearable now moments. The sense of coherent temporal progression will be lost. A patient of Kimura writes: "*Time is also running strangely. It falls apart and no longer progresses. There arises only innumerable separate now, now, now — quite crazy and without rules or order"* (Kimura, in Fuchs, 2013, p.84; italics added). To go back to the A's self-reports: "[...] But the "disappearable" of time is not there, and how can you take hold of time, when it was yesterday! There it goes on inside of me, always farther behind, but where? *Time breaks*"

(Minkowski, 1933/1970, p.287; italics added). Given that the present consciousness still intends *its own* temporal phases, the subject will be still aware that it is oneself to whom such an anomalous experience is given. Hence, the disarticulation of time *experience*, as such, would be possible.

Further, given that the retention of the present consciousness does not decrease the affective intensity of *its own just-past consciousness*, it follows that it is not just the previous now moment that is non-disappearable but also the retained just-past consciousness. Given that the present consciousness retaining its own just-past consciousness is an instance of self-consciousness (to be specific, the pre-reflective form of self-awareness that I am the subject of my own experience, viz. minimal self), it follows that this non-disappearable previous now consciousness *is* the non-disappearable *self*-consciousness. Given 1.) the just-past self-consciousness no longer fades away into the past but remains present and 2.) this self-consciousness just is minimal self, in every actual now, one will experience two different minimal selves: one that is having the actual now experience as its own (call this S1) and another one that had the just-past experience as its own but remains present in the actual now (call this S2). If this is the case, then the S1 will no longer experience the just-past experience as its own but as an experience *mediated* by the S2. The S1 will then experience the S2 as a distinctive subject whose experience first-personally to itself (not to the S1): the S1 will not experience the S2 as the just-past self that is identical to itself but as an alien self endowed with its own ego-pole. Therefore, the basic sense of existing as a self-identical subject of one's own experience across time, or that it is obviously me who is having my experience as my own across time and *no one else*, will be lost. The prime instance of which is the fragmentation of self-experience. When the above patient of Kimura experiences time as "now, now, now", she writes "*it is the same with myself. From moment to moment, various 'selves' arise and disappear entirely at random. There is no connection between my present ego and the one before*."

§4.4.5. Summary and Delusional Mood

So far, I have analysed the anomalous temporal experience particular to schizophrenia from its affective dimension. In contrast to the structural account, the account I provided presupposes the structural integrity in the inner time-consciousness, i.e., the synthetic, self-intending feature of the present consciousness. In so doing, the proposed account retained the subjective dimension of

anomalous temporal experience present in schizophrenia. By employing the concept of affective modification, it further detailed the anomalous temporal experiences documented and discussed both in the traditional and contemporary field of psychopathology: 1.) Time Stop, 2.) Ante-festum, 3.) Déjà vu/vécu, and 4.) Time Fragmentation. The central tenet of the provided account is the following: the retentional intentionality no longer diminishes the affective intensity of the just-past consciousness, and this affective modification dysfunction underpins the schizophrenic temporal mode of experience. It should be emphasized here that this account is only a provisional, speculative one based on the secondary data collated by previous researchers. I do not doubt that there are other types of anomalous temporal experiences particular to schizophrenia that cannot be counted as an instance of either one of those above stated categories. Nor do I not doubt that there are temporal experiences that belong to one of those four categories but cannot be counted as the manifestation of the so clarified structural underpinning. As such, in this chapter, the status of the distinctions of schizophrenic temporal experience into the above four categories remains to be ideal-typical: a set of experiences described under the heading of each category is not necessarily essential to but characteristic of schizophrenia. However, if the presented account is somewhere along the right lines, it can be taken as a tentative account for understanding schizophrenic temporal mode of experience without having us commit to the view that the very dimension of subjective experience is collapsed, broken down, or fundamentally fragmented.

Moreover, approaching anomalous temporal experience present in schizophrenia from its affective dimension can further illuminate the nature of the pre-psychotic phase known to precipitate the crystallization of primary delusion found in schizophrenia, namely, delusional mood. Delusional mood is a psychological state wherein a subject experiences an all enveloping sense of something important impending. An afflicted individual often describes such a mood as "Something is going on; do tell me what on earth is going on [...] How do I know, but I'm certain something is going on" (Jaspers, 1913/1997, p.98). In this state, although an individual cannot determine what exactly it is that has changed or what it is that it is going to happen to them, one remains certain that something did change and something is going to happen (Müller-Suur, 1950, p.45). After a while, Klaus Conrad suggests, there comes the "aha" moment wherein an individual understands what it is all about. In this moment, the indeterminate "something" that has thus far eluded one's grasp is cognitively elaborated and specified into a determinate belief content (Parnas & Henriksen, 2019, p.2). Conrad details such a transformative moment as a "reflexive turning back

on the self" in which the self is experienced as the centre of the universe, as a middle point around which the universe "revolves" (Conrad, 1959, as translated in Mishara, 2010, p.10).

One way of understanding the above described delusion formation stage is by approaching it from its affective dimension. If the affective intensity of the temporal experience is not modulated, so will be that of what one experiences through such a mode. Meaning, a perceived particular object and its surrounding context that one experiences, whose affective intensity is usually diminished as it slips way into the past, will exercise a constant level of affective pull *across time.* A passing bus, for instance, which would have simply been perceived as another passing vehicle, may *constantly* attract one's attention and grab hold of one's attention to its every insignificant detail as it passes by, e.g., to its colour, size, number, side-banner, the people who are on the bus, etc. At the same time, its perceived surrounding context would equally gain such a peculiar saliency. The road, road signs, bus-stop, pedestrians, trees around the bus stop, etc. which would have been simply perceived as the background context of the passing bus may no longer be perceived as such but as a set of distinct objects that all solicit one's attention. Susan Weiner, a 31 years old graduate student at the time of her diagnosis, writes: "Schizophrenia is a disease of information. And undergoing a psychotic break was like turning on a faucet to *a torrent of details,* which overwhelmed my life [...] The movies, TV, and newspapers were alive with information for *those who knew how to read* [...] An advertising banner revealed a secret message *only I could read.* The layout of a store display conveyed a clue. A leaf fell and in its falling spoke: nothing was too small to act as a courier of meaning" (Susan, 2003, p.877; italics added). Meaning, one experiences oneself as the centre of the universe, or as the middle point around which the universe revolves, because every insignificant detail of one's surroundings constantly exercises intense affective allure to one self and solicits one's attention. This affectively prominent world-experience, coupled with the stifling tension that 'something' is going to happen, may propel an individual to take things into one's own hands. For the case of Susan, she frequented the movies as "they helped make sense of what was happening to me by providing clues to clarify and organize my activity" (Susan, 2003, p.878). After months of "putting pieces together", she came to the realisation that "there was a secret history of the world to which I now became attuned [...] An evil dictator was gathering power to himself, and he meant to perpetuate a holocaust on the Nation" (Susan, 2003, p.878). In this moment, "a sense of clarity that is more compelling than reality" dawned on her. She knew what was going to happen, not indeterminate 'something' but 'the

inevitable emergence of the dictator': the exaggerated anticipation that something impending is fulfilled. The bewildering, enigmatic appearance of the world made sense to her: the world was warning her the coming of the dictator. Delusion sets in.

The above is a speculation. If it were to have some footing in the contemporary phenomenological discussion of delusional formation, it would have to clarify the relationship between the affective modification dysfunction and the particular type of thematization involved in constructing schizophrenic delusion. Moreover, delusional mood is also most notably characterised by the sense of uncanniness of the world, the loss of the practical significance of an object , and the perceptual field fragmentation (Jaspers, 1997; Fuchs, 2005a; Conrad, 1958; Mattusek, 1987). Hence, the above analysis is not an exhaustive account. However, the general point is the following. If the experience of a strong and pervasive attraction or pull people with schizophrenia have constantly reported regarding the time and world experience can be analysed in its own terms, then one can begin to clarify the nature of such an affective experience. One can begin to analyse the global effect such an experience can have on the way one experiences time, oneself, and world. The analysis of which, in turn, can chart out possible ways to better understand schizophrenia temporal mode of experience and delusional mood by identifying its specific structural underpinning.

§4.5. Conclusion

In this chapter, I have provided a phenomenological account of schizophrenic temporal mode of experience, which has been the central object of phenomenological investigation since the days of Jaspers. I first detailed one of the conceptual tools thus far employed to make sense of such an experience in their conceptual unity, i.e., Husserl's account of inner time consciousness. I then presented the prevailing accounts according to which the structural breakdown in the inner time consciousness underpins schizophrenic temporal and self experience. Afterwards, I rejected it on the charge of radicality: the structural disturbance in the inner time consciousness does not simply implicate anomalous experience but also the impossibility in having any subjective experience. I then provided an alternative account that can better accommodate the target experience. To be precise, the account that can appreciate the basic experiential fact that schizophrenia temporal experience is possible and organise it in relation to its underlying

phenomenological core. I termed such a core as “affective modification dysfunction” and employed it as a conceptual tool to detail and organise anomalous temporal and self experience into the following categories 1.) Time Stop, 2.) Ante-festum, 3.) Deja/Vecu, and 4.) Time Fragmentation experience. Afterwards I briefly demonstrated how approaching schizophrenic temporal mode of experience from its affective dimension can further help us make better sense of the delusional mood.

In the following chapter, I focus on the delusional mood experience and develop its affective centred account. I aim to address the following questions: What is this delusional mood? How does this experience come about? And does its ‘affective’ analysis have any relevance outside the circle of phenomenological psychopathology? In addressing these questions, I hope to achieve two aims. The first is to clarify the nature of delusional mood so as to render its role in bringing about primary delusions clear. The second is to advance a mutual enlightenment thesis between the phenomenological affective account I soon propose and the neurobiological account of delusional mood. Let me proceed.

Ch.5 Delusional Mood and Affection[72]

§5.Introduction

In the previous chapter, I focused on the affective characteristic of schizophrenic temporal experience and provided an alternative account. In so doing, I have brought attention to the general disturbance in the affective distribution in the living present of the people living with schizophrenia. With this, I briefly demonstrated how approaching delusional mood from its affective dimension can help us better understand its role in bringing about primary delusion. In this chapter, I hope to develop the affective account of delusional mood and map out how a structural alteration in affective experience can give rise to an experience like delusional mood. I conclude by relating the phenomenological account I propose here with the neurobiological account that also posits the affective salience experience as its target phenomenon, i.e., aberrant salience hypothesis, and advance a mutual enlightenment thesis[73].

As with the schizophrenic temporal experience, delusional mood has been one of the central objects of phenomenological investigations in the study of primary delusions. Clarifying the status of delusional mood in the context of psychiatry, Klaus Conrad writes: "Here we refer to the most important concept of classical psychiatry, i.e. delusional mood, which signifies the peculiar borderland between normal and psychotic experience" (Conrad, 2002, p.83). The notable characteristics of delusional mood include several experiential abnormalities. As identified by Karl Jaspers, the first (and the most well-known) characteristic of delusional mood is the global, atmospheric change. The sense of uncanniness of the world and the ineffable, oppressive tension that "something is going to happen" have been known to pervade and envelop a patient's life (Jaspers, 1997, p. 98-100). The second characteristic, the most extensively studied by the Gestalt

[72] This is an Accepted Manuscript of an article published by Taylor & Francis in *Philosophical Psychology* on 2022/05/19, available online: DOI: 10.1080/09515089.2021.1988546. To maintain the narrative thread of this thesis, minor changes have been made with respect to the introduction, the first section, the footnotes, and the conclusion. Please refer to the published article for its citation: Sul, JR. (2022). Delusional mood and affection, *Philosophical Psychology*, 35 (4), 467-489, DOI: 10.1080/09515089.2021.1988546.

[73] Of note, this mutual enlightenment thesis is different from the mutual complementarity thesis proposed in chapter 2. The complementarity thesis is advanced for the ideal type and the essential type classificatory approaches. The enlightenment thesis I propose here is regarding phenomenologically oriented research and neurobiological research into delusion formation.

School, is the splintering of an object phenomenon and the bewildering, enigmatic manifestation of the world (Conrad, 1958; Mattusek, 1987). An object is no longer perceived as a unified, whole object in its meaningful relation to its surrounding environment, but in its fragmented aspects and its surrounding acquires a peculiar saliency (Mattusek, 1987, p. 90-96). The third characteristic is the loss of the familiar, determinate meaning of an object, or its practical significance. In this state, "[the patient] does not know any more 'what it is all about', why the things he encounters are here at all, and what to do with them" and the determinate meaning of an object remains "abstract and arbitrary" (Fuchs, 2005, p.136). As briefly mentioned in the previous chapters, these experiential abnormalities have been proposed to not only precede the development of schizophrenic delusion but also "prepare the ground for the entry into a delusional world" (Sass & Pienkos, 2013a, p. 642). Hence, the question of how the delusional mood emerges has been the central subject of enquiry in the discussion of primary delusion formation.

So far, it has often been mentioned that the peculiar saliency of the world experience, whereby every insignificant detail of one's surroundings become conspicuously salient, may involve the emergence of the delusional mood (Conrad, 1958; Mattusek, 1987; Jaspers 1997; Sass & Byrom, 2015; Kapur, 2003). In the following, I focus on its affective characteristic and demonstrate how such an experience can implicate the aforementioned notable characteristics of the delusional mood. I conclude by advancing a mutual enlightenment thesis with the neurobiological account of the delusional mood. My argument proceeds as follows.

I begin by reviewing contemporary accounts of delusional mood. Husserl's phenomenology has been already employed to explain the emergence of the delusional mood. Most notably, Thomas Fuchs (2005) and Osborne Wiggins and his colleagues (1990) have argued that the disturbance in 'temporal synthesis' and 'Urdoxa' underpins the delusional mood experience. Although this is a prevailing account endorsed and developed by various prominent figures (Stanghellini et al., 2016; Sass & Pienkos, 2013b), I contest it on two grounds. First, as argued in the previous chapter, the structural disturbance in temporal synthesis implicates the impossibility in having any subjective experience. Second, urdoxa, as shall be demonstrated, is the precondition of doubting/affirming a given state of affairs. Therefore, its disturbance or 'shattering', as opposed to what the contending view suggests, does not lead to the global sense of uncanniness and suspiciousness characteristic of delusional mood. After raising this objection, I

appeal to Husserl's account of affection and affective syntheses (Husserl, 2001b). This is to develop a new avenue for providing a more detailed and nuanced phenomenological account of the delusional mood *experience.* From the discussion of affection and affective syntheses, I glean two conceptual tools necessary for providing an alternative account of the delusional mood: affective repression and affective propagation. In short, the former regulates the prominence of a perceived object and its encompassing context, the latter enables the past experiential life of a subject to provide a framework of determinate sense and familiarity to the present experience. Third, employing those concepts, I identify the structural underpinning of delusional mood as the failure of affective repression. I argue that this structural alteration underpins the affective saliency experience and demonstrates how such an experiential abnormality further implicates the notable characteristics of the delusional mood. Fourth, I relate the above finding to the aberrant salience hypothesis (Kapur, 2003, 2005) and advance a mutual enlightenment thesis. I tentatively suggest that the neurobiological hypothesis can complement the proposed phenomenological account by identifying the neurobiological correlate of the failure of affective repression. In turn, the proposed phenomenological account can complement the hypothesis by illuminating how exactly it is that the peculiar affective saliency experience, or in neurobiological terms, aberrant salience phenomenon, can give rise to the delusional mood experience, and thereby resolving its enduring issue concerning the mind-level explanation of the delusional mood.

§5.1. Delusional Mood, Temporality, and Urdoxa

According to Jaspers, primary delusion often originates from the alteration in the form of experience, that is, the manner in which one experiences time, the world, others, oneself and objects (Jaspers, 1997, p.58–59). As the term delusional mood suggests, the alteration Jaspers focuses on is the atmospheric change involved in the early stage of schizophrenia. In this state "patients feel uncanny and that there is something suspicious afoot [...] there is some change which envelops everything with a subtle, pervasive and strangely uncertain light" (Jaspers, 1997, p.98). Not surprisingly, a fully formed schizophrenic delusion is often characterised by the conviction of being conspired against, surveilled upon, and persecuted. In contemporary phenomenological research context, Husserl's phenomenology has been constantly employed to better clarify the "transformation of our total awareness of reality" (Jaspers, 1997, p.95). Most notably, Fuchs (2005) and Wiggins and et al., (1990) argue that the delusional mood can be best regarded as the

result of fundamental disturbance in the way one experiences one self and the world across time, that is, in "temporal synthesis" and "Urdoxa". In the following, I explain these technical concepts, presenting both authors' accounts. I then contest the disturbance claim regarding temporal synthesis and Urdoxa. Afterwards, I chart out an alternative avenue for providing a more nuanced account that can accommodate delusional mood *experience.*

As discussed in detail in the previous chapter, temporal synthesis, in essence, refers to the automatic, self-intending feature[74] of the present consciousness which constitutes the enduring identity of a given object and of one self across time (Wiggins et al., 1990, p. 26-27). To take the current perception as an example, the basic idea here is that, in every present moment, one's consciousness is not only aware of a given object (e.g., this computer) but also aware of (or 'retains') its own just-past consciousness. As such, one can be aware not only that this computer one perceives now is the *same* computer one perceived just before but also that it is one's consciousness that has been enduring, or that it is *me* who has been having this experience (Wiggins et al., 1990, p. 26-27). In usual perception, Wiggins and et al. suggest that this unity of identity of an object and that of self constituted by the temporal synthesis "are experienced as invariant and necessary features to our being", as "ontological features" (Wiggins et al.,1990, p.27-28).

In addition to the synthetic function of consciousness, the researchers highlight another dimension of experience which usually remains stable and goes unnoticed in everyday life case, that is, the take-for-granted belief *in* the existence of the world and one self, or as Husserl calls it, "Urdoxa" (Wiggins et al., 1990, p.26, 28; Fuchs, 2005, p.135). The researchers emphasise that such a belief is not a belief whose content can be cancelled out by some corrective experiences. Instead, it is the background belief that enables such a cancelling out (Wiggins et al., 1990, p. 25; Husserl, 1983, p.251-272). For instance, the belief one has towards the content of, say, a water bottle and its correlating attitude (in Husserlian terms, 'doxic positionality'), or the *certainty that* it is water can change to *doubting that* it is water as one starts drinking its content and tastes its fizziness. In the midst of this alteration, one nevertheless does not doubt that it is one self who has

[74] Husserl terms this consciousness directed intentionality, or the non-objectifying intentionality by which one can pre-reflectively, immediately experience the temporal coherence of one's consciousness, as 'longitudinal intentionality' (Husserl, 1991, p.391-392). In this chapter, I do not use this jargon for the sake of clarity. For its explanation, please refer to the previous chapter.

been drinking the content of the water bottle and that what one is drinking now is from the same water bottle one was just drinking from. Against the backdrop of this unquestioned certainty, the earlier positionality one took (the certainty that it is water) can be altered with respect to corrective experiences (that the same "it" is not water but soda). In other words, the unity of identity of object and oneself constituted by the temporal synthesis, and the absolute certainty one takes in such features, Urdoxa, remains invariant and must be so for doxic positionality to alter.

Employing the above understanding, Wiggins and his colleagues argue that the initial stage of schizophrenia involves an alteration in what usually remains unaltered and invariant: temporal synthesis and Urdoxa (Wiggins et al., 1990, p.28). As a result of the disturbance in the temporal synthesis, the researchers claim that "objects and myself may appear splintered, inchoate, and fragmented" (Wiggins et al., 1990, p. 29). A patient of Chapman, describing this experience of fragmentation and disunity, writes: "Everything I see is split up. It's like a photograph that's torn to bits and put together again" (Chapman, 1966, p.229). As the unity of identity of an object and self become unstable, so too does the Urdoxa. In this state, "the very being of the world and self", the researchers argue, becomes "dubious" and "uncertain" (Wiggins et al., 1990, p.30), eliciting the atmospheric feeling the atmospheric feeling that "the reality in its entirety, including his or herself, is fundamentally different, bewildering, dubious or strange" (Wiggins et al, 1990, p.30, 28)

The splintering of an object phenomenon emphasised by Wiggins and et al in the analysis of the delusional mood contrasts with other experiential abnormality studied by Fuchs, namely the loss of the determinate, familiar meaning of an object. Similar to Wiggins and et al.'s proposal, Fuchs suggests that our perception of an object involves multiple mental processes that are associated into a unity by the temporal synthesis (Fuchs, 2005, p.134). In contrast to Wiggins et al., Fuchs, however, emphasises the "gnostic" or "cognitive" aspect of the mental processes synthesised by temporal synthesis, that is, their active "meaning bestowing" aspect and prefers to call these synthesised mental processes as "synthetic intentionality" (Fuchs, 2005, 134). By highlighting this meaning giving aspect of perception, Fuchs aims to suggest that our perception actively means the object itself. So that, say, when we see a table, we can see it *as* a table that matters to us, as an object that one can sit at and prepare a meal on (Fuchs, 2005, p.134-135). Without this synthetic intentionality, which is continuously unified by temporal synthesis and

actively means the object itself, Urdoxa, or "the normal perceptual belief in the existence of the world and self", "would be shattered" (Fuchs, 2005, p. 135). At the onset of schizophrenia, Fuchs argues that the temporal synthesis is "seriously disturbed" to the point of its "destruction" or "fundamental disintegration", such that the patient's synthetic intentionality can no longer mean the object itself. (Fuchs, 2005, p.136). As a result, an object is given to the patient not only in its fragmented aspects but also as meaningless "images", "surfaces". In this state, "[the patient] does not know any more 'what it is all about, why the things he encounters are here at all, and what to do with them" and the determinate, familiar meaning of an object "remains arbitrary and abstract" (Fuchs, 2005, p.136). Due to the radical disturbance in temporal synthesis, Fuchs suggests that *Urdoxa* is seriously disturbed, eliciting the pervasive sense of uncanniness and unrealness of the world typical of the delusional mood (Fuchs, 2005, p. 136).

In short, Fuchs and Wiggins et al. identify the disturbance in temporal synthesis and Urdoxa as the structural disturbance that underpins the emergence of delusional mood. At first glance, the researchers' use of Husserl's concept of temporal synthesis seems well motivated. It is intuitive to conceptualise the splintering of an object phenomenon typical of delusional mood as the result of a radical disturbance in what usually constitutes its unity: temporal synthesis. Further, given temporal synthesis constitutes the ontological features of the world of experience and one self, it follows that its radical disturbance can shake the fundamental belief in the existence of the world and one self, or Urdoxa -- thereby eliciting the global sense of suspicion and ontological doubt typical of delusional mood. Although I have focused specifically on Fuchs' and Wiggins et al.'s account here, the disturbance claims with regards to the temporal synthesis and Urdoxa is a widely accepted view. As detailed in the previous chapter, Louis A. Sass, Elizabeth Pienkos (2013b), and Giovanni Stanghellni and his colleagues (2016) have proposed that the initial stage of schizophrenia involves a "total break down" (Stanghellini et al., 2016, p. 49) or "collapse" (Sass & Pienkos, 2013b, p.140) in temporal synthesis. The researchers have proposed that such a disturbance results in the disunity of what they call "minimal self" or the basic experiential sense of existing as a self-identical subject across time, eliciting the fragmentation experience emphasised in Wiggins et al's analysis. This radical disturbance in temporal synthesis is postulated to further disturb the natural perceptual belief in the existence of the world, eliciting the above discussed atmospheric change. However, here we must reconsider this prevailing view.

§5.1.1. Temporal Synthesis and Urdoxa: Are They Disturbed?

As Wiggins and his colleagues suggest, temporal synthesis essentially designates the automatic self-intending feature of the present consciousness (Wiggins et al., 1990, p.27), intending its own temporal phases. Since the present consciousness intends *its own* temporal phases, on Husserl's account, one can immediately be aware *not only* of the temporal unity of experience *but also* of such a temporally unified experience being given to the subject as one's own, as my experience (Husserl, 1991, p.84, p. 361-363). To cut to the core, as the researchers themselves would have claimed, temporal synthesis constitutes the temporal unity of an experience *and*, in so doing, its first personal givenness as well, thereby enabling one to be aware of oneself as the very subject of one's own experience across time, or the "minimal self[75]". This is exactly the reason that Sass and Pienkos correctly claim that "the microstructure of the minimal self or first-personal givenness *just is* the structure of inner time consciousness [temporal synthesis]" (Sass & Pienkos, 2013b, p. 138). Therefore, the disturbance in the temporal synthesis *is not* a disturbance in the structure of consciousness that *only* establishes the temporal unity of an experience. The disturbance in temporal synthesis *just is* the severe attenuation, fundamental disintegration, total breakdown, or collapse in the *same* structure that *also* enables the first-personal presentation of an experience: people with schizophrenia should not have had any experience[76]. Delusional mood *experience* as such should have been impossible[77].

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[75]"Inner consciousness", in Husserl's term (Husserl, 2001, p.607).

[76]I do not exclude the possibility that temporal synthesis can be disturbed. Another much-neglected aspect of the temporal synthesis, as detailed in the previous chapter, is the affective modification carried out by retention, whereby the affective intensity of the retained just-past consciousness is constantly diminished (Husserl, 2001, p.217-221). 'Disturbance' may be attributed to affective modification as it is responsible for the temporal unity of experience, not, in its final analysis, the constitution of the formal identity of the stream of consciousness, i.e., its first-personal givenness (Husserl, 2001, p. 171, 173; Husserl, 1939/1973, p.177-178). Affective modification disruption claim may better accommodate the anomalous temporal and self experience present in schizophrenia (e.g., time stop, ante-festum, déjà vu/vécu, and time fragmentation). For a more elaborate discussion of the raised objection and its implication in the analysis of self-disorder present in schizophrenia, please refer back to the previous chapter. Concerning urdoxa alteration, what the above-mentioned researchers took to be the manifestation of urdoxa disturbance can be best understood as a disruption in habitual expectation. I discuss this shortly, in § 2.3. and 3.3.

[77] Wiggins et al. use the expression "severe weakening" to describe the disturbance of temporal synthesis. Since the present consciousness *still* intends itself, albeit weakly, it can be argued that one can be *still* aware of anomalous experience as his, *subjective* experience. As such, it can be suggested that Wiggins and et al.'s argument is immune from the objection I raise. However, as the researchers have argued, on Husserl's account, a.) temporal synthesis constitutes the temporal unity of an experience *and* its first-personal giveness (Wiggins et al., 1990, p.27). And schizophrenic temporal experience, as the researchers have

Moreover, 'Urdoxa', or the passive, taken-for-granted belief in the existence of the world and one self, seems to remain undisturbed in the delusional mood. Consider the following vignette of Conrad:

> He got a peculiar feeling that "something was in the air"; what it was, he could not say [...] Suddenly, he felt that he was supposed to play some "role" during the night; perhaps his peers would come behind him and stamp him with a hammer and sickle. So he stayed alert in his bed, watching its immediate surroundings (Conrad, 1958, p. 8-9, as translated in Bovet & Parnas, 1993, p.586).

Had it been that Urdoxa was disturbed — the primary belief upon which the doxic positionality *can* alter as the researchers have claimed — nothing should have been doubted nor affirmed. However, as the self-report indicates, although Karl cannot determine what exactly it is that has changed thus expressing the kind of 'dubiousness' and 'uncertainty' the researchers identified, he is *certain that* something is off in the air and something is going to happen to him. The implication being that Urdoxa still operates as the foundational belief in the existence of the world and oneself, providing a background sense that that the world and oneself *exist*. As such, Karl *can* affirm that something *about his surroundings* has changed and something is going to happen *to him.* Even in the case where the existence of the world and one self is doubted, this doubt has to presuppose the certainty in being. If one has no certainty in the existence of the world and self whatsoever, or if Urdoxa is shattered, one would not be able to doubt their existence. There would be nothing to be doubtful *of.* In other words, the ontological doubt, or "uncertainty" and "dubiousness" of the world present in delusional mood, necessitates the preservation of ontological certainty, that is, the certainty in being: Urdoxa.

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claimed, is the kind of experience wherein one can no longer experience the present experience "as having arisen" arisen from its earlier phase and "as bout to give way to oncoming future intending" (Wiggins et al., 1990, p.32). In short, b.) schizophrenic temporal experience is characterised with the loss of temporal unity. Given a.) and b.), we are liable to conclude that it is nothing but the temporal synthesis that is disturbed in the case of schizophrenia. That is, again, the structure of consciousness responsible for both the constitution of temporal unity of experience *and* its first-personal giveness. Therefore, its disturbance claim leads to the conclusion that schizophrenic temporal experience is impossible. *One* way of preempting the objection I raise is to revise the a.) and make a conceptual distinction between the temporal and affective modifications in temporal synthesis. I did so in the previous chapter and provided a *provisional* analysis that can better accommodate schizophrenic temporal experience.

To clarify, my argument is not that the people with schizophrenia do not have the above discussed experiential abnormalities characteristic of delusional mood. I am not making the following argument:

1. Temporal synthesis and Urdoxa are not disturbed.
2. Therefore, people with schizophrenia cannot have anomalous experiences characteric of delusional mood.

I am arguing the other way around:

1. People with schizophrenia have those anomalous experiences characteristic of the delusional mood.
2. Therefore, the precondition of having an experience, that is, temporal synthesis, is not disturbed.

Specifically, with regards to the atmospheric change involved in the delusional mood, one can still affirm with certitude that something about their world has changed and something is going to happen to them. Therefore, the precondition of such an affirmation, Urdoxa, is not disturbed. My argument is levelled at the thus far provided a phenomenological explanation of the delusional mood— the claim that the disturbance in temporal synthesis and Urdoxa underpins its emergence. not at its explanandum, as this phenomenological explanation is too radical to accommodate the delusion mood *experience*.

As discussed in detail in the previous chapter, this particular difficulty involved with making a disturbance claim regarding temporal synthesis arises from Husserl's own construal of temporal synthesis as the formal synthesis which associates the temporal form of experience, without which no coherent-and-subjective experience is possible (Husserl, 2001b, p. 273). As the 'formal' temporal synthesis, on Husserl's phenomenology, it is the most primary and general synthesis that is "the basic, essential conditions of the possibility of subjectivity itself" (Husserl 2001b,p. 169, 273). For the present purpose of argument, we should here, however, acknowledge that Husserl's account of temporal synthesis and Urdoxa was only the first yet fundamental step

towards his systematic inquiry into human subjectivity (Husserl, 2001b, p.170-171). They take the "A" of the "ABCs" of phenomenology, without which no subjective experience as such is possible. In contrast to the emphasis laid on the temporal form of experience, in the "BCs"[78] of his phenomenology, so to say, Husserl concerns with "the syntheses concerning the content that extends *beyond* a transcendental synthesis of time" (Husserl, 2001b, p.171; italics added), i.e., affective syntheses. Briefly put, these associations enable one to perceive an object against the backdrop of its encompassing context and interact with the world as a historical subject, as a subject whose past experiential life constantly informs and contextualises one's life and imbues it with habitual expectation. Going back to the dialectic of the argument, since those associations are primarily concerned with the association of experiential content, not the temporal form of experience, their alteration would not necessarily implicate the impossibility of subjective experience. Instead, it would implicate a certain alteration in the affective dimension, that is to say, in the way one finds the world as a living, historical subject. Therefore, it would provide us a new avenue of explaining the delusional mood, without having to posit that Urdoxa and temporal synthesis, which are the precondition of having an experience, are fundamentally disturbed.

Approaching delusional mood from its affective dimension can further help us clarify the nature of the peculiar affective salience experience so often mentioned in both phenomenological and neurobiological analyses of the delusional mood (Conrad,1958; Mattusek,1987; Jaspers, 1997; Sass & Byrom, 2015; Kapur, 2003). This experience refers to the state in which insignificant details of one's surroundings become conspicuously salient, eliciting the feeling that somehow everything "turns around" or "looks at" an afflicted individual (Conrad, 1958, p.161; as translated in Mishara, 2010, p. 10). By employing the concept of affective syntheses, I aim to illuminate the underlying structure of such an experiential abnormality and map out how its structural alteration can further implicate the above-discussed notable characteristics of the delusional mood. To carry out this task, in the following I discuss the conceptual tool necessary for the analysis of the delusional mood: affective syntheses.

[78]In accepted terms, "genetic phenomenology".

§5.2. Affective Syntheses Overview

Affective syntheses can be categorised into primordial, reproductive, and anticipatory association[79]. In essence, primordial association is responsible for the unity formation of sense data and object constitution. Reproductive association enables the lived past experience of a subject to constantly inform and contextualise the present perception of a subject. Anticipatory association, as founded upon reproductive association, establishes habitual expectation that guides one's everyday life interaction with the world. In the following, I detail these syntheses and glean the following two structural moments of consciousness from the discussion of primordial association and reproductive association: affective repression and affective propagation. The first will be necessary for the inquiry into the splintering of an object phenomenon and the bewildering, enigmatic manifestation of the world, the latter for the loss of the determinate, familiar meaning of an object and the global sense of uncanniness and the intoxicated anticipation that "something" is going to happen.

§5.2.1. Primordial Association

As a type of experiential content association, primordial association is responsible for the unity formation of 'what' one primarily experiences through one's bodily organs, i.e., sensory

[79]In this chapter, these associations bear the title of "affective syntheses" because they function affectively (Husserl, 2001b, p.213-214, 420-421). As I detail it soon, these associations can constitute what they constitute only through affective propagation and affective repression. Further, on Husesrl's account, these associations, in essence, refer to the ideal, eidetic regularity our consciousness follows without which the world cannot appear itself in the way it does with its meaning. In short, these associations are the constitutive dimension of the world we inhabit.

data[80], and establishes the phenomenon of "affection" (Husserl, 2001b, p.176-196) [81]. As opposed to the everyday life usage of the term affection suggests, on Husserl's account, it does not strictly refer to emotion but the intrinsic impressional, receptive character of experience. In Husserl's term, "By affection we understand the allure given to consciousness the peculiar pull that an object [immanent sense data[82]] given to consciousness exercises on the ego" (Husserl, 2001b, p.196). Affection is a term reserved to designate the constant interaction between the "alluring" or

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[80]Husserl designs a technical term to mean sensory data or sensuous experience in general, i.e., hyle or hyletic experience (hyle: in Greek, stuff or matter) (Husserl, 1983, pp.203-204;§85). One of the reasons for this proposal is that, for Husserl, sense data, understood as the quality of a perceived object, is already a fully constituted object. However, his transcendental analysis aims at clarifying how exactly it is that such a constitution is possible from the beginning. To stick to the above example, his analysis is motivated by this kind of question: What necessarily has to be the case for one to a.) perceive a car, b.) abstract its 'redness', c.) apprehend it as a particular type of sense data, d.) attribute it to the particular perceived car, and e.) across time? Answering this kind of question with 'sense-data', which is already a constituted object, would defeat the purpose of his transcendental investigation. As such, he coined the term 'hyle' or 'hyletic experience' to mean the sensory experiences of the 'foreign matter' originating from the world whose appearance into a fully fledged object (e.g., 'the redness of a car outside', etc.) requires an additional cognitive act (Husserl, 1983, p.203-204;§85). To be very specific, hyle or hyletic experience refers to the pre-reflective, pre-cognitive receptive sensuous or sensory experience (e.g., the colour of a car before being apprehended as the redness of a particular car outside, the general acoustic of this building before being apprehended as the footstep of my neighbour, the general bodily discomfort before being apprehended as the back pain, etc.). In this chapter, by 'sense-data' or 'immanent sense data', I specifically mean hyle or hyletic experience. I do not use this technical term as it would have required me to introduce another strand of clarification and justification that has no relevance to the argument I wish to make.

[81]In a little bit more detail, primordial association refers to a regularity our sensory experiences follows, whereby a similar type of sense data (acoustic with acoustic, tactile with tactile, visual with viasal) is associated into a unity of partial commonality and contrast (Husserl, 2001b, p.175). For instance, the sound of someone coming into this room is experienced in its unity with the sound of a passing car outside, that is, as belonging to the same kind of experiential modality (i.e., acoustic). And, at the same time, the sound of someone coming into this room (call it S1) is experienced in contrast with the sound of a passing car outside (call it S2), in the sense that, S1 is experienced as having a different physical point of origin, different level of intensity, frequency, etc. than S2. It is against the backdrop of this contrast, Husserl argues, a senorial unity acquires relative prominence and pull oneself into it, thereby eliciting the state of affection (Husserl, 2001b, p.175-177). Although detailing primordial association with respect to its principle would be important to clarify Husserl's account of affection and sense data, its thorough exegetical analysis simply goes over the current purpose of the chapter.

[82]In his later work, Husserl cautions that the "object" here is not used in its proper sense. For Husserl, an object as such, that is, a phenomenologically rich object that presents itself in its identity and with its meaning, (eg., an object *as* a passing car outside, as *this* laptop I can write with, etc.), is constituted by the active, cognitive apprehension of immanent sensorial unity (Husserl, 1983, p.85). However, the target of his inquiry for primordial association is not yet a fully fledged phenomenologically rich object but the precognitive, passive receptive aspect of the self, or its state of being as always affected by something that is foreign to itself, or hyle.In other words, affection is a relational concept that designates the essential correlation between the affected self and the "foreign-to-the-I" affectant, or hyletic unity.

"pulling" sensorial unity and the consciousness "pulled" into and "turned towards" it (Husserl, 2001b, p.196). By construing sense data as an affective sensorial unity, Husserl highlights that perception of an object always involves an interplay between the sensorial unity that passively solicits one's attention and the consciousness that actively responds to and turns towards such an attraction. Husserl contends that it is through such an interplay what makes one to turn towards, an affectively prominent sound can be given to oneself as a concrete, phenomenologically rich object, say, *as* the sound *of* a passing car outside (Husserl, 2001b, p.210). In short, affection is the precondition for the perception of an object. In what follows, I contrast two types of prominences of sensorial unity which pull us in (henceforth affective pull) and identify the phenomenon of "affective repression". This will be necessary for our analysis of the splintering of an object phenomenon and the bewildering, enigmatic manifestation of the world.

The first type of affective pull is the one whose relative intensity is strong enough to trigger the actual state of affection or make one turn towards it and grasp it as the direct object of perception (Husserl, 2001b, p.210; Husserl, 1973, p.108). A screaming sound, for instance, in the context of the general acoustic context of this building would belong to this type. In contrast, the second type of affective pull is the one whose relative intensity is not strong enough to yield the actual affection. Say, the general acoustics of this building, the smell of this room, the colour of this desk etc. would belong to this type. Since the intensity of these pulls is weak compared to that of screaming and thus does not trigger actual affection, they are not apprehended as the direct object of perception[83]. Instead, Husserl suggests that they are immediately experienced in their sensible organisation as the surrounding environment of the apprehended particular object (Husserl, 2001b, p.196-197, 201-203).

Important to our analysis, Husserl argues that what determines the intensity of affective pull is nothing but the dynamic interplay between the pulls themselves (Husserl, 2001b, p.197-

[83]To be specific, Husserl distinguishes two types of affective pull based on its relative intensity (Husserl, 2001b, p.197). The first affective pull is the one whose relative intensity is strong enough to elicit 'the actual state of affection'. This state refers nothing but to the one discussed above, wherein one actively turns towards and attentively grasps an affectively prominent object. The second type is the one whose intensity is not strong enough in the present moment but can be so in the right conditions. This type of pull exists as "tendency towards affection" or "affective tendencies" and belongs to the realm of pre-affective state, e.g., the sound of passing cars outside, the acoustics of this building, the tactile sensation of my hat covering my head, etc.

198). The intensity of the screaming sound is stronger than that of other pulls not because its intrinsic nature determines it to be so. Instead, it *can be* stronger than that of other pulls because, as it starts to become prominent, it represses the intensity of other pulls that has thus far attracted one's attention (Husserl, 2001b, p.197). As such, when I hear someone screaming, I can immediately (and quite literally) turn my head towards it without having to have my attention kept being captivated by this computer. Generally put, it is thanks to such an affective repression, when a relatively prominent affective pull triggers actual affection and enables one to attentively grasp it as an object, the intensity of other pulls can be sensibly regulated. So that, to use an everyday life example, when I turn towards this computer and apprehend it as the direct object of my perception, the intensity of other pulls (e.g., that of its surrounding object, the lighting of this room, the sound of a passing car outside, etc.) do not all become prominent but experienced as the general background context of this computer. Therefore, a certain alteration in the affective repression would implicate dysregulation in the affective prominence that solicits one's attention. This dysregulation would entail the prominence of what usually remains unnoticed and a certain alteration in the experiential distinction between perceived particular object and its encompassing context.

§5.2.2. Reproductive Association

Reproductive association, in essence, enables a subject's past experiential life to constantly inform and contextualise his present experiential life. In the following, I discuss this association with respect to its structural moment in virtue of which the past experience can be implied in the present experience, i.e., affective propagation. This will be necessary for our analysis of the loss of the meaning of an object and the pervasive sense of uncanniness of the world.

In the above, I have suggested that in the state of actual affection we turn towards the pull whose prominence is relatively strong. Husserl suggests that when one turns towards the pull and attentively grasps it as an object, one gets to know about the grasped object "more closely" and also of our self:

> It is a pull that is relaxed when the ego turns toward it attentively, and progress from here, striving towards self-giving intuition, disclosing more and more of the

self and the object, this striving towards an aspect of knowledge, towards a precise view of the object (Husserl, 2001b, p.196).

The knowledge acquired from this relaxation of the pull (or turning towards the affective pull) is the everyday life, taken-for-granted self and object knowledge. The knowledge that, to put it in the broadest sense, I have a body capable of responding to the affective pull exercised by an object and that an object given to me is an object I can respond to and engage with. The affectively prominent present experience and the knowledge acquired therein, Husserl suggests, gradually lose their intensity as they slip away into the past and constitute the historicity of a subject, or "the affective past horizon[84]" (Husserl, 2001b, p.204).

Relevant to our analysis, Husserl argues that the affective past horizon can inform and contextualise the present perception via affective propagation that constantly emanates from the present to the similar past experience (Husserl, 2001b, p.189). The basic idea here is that the affective pull that triggers actual affection does not simply attract one's attention to the object perceived in the present moment. Instead, it also travels towards the affective past horizon and calls to attention or "awakens" the similar past experience whose affective intensity is lost[85] (Husserl, 2001b, p.222-224). To take the present perception as an example, the affective pull of this computer propagates towards the sedimented similar past experience wherein I perceived and used a computer before. Through such propagation, Husserl argues, the past experience and the common-sense knowledge acquired therein can inform (or "impart" or "sketch in") its determinate,

[84] Retention plays an important role in constituting the historicity of a subject. As discussed in the previous chapter, retention not only retains the just-past consciousness but also gradually decreases its affective intensity. In its diminishment of affective intensity, Husserl suggests, retention preserves or sediments the specific sense acquired from the retained past experience. Describing this sedimentation process, Husserl writes: "[...] every accomplishment of sense or of the object becomes sedimented in the realm of the dead, or rather, dormant horizontal sphere. While at the heading, the living process receives new, original life, at the feet, everything that is, as it were, in the final acquisition of the retentional synthesis, becomes steadily sedimented." (Husserl, 2001b, p.227). In other words, for Husserl, the past is not a realm of pure non-affective nothing. It is a "dormant horizontal sphere" or "affective past horizon" (Husserl, 2001b, p.204) that can be rekindled by the affective force emanating from the living present.

[85] Affective propagation accordingly does not refer to an occasional event wherein one becomes explicitly conscious of a similar past experience based on the present experience. In Husserl's term, "Awakening does not imply an explicit process of bringing to intuition" (Husserl, 2001b, p. 405-406) and "within every living present affection are constantly at work beyond themselves; we always find affective awakenings, that is, associations" (Husserl, 2001b, p.35). I will detail this claim soon.

articulate sense to the present perception (Husserl, 2001b, p.44, 224). So that, to stick to the example, this computer can appear to me as an object with its determinate, familiar meaning, as an object I can use to type this paper with. Husserl contends that this affective propagation is "constantly at work" (Husserl, 2001b, p.206) and enables the past experiences of a subject to be always-already "implied in the background consciousness, in the non-living form" (Husserl, 2001b, p.228), thereby providing a framework of determinate sense and familiarity to the present experiential life. Therefore, a certain alteration in affective propagation would implicate a change in the meaning manifestation of an object and the way one perceives the world as a familiar place.

§5.2.3. Anticipatory Association

Anticipatory association imbues the present perceptual experience with habitual expectations, enabling one to anticipate with a determinate sense how the present perception and the perceptual object will continue to unfold in the following moment (Husserl, 2001b, p.139-140, 424). Habitual expectation essentially refers to the anticipatory aspect of our present perception that takes the form of certainty. For instance, when I perceive a chair, I anticipate with *certainty that* if I turn the chair around I will be able to see its back, that if I attempt to sit on the chair my bodily capacity will not fail and that the chair will be used as an object I can sit on, etc. This anticipation involved in the present perception can take such a form of certainty because, simply put, I have used chairs for many years. To put it otherwise, the determinate, articulate sense the anticipatory aspect of our perception has, the anticipatory *certainty that* I will be able to sit on the chair, is the one imparted from the affective past horizon via affective propagation (Husserl, 2001b, p.424, 235). Therefore, a certain alteration in the affective propagation, in virtue of which the past experience can inform and contextualise the living present, would also implicate a radical alteration in the anticipatory style of perception.

§5.2.4. Summary

So far, I have examined three different types of affective syntheses with respect to their structural moments: affective repression and affective propagation. In essence, affective repression enables one to turn towards a relatively prominent affective pull and attentively grasp it as an object with respect to its surrounding context. Affective propagation, in turn, enables one to turn towards an affectively prominent pull as a historical subject, whose past experiences constantly

provide a framework of determinate sense and familiarity to the present experiential life and establishes habitual expectation. Below, I employ these concepts to provide a detailed phenomenological account of the delusional mood. I argue that firstly in the state of the delusional mood, there occurs the failure of affective repression whereby every experienced feature of an object and objects themselves become prominent. I demonstrate how this affective dysregulation experience can manifest in the form of the splintering of an object phenomenon and the bewildering enigmatic manifestation of the world. Afterwards, I argue that the failure of affective repression adds something entirely new or bestows an alien affective prominence to the present experiential life that cannot be adequately accommodated by the affective past horizon. I then show how this phenomenological abnormality manifests itself as the loss of the determinate, familiar meaning of an object and the pervasive sense of uncanniness of the world and that of intoxicated anticipation. I conclude by relating this finding to the neurobiological explanation of the delusional mood, namely aberrant salience hypothesis, and sketch out a possible way towards the mutual enlightenment of both approaches.

§5.3.1. Delusional Mood: The Bewildering, Enigmatic Manifestation of the World

Let us begin with the splintering of an object phenomenon. Consider the following self-reports. A patient of Chapman writes: "If I look at my watch, I see the watch, watch strap, face, hands, and so on, then I have to get to put these together into one piece" (Chapman, 1966, p.229). Renee reports a similar sort of experience: "For I saw the individual features of her face, the teeth, then the nose, then the cheeks, the one eye and the other" (Sechehaye, 1970, p. 51). In the above discussion of affective repression, I have suggested that in everyday life case, if, say, the colour of a door attracts one's attention and thus enables one to turn towards and attentively grasp it as the physical quality *of* the door, that colour normally represses the prominence of other experienced features of the door. So that its other features, say, the contour, its size, etc., do not all become prominent and all attentively grasped as individual objects of perception. However, in the state of delusional mood, the affectively prominent experienced features of an object seem to no longer *repress but bolster* the prominence of other experienced features[86]. Kapur details such an

[86]In non-phenomenological terms, this disturbance may correspond to selective attention impairment. Selective attention involves the operation that "prioritizes the process of a subset of available sensory inputs while *suppressing* the processing of other inputs" (Gold et al., 2018, p.1227; italics added). Given, in the instance of delusional mood, the usually unattended features of an object and/or its surrounding become

experience with the following self-reports: “my senses were sharpened. I became fascinated by the *little insignificant things around me*”, “Sights and sounds possessed a *keenness* that he had never experienced before”, “my senses seem *alive… Things seemed clearcut,* I noticed things that I had never noticed before”, “It was as if parts of my brain awoke, which had been dormant” (Kapur, 2003, p.15; italics added). In other words, as all of the experienced features of a given object become prominent, an afflicted individual feels as though one’s sensory experience is “alive”, “keen”, “heightened”, and those affectively prominent individual features are, in turn, attentively grasped and perceived as individuated and distinct parts of a given object, eliciting the splintering of an object phenomenon.

This affective repression failure may further implicate perceptual field disturbance whereby perceived surroundings look fragmented and ‘turned towards’ an afflicted individual. If affective repression fails such that an affectively prominent object no longer represses but bolster the prominence of the surrounding objects, the surrounding objects will be no longer perceived as such, as constituting the background context of a perceived particular object. Instead, they will be perceived as a set of individual objects in themselves. Recounting this kind of experience, Renee writes: “I heard the street noises—a trolley passing, people talking, a horse neighing, a horn sounding, each detached, immovable, separated from its source, without meaning” (Sechehaye, 1970, p.29). Mattusek’s patient similarly reports: “I only saw fragments: a few people, a kiosk, a house [...] They did not stand together in an overall context, and I saw them as meaningless details” (Mattusek, 1987, p.92). In other words, as every object that constitutes one’s perceptual field becomes affectively prominent, those objects are, in turn, perceived as a collection of individual objects in itself, isolated, cut off from each other, no longer standing in meaningful relation to one another (Mattusek, 1987, p.92). Correlatively, as every object that constitutes one’s perceptual field becomes affectively prominent and invites one’s attentive regards, an afflicted individual simultaneously feels as though everything somehow ‘turns around’ or ‘looks at’ him/her. Renee, recounting on the encounter she had with her friend in which her friend’s individual facial features captivated her attention, writes that she “sees” not only her friend’s “brown eyes” but also her “shining white teeth looking at” her (Sechehaye,1970, p.37). Detailing this sort of experience,

prominent, the involved attentional impairment may be specified as a dysfunction in the bottom-up attentional control (Gold et al., 2018; Carr & Wale, 1986; Hemsley, 1975).

Conrad documents that one of his patients feels wherever his "glance falls, every "component of his experiential field" appears to stand in a special relation to him and "everything becomes conspicuously salient" (Conrad, 1958, p. 161; as translated in Mishara, 2010, p.10). In other words, correlative to the perceptual object abnormality wherein certain aspects of an object (or objects) acquire unusual prominence, there belongs a subjective side or perceptual act abnormality wherein one's attention is involuntarily captivated by such a prominence and feels as though something significant is weighted by it — as opposed to simply ignoring such prominence[87].

In sum, in the state of delusional mood, there seems to occur the failure of affective repression whereby an affectively prominent feature of a given object or an object itself no longer represses but bolsters the prominence of other affective pulls. The prominence of which, in turn, is attentively grasped and perceived as distinct, accentuated features of a given object (for the splintering of an object phenomenon) and/or as an object in itself, isolated from its background context (for the perceptual field disturbance). And that same affective prominence is felt by an afflicted individual as if one has become the centre of the attention of the world. The world, therefore, confronts an afflicted individual as an enigmatic place that constantly invites and allures one's attentive regards.

§5.3.2. Delusional Mood: The Loss of the Determinate, Familiar Meaning of an Object

The above-discussed disturbance in perceiving an object and its surrounding context has been known to accompany the loss of the meaning of an object. The perplexing characteristic of this meaning disturbance is that an afflicted individual can still identify a perceived object, say a cup as a "cup", and recall and articulate its practical significance, that it is an object to drink from (Fuchs, 2003, p.136). However, at the same time, afflicted individuals report the unfamiliarity and the loss of its meaning:

[87]This correlative subjective side abnormality has been described as "prolonged gazing" by Mattusek (1987, p.93) and, most recently, "hype-reflexivity" by Sass and Byrom (Sass & Byrom, 2015, p.161). If the above analysis is correct, it can be reasonably postulated that such a subjective side abnormality and the perceptual object abnormality are two sides of the same coin. They are distinct interdependent moments of one and the same modal alteration, i.e., affective repression failure. I detailed this claim in the next chapter, specifically, in "Decontextualisation and Hyper-reflexivity" section.

> I attempted to escape their hold by calling out their names. I said, "chair, jug, table, it is a chair" [...] I saw things, smooth as metal, so cut off, so detached from each other, so illuminated and tense that they filled me with terror. When, for example, I looked at a chair or a jug, I thought of not their use or function-- a jug as something to hold and milk, a chair not as something to sit in-- but as having lost their meanings, functions, and their names, they become "things" and began to take on their life, to exist (Sechehaye, 1970, p. 55-56).

I have argued above that the failure of affective repression intensifies the prominence of every experienced feature of a given object and/or objects themselves, such that each feature is individually apprehended as accentuated parts of the perceived object and/or as individual objects themselves that seem isolated from its surrounding context. This affective prominence dysregulation seems to underpin the above-described anomalous experience whereby Renee saw objects as "alive" and "saw things, smooth as metal, so cut off, so detached from each other, so illuminated and tense". Let us here further specify the nature of the failure of affective repression to systematically account for the meaning disturbance.

Firstly, as the self-reports indicate, the failure of affective repression does not split a perceived object into two different types: one that is given in its unity and the other that is given in its fragmentation. Had such been the case, the affectively prominent parts of an object would have been perceived as a collection of distinct objects in their own right, not as fragmentations *of* an object. Although Renee reports that objects appeared to her as cut off from one another, they were nevertheless still perceived as a single, distinct object. Even when she was describing the fragmentation experience she still saw "the teeth, the nose, the cheeks, the one eye and the other" as those *of* her friend's face. Similarly, Chapman's patient could still identify the fragmented aspects of a watch, as "watch strap", "face", "hands", and so on. In other words, the apprehended individual features of an object are still perceived as parts of a single object, albeit accentuated and distinct. The implication being that for any given object(s), the failure of affective repression intensifies the affective prominence of the experienced features of one and the same object, and those prominent features are apprehended as individuated and accentuated aspects *of* a single object.

Secondly, in §2.3. I argued that the past experience of a subject and the commonsensical, everyday life knowledge acquired therein is sedimented into the affective past horizon and constantly informs and contextualises the subject's present perception. This is made possible by the affective propagation that continuously emanates from the present perception to the sedimented similar past experience. Similarly, in the state of delusional mood, the affective force of the perception that presents a given object as a single object, say a cup as *a* cup, still propagates towards the affective past horizon and awakens the similar past experience and the knowledge acquired therein, thereby enabling one to perceive it as a familiar object whose name one can recall and articulate its practical significance. However, the affective force of the *same* perception that presents the *same* object *at its intense vivacity* has no similar past experience to propagate towards. Within the affective past horizon, there just is no similar past experience in which every experienced feature of an object had become prominent and imposed its tantalizing vivacity on the subject. Recall: "my senses were sharpened. I *became* fascinated by the little significant things around me", "Sights and sounds possessed a keenness that *he had never experienced before*", "my senses seem alive. Things seemed clear-cut, *I noticed things that I had never noticed before*", "It was as if parts of my brain awoke, *which had been dormant*" (Kapur, 2003, p.15; italics added). In other words, affective repression failure adds something *entirely new* or bestows an *alien* affective prominence to the living present that cannot be adequately accommodated by the affective past horizon. Given the affective propagation fails with respect to this alien prominence exercised by the very same object that appears familiar, it follows that the perceived object will also paradoxically appear to oneself as an unfamiliar object, as an object whose precise meaning remains to be determined. In simple terms, the problem that underlies the meaning disturbance is not that an afflicted individual completely forgets the name, or the everyday life use of a given object. A person knows what a given object is, say, a cup is an object to drink from. The problem is that an afflicted individual perceives *alien something more* in a given familiar object that simply goes beyond the scope of what one already knows about the object.

This may closely correspond to David Hemsley's cognitive model of schizophrenia (1986, 2005a, 2005b). As opposed to the total loss of past experiences and previously acquired perceptual knowledge, this model postulates that in the early stage of schizophrenia, impairment occurs in the "rapid and automatic assessment of the significance or lack of significance" (Hemsely, 2005a, p.979), eliciting the above-discussed anomalous experience whereby every insignificant detail of

one's surrounding becomes conspicuously salient. It has been further postulated that such an alien experience cannot be adequately processed by the stored memories of past experiences and perceptual knowledge (Hemsley, 1986, p. 54; Hemsley, 2005a, p. 979; Hemsley, 2005b, p.48), leading to the experience wherein a familiar, everyday life object appear unfamiliar, as having acquired "properties different from those that exist when the normal contextual influences are operative" (Hemsley, 2005b, p.47).

To put it in phenomenological terms, the affective force of the present perception still propagates towards the affective past horizon and awakens the past experience and previously acquired knowledge. However, the awakened past experience and knowledge, which still enable one to perceive a given object, cannot adequately inform and contextualise the peculiar affective prominence exercised by the object. Bluntly put, the perceptual knowledge that "a cup is an object to drink from" cannot explain just exactly why it is that every individual feature of a perceived cup, its lip shape, colour, crack, handle, etc. have become prominent and captivate one's attention. Therefore, a perceived object not only appears to oneself as a familiar object whose name and practical significance one can recall and articulate, as "a chair", "a jug", "a table", etc. The same object also simultaneously appears as "alive", "smooth as metal, so cut off, so detached from each other so illuminate and tense" whose precise meaning is yet-to-be-determined, as an indeterminate, unfamiliar object. With this understanding in mind, let us now move on to the final characteristic of the delusional mood, the global sense of uncanniness and intoxicated anticipation.

§5.3.3. Delusional Mood: The Pervasive Sense of Uncanniness and Intoxicated Anticipation

Consider the following vignette of Jaspers:

> Something must be going on; the world is changing, a new era is starting. Lights are bewitched and will not burn [...] the house-signs are crooked, the streets look suspicious; everything happens so quickly. The dog scratches oddly at the door. "I noticed particularly" is the constant remark these patients make, though they cannot say why they take such a particular note of things nor what it is they suspect (Jaspers, 1997, p.100).

In §3.1, I argued that the failure of affective repression underpins the affective dysregulation experience wherein every object that constitutes one's perceptual field becomes prominent and allures one's attention to its individual features and to the individual object itself. In the case of Jaspers' patient, this affective dysregulation manifests itself in the form of constantly noticing every detail of one's surroundings (hence the constant remark of "I noticed particularly"). As the self-reports indicate in this state, one can still perceive a given object as an object as such, a dog as a dog, a candle as a candle, etc., and one's surroundings as having been perceived before but somewhat different. Meaning, the affective force of the present perception still propagates towards the past experiences whereby one perceived given objects and their surroundings. In the above, I specified that the failure of affective repression bestows an alien affective prominence to the present perception. To go back to the case of Jasper's patient, a dog or a candle *not only* appear to oneself as mundane, familiar objects *but also* as something that constantly allure one's attention to insignificant details— for the case of the dog, to the way it scratches the door, and for the candle, to its flame that seems bewitched. This 'added on' affective prominence, I have argued, cannot be adequately informed and contextualised by the awakened past lived experience and prior knowledge, hence Jasper's comment that afflicted individuals "*cannot say why* they take such a particular note of things nor what it is they suspect". In other words, the affective prominence of the perceived familiar surroundings and objects therein not only attracts one's attention to meaningless details but that very attraction or allure is felt as an unfamiliar and indeterminate phenomenon. Therefore, not only not does an afflicted individual perceive his surroundings as a familiar environment but he also simultaneously experiences that "something" is different, "something" has changed, experiencing indeterminate unfamiliarity from the very same environment he finds familiar or, by definition, uncanniness.

This affective dysregulation experience can further radically alter the anticipatory aspect of perception. In § 5.2.3, I argued that the habitual expectation that one takes for granted in everyday life interaction with the world is founded upon the subject's past experiences. To be specific, the affective propagation that emanates from the living present towards the sediment lived past experiences and perceptual knowledge acquired therein determines the content of habitual expectation to a certain extent. In simple terms, thanks to my past experiences, I anticipate not anything at all but with *certainty that*, say, the glass will be shattered if dropped, that I will see the backside of the chair if I turn it around, etc. However, if affective repression fails such that it

bestows an alien affective prominence to the living present that cannot be adequately accommodated by the affective past horizon, the content of habitual expectation will be radically underdetermined. Correlatively, as its content remains underdetermined, the perceptual expectation will no longer take the form of habitual certainty but that of dubiousness and uncertainty, hence eliciting the intoxicated anticipation or the oppressive tension that "*something*" must be going on, "*something*" is going to happen.

§5.3.4 Summary

So far, I have examined delusional mood experience from its affective dimension. In contrast to the prevailing account that zeros in on the fundamental structure of subjectivity, I have shifted the focus of inquiry to the affective nature of delusional mood. This was to provide a phenomenological account that can accommodate the intricate nature of the delusional mood without having to posit that the basic, necessary constitutive dimension or the very precondition of having an experience is broken down, collapsed, fundamentally disintegrated, or shattered. The central tenet of the proposed account is the following: the failure of affective repression underpins the experience whereby every feature of an object (or objects) becomes prominent and captivates one's attention (viz. affective dysregulation experience). This experience, as demonstrated above, underpins the characteristic features of delusional mood. Of interest, this kind of experience has been also the target phenomenon for one of the most enduring neurobiological hypotheses, i.e., aberrant salience hypothesis. In the following, I conclude by relating this finding to a neurobiological account and suggest that exchanges between these two approaches may be possible and further points to mutual enlightenment for both approaches.

§5.4. A Possible Mutual Enlightenment

Aberrant salience hypothesis (Kapur, 2003; Kapur et al., 2005) postulates that the early stage of schizophrenia involves elevated presynaptic striatal and subcortical dopamine synthesis and release capacity (Kapur & Howes, 2009, p.551). This dopaminergic dysfunction has been known to cause the "aberrant salience" phenomenon, whereby insignificant details of one's experience acquire salience and captivate one's attention (Kapur, 2003; Kapur et al., 2005). The phenomenological equivalent of which is the above-discussed affective dysregulation experience. This neurobiological account may serve to corroborate the phenomenological analysis I have put

forward by identifying the neurobiological correlate of affective repression failure as dopaminergic dysfunction. In turn, the proposed phenomenological analysis may serve to complement the hypothesis by providing a more detailed mind-level explanation of the delusional mood.

As pointed out by Mario Maj in the recent review of the hypothesis, the experiences described under the heading of aberrant salience only share a partial commonality with those described for delusional mood by Jaspers and other psychopathologists (Maj, 2013, p. 234). The aberrant salience, or as Maj terms it "heightened intensity of perception", is not the only experiential abnormality present in the delusional mood. As has been discussed so far with reference to the traditional phenomenological accounts, delusional mood is also characterised with the meaning disturbance and the global atmospheric shift (Maj, 2013, p.234). In this light, Aaron Mishara and Paolo Fusar-poli claim: "How do the dopaminergic alterations affect the creation of a "new (psychotic) world"? There remains an explanatory gap between what we know about the neurobiology of early psychosis and what we understand about its subjective psychopathological experience" (Mishara & Fusar-Poli, 2013, p.284). In simple terms, the question that has to be answered at the mind level for a more robust neurobiological explanation is: How does one go from having "heightened intensity of perception" to having a full-blown delusional mood experience? The phenomenological analysis I have advanced can help resolve this issue.

In the above, I argued that in the delusion mood there occurs the failure of affective repression whereby every experienced feature of a given object/objects become prominent, eliciting the affective dysregulation experience. In clarifying affective repression failure, I have argued that such a structural alteration bestows an alien affective prominence to the present perception that cannot be adequately accommodated by the affective past horizon. If the affective dysregulation experience can be identified with aberrant salience phenomenon, then it can be reasonably postulated that aberrant salience experience is not merely a heightened intensity of perception whereby one notices insignificant detail of one's surroundings. Instead, it is the generative disturbance that globally challenges the contextualization of the present perception with the sedimented past experience. The phenomenological abnormality of which underpins the characteristic features of the delusional mood.

If this is somewhere along the right lines, then it can be reasonably postulated that the aberrant salience experience necessarily implicates the meaning disturbance and the atmospheric change involved with the delusional mood. If this mind-level implication holds, then it may be provisionally hypothesized that the dopaminergic dysfunction causes not only aberrant salience experience but also, by transitivity, the disturbance in the meaning manifestation of an object and the atmospheric change. In neurobiological terms, the dopaminergic dysfunction in the limbic areas (to be specific, amygdala and hippocampus) can be postulated to disturb the activation of appropriate stored context material from the long-term memory (Maclean, 1970; Pankow et al., 2012) for the meaning disturbance. This long-term memory deficit may be hypothesised to further implicate the disturbance in the generation of appropriate habitual expectancies (Hemsley & Garety, 1986; Gray et al., 1991; Corlett et al., 2010) to accommodate the global atmospheric change. In such a way, the phenomenologically informed neurobiological analysis can aim for a more detailed explanation of the delusional mood. Of course, there is much more to be said, and this is only a speculative outline. However, I have attempted to show that exchanges between phenomenological and neurobiological approaches may be possible and have sketched out what these exchanges would amount to, by providing a phenomenological account of the delusional mood *experience*.

§5.5. Conclusion

In this chapter, I have provided an affective centred analysis of delusional mood. I began by challenging the prevailing account according to which a radical disturbance in temporal synthesis and Urodxa underpins the emergence of delusional mood. I contested this account on two grounds. First, temporal synthesis is the condition of possibility of subjective experience. Therefore, its radical disturbance leads to the impossibility in having delusional mood experience. Second, Urdoxa is the condition of possibility for the alteration in doxic positionality. Therefore, its disturbance does not lead to the characteristic experience of delusional mood wherein a person (*can still*) affirm something has changed, something is going to oneself. It leads to the impossibility in such an affirmation. Afterwards, I focused on the affective dimension of delusional mood experience. Employing the concept of affective repression and affective propagation, I

demonstrated how the peculiar affective salience of the world experience can implicate the notable characteristics of the delusional mood. I conceptualised its underlying core as the affective repression failure and linked it to the aberrant salience hypothesis. In doing so, I hope to have shown that the peculiar affective saliency experience plays an important role in bringing about delusional mood.

In the following chapter, I sustain my focus and clarify how such an experience may lead to the formation of primary delusions. I look to achieve two aims. The first is to clarify the formative stage of primary delusions from a phenomenological perspective. The second is to complement one of the most contending phenomenological models of schizophrenia, which has been only briefly mentioned throughout this thesis, namely, the ipseity (or minimal self) disturbance model. Let me proceed.

Ch.6 Primary Delusion and Affection

§6. Introduction

In the previous chapter, I challenged the prevailing view that the structural disturbance in temporal synthesis and Urdoxa underpins the emergence of delusional mood. I then shifted the focus of investigation from temporal synthesis and Urdoxa, which Husserl took to be the "A" of the "ABCs" of phenomenology, to the "BCs". That is to say, to the topic of affection wherein the innermost structure of human subjectivity is viewed to be in constant interplay with the allure or pull of something that is not itself (i.e., the world) and always-already conditioned by the past experiences (i.e., affective past horizon). I then gleaned two concepts from its theoretical discussion: affective repression and affective propagation. After clarifying each concept, I demonstrated how affective repression failure could underpin the various characteristic features of delusional mood and linked it to the aberrant salience hypothesis.

In this chapter, I turn my attention to the topic of the formation of primary delusion. In phenomenological literatures, primary delusion has been often conceptualised as a 'quasi-belief' or belief-like state whose defining features are 'double bookkeeping' and 'revelatory themes' (Beluer, 1924, p.392; Jaspers, 1913/1997, p.105; Sass & Byrom, 2015; Parnas & Henriksen, 2016; Feyaerts et al., 2021, p.3). As shall be detailed soon, double bookkeeping refers to the seemingly contradictory attitude wherein a person exhibits both 'incorrigible' *and* 'inconsequential' attitude towards their delusional content. Revelatory themes refers to the type of delusional content and its experiential state: primary delusions exhibit an ecastological theme, and they occur to one self as a sudden revelation. As briefly mentioned in the previous chapter, it has been argued that primary delusion often arises from the delusional mood experience (Jaspers, 1913/1997; Mattusek 1987; Conrad, 1958; Bovet & Parnas, 1993; Parans & Ratcliffe, 2013; Sass, 2014; Ratcliffe, 2013; Mishara, 2010; Mishara & Fusar-poli, 2013). In an effort to clarify the transitory stage from the delusional mood experience into primary delusion, most notably, the proponents of the ipseity disturbance model have focused on anomalous self experience present in delusional mood and proposed that such an experience underpins both the emergence of the delusional mood and primary delusions (Sass, 2014; Sass & Byrom 2015; Parnas et al., 2020; Feyaerts et al., 2021). In

this chapter, I link the affective account I provided in the previous chapter to the ipseity disturbance account. In so doing, I highlight the possibility that the current overemphasis laid in identifying anomalous self-experience present in the delusional mood could have overshadowed other possible modal alterations involved in the delusional mood experience. The alteration with which one can better accommodate the formation of primary delusion from the delusional mood experience, that is, as identified in the previous chapter, the affective repression failure and its correlating experiential abnormality, i.e., the experience of perceiving something inexplicable new from the mundane, familiar environment. I present my argument in the following order.

First, I begin by reviewing the contemporary phenomenological accounts of the formation of primary delusions. Josef Parnas, Annick Urfer-Parnas, and Helene Stephensen (2020) and Jasper Feyaerts, Mads G Henriksen, Stijn Vanheule, Inez Myin-Germeys, Louis A Sass (2021), have all recently argued that delusional mood is a kind of mental state that involves an alteration in the self-world structure, i.e., ipseity disturbance. This structural disturbance, according to the researchers, not only brings about delusional mood but also sustains its development into primary delusions. The gist of their argument is the following.

a.) Ipseity disturbance -- viz. a disturbance in the basic sense of existing as a self-identical,vital subject of one's own experience-- is present in delusional mood.

b.) Ipseity disturbance implicates the involuntary form of hyper-awareness (i.e., hyper-reflexivity).

c.) Hyper-reflexivity leads to the experiential states typical of delusional mood.

d.) The experiential states typical of delusional mood lead to primary delusions.

e.) Therefore, ipseity disturbance, by transitivity, gives rise to primary delusion.

Second, I contest its generative claim, or, to be specific, the c.). As shall be explained in detail, the researchers justify the c.) claim with the experiential evidence that hyper-reflexivity is

present in delusional mood. My wager is the following: it is one thing to say that hyper-reflexivity is present in the experiential states typical of delusional mood, and it is another thing to say that, *as such*, it leads to those states. Third, I link the affective account I provided in the previous chapter to the ipseity disturbance account. I argue that hype-reflexivity can be best understood as the complementary aspect of affective repression failure. I justify this claim throughout the analysis of delusional mood. In so doing, I shift the focus of contemporary phenomenological research from finding the traces of ipseity disturbance in delusional mood back to the delusional mood experience itself. To be precise, I bring attention to the affective experience that transpires through various characteristic features of the delusional mood, that is, the experience of perceiving something inexplicable new from the mundane, familiar environment. Fourth, I demonstrate how this experience elicits the pressing need to find a new conceptual framework of understanding oneself and the world. That is, to specify, the mode of understanding whereby one makes sense of such an alien experience with respect to oneself and the world. In so doing, I aim to provide a more coherent and detailed phenomenological account of the formation of primary delusion that can accommodate its defining features, i.e., double bookkeeping and revelatory themes. I conclude by briefly demonstrating the relevance of the affective centred account I propose in this chapter in relation to the significant development in the neurobiological research of delusion formation.

§6.1. From Delusional Mood to Primary Delusion

As mentioned in the previous chapter, delusional mood has been understood as a generative experience that leads to primary delusions. In contemporary phenomenological research, the *general* argument for clarifying the generative role of delusional mood has the following usual form. First, delusional mood is a kind of experience that involves a global shift in the way (or the 'mode') one experiences the world. Second, the change in the mode of experience is a change in the ontological dimension of the world of conscious experience, i.e., selfhood, intentionality, intersubjectivity, temporality, affection, etc. Third, primary delusion is a belief-like state or quasi-belief that reflects such an ontological alteration. Fourth, therefore, the ontological alteration involved in delusional mood gives rise to primary delusion. Take Feyaerts and et al., (2021) analysis as an example.

> Delusional atmosphere involves a kind of global experiential change that is not restricted to particular contents within everyday reality, but which extends to a more pervasive (ontological) transformation of reality experience itself, affecting the sense of encountering something as real or unreal [...] Delusional claims [primary delusions] expressing eschatological themes (eg, "I must keep awake or else the world will come to its end") or grandiose-ontological preoccupations (eg, "everything from the largest to the smallest is contained within me"), [...] can be grasped as expressing experiential transformations in the mind-(in)dependent status of reality or in the general relationship between experiencing subject and experienced object (Feyaerts et al., 2021, p.3).

One of the motivations for following the above-mentioned general form is to accommodate two distinctive features of primary delusions: double bookkeeping and revelatory themes. Double bookkeeping refers to the seemingly contradictory attitude expressed by a person living with schizophrenia regarding their delusion. In the instance of primary delusion, one does not act on their delusional claim despite their unshakable certitude, exhibiting both incorrigible *and* inconsequential attitude. Regarding such an experience, Eugene Bleuere writes: "They [people living with schizophrenia] really do nothing to attain their goal; the emperor and the pope help to manure the fields; the queen of heaven irons the patients' shirts or besmears herself and the table with saliva" (Bleuler, 1924, p. 392). In a little bit more detail, Jaspers describes such an attitude as follows: "With these patients, persecution does not always appear quite like the experience of people who are in fact being persecuted; nor does their jealousy seem like of some justifiably jealous persons [...] Hence, the attitude of the patient to the content of his delusion is peculiarly inconsequent at times" (Jaspers, 1913/1997, p.105). Consider the following excerpt from Daniel Paul Schreber's memoir which does not fail to be mentioned as a prototypical instance of double bookkeeping:

> I have to confirm the first part (a) of this [Dr. Weber's] statement, namely that my so-called delusional system is unshakable certainty, with the same decisive 'yes' as I have to counter the second part (b), namely that my delusions are adequate motive

> for action, with the strongest possible 'no'. I could even say with Jesus Christ: 'My Kingdom is not of this world'; my so-called delusions are concerned solely with God and the beyond; they can therefore never in any way influence my behaviour in any worldly matter (Schreber 1988/1903, p. 301-302).

The other feature of primary delusions is that, unlike other types of delusion present in the mental disorder other than schizophrenia (e.g., paranoid delusion found in the delusional disorder), primary delusion exhibits revelatory themes, both in its experience and content. Primary delusion immediately articulates its delusional meaning and its content reflects echastological, metaphysical, or charismatic themes (Parnas et al., 2020, p.3). As concisely described by Parans and et al., "the delusional meaning [in the case of primary delusion] is revealed to the patient in an imposing manner rather than being grasped through cognitive efforts. This crystalisation is not a product of step by step inferential reasoning or reflection, but possesses a character of immediacy and revelation" (Parnas et al., 2020, p.3). Consider the following case offered by the researchers:

> One of our patients with schizophrenia, a 22-year old male, reported the onset of his illness in the following way: one evening he met some old friends in an amusement park in Copenhagen and during this encounter, he was overwhelmed by a global feeling of intense happiness. On the way home, he suddenly got a thought that he was perhaps a savior, destined to bring peace in the world. This idea formed the basis of subsequent delusional elaborations (Parnas et al., 2020, p.3).

In an effort to identify the underlying structural alteration that underpins both 'double bookkeeping' and 'revelatory theme' features of primary delusions, Sass and Byrom (2015) and Parnas and Henriksen (2014) zero in on the self-world structure disturbance involved in delusional mood. This disturbance refers to the alteration in the sense of existing as a self-identical, vital subject of one's own experience and in the taken-for-granted belief in the mind independent existence of the world. Such a disturbance, Sass and Byrom suggest, "may throw the patient into a new ontological-existential perspective, an often solipsistic framework, no longer ruled by the 'natural' certitudes concerning space, time, causality, and noncontradiction" (Parnas & Henriksen, 2014, p. 544), thereby facilitating experiences of the world as staged or mind-dependent, and a

grandiose sense of gaining access to deeper layers of reality (Sass & Byrom, 2015, p.166)". Before presenting their argument any further, let me unpack this self-world structure disturbance claim.

In everyday life case, one perceives the world, others and objects in the attitude that posits them as objectively existing beings whose characteristics are bounded by more-or-less clearly grasped natural laws. Say, one perceives a cup sitting on a desk as an object that exists not only for oneself but also for others, to be precise, as an object that is, in principle, perceptually available to others. One perceives a cup sitting on the desk as an object that will shatter if pushed off the desk, not, at the very least, as an object to be turned into a dragon in mid-flight and fly off before the impact. One perceives a cup sitting on one's desk as an object that will exist as it has been, not as an object that will disappear into the thin air in the very next moment. One perceives a stranger on the walk as an actually existing person with their own life, not as a product of one's own mind. One perceives a stranger as someone who is not oneself but others. In the case of schizophrenia, the claim is that this taken-for-granted certitude is significantly destabilised, leading to the emergence of the reality wherein one is unsure whether the world actually exists, whether the other is not simply an 'automaton', whether the other has a direct access to one's own experience, etc. The result of which is the emergence of two different realities of conscious experience: one quasi-solipsistic delusional world and the other natural, public world. Consider the following self-reports offered by Parnas and Henriksen:

> There are two worlds. There is the unreal world, which is the world I am in and we are in. And then there is the real world. The only thing that is real in the unreal world is my own self. Everything else—buildings, trees, houses—is unreal. All other humans are extras. My body is part of the charade. There is a real world somewhere and from there someone or something is trying to control me by putting thoughts into my head or by creating (…) screaming voices inside my head (Parnas & Henriksen, 2016, p.83).

In other words, a person who has primary delusion is aware of the separation between two different realms of reality and is aware that the reality ascribed within their delusional content pertains only to one's subjectivised, quasi-solipsistic world. If this is the case, according to Sass

and Byrom, then the double-bookkeeping feature of primary delusion is not a mystery. A person does not act on their primary delusional content despite their certitude because it does not pertain to the public world co-inhabited with other people but one's own delusional reality. In this regard, Sass and Byrom write:

> But if the delusion is felt to be true only *for me*, in my mind's eye and for me alone (or, at least, only for me and my *delusional* others), [...] one need hardly seek evidence for an experience (akin, in some respects, to an imaginary realm) that makes no claim with regard to normal intersubjective reality; one will hardly take action *in actuality* with regard to what one senses as existing in a purely or quasi-virtual realm (Sass & Byrom, 2015, p.166)

Echoing the above, proposal, Feyaerts and et al (2021), claim:

> Indeed, rather than mistaking their delusions for reality, patients regularly point how their delusions (and the same holds for auditory hallucinations in schizophrenia) pertain to a different kind of subjectivized or quasi-solipsistic realm lacking the full actuality, practical consequences, and availability to others that goes together with real-world experience (Feyaerts et al., 2021, p.8).

In sum, the double bookkeeping feature of primary delusion has been explained as follows. First, the self-world structure disturbance underpins the emergence of two different realities of conscious experience: the one that is mind-dependent, quasi-solipsistic world and the other that is mind-independent, intersubjectively available public world. Second, primary delusion is a claim regarding the former reality, or the virtual world. As such, the actual state of affairs that occurs in the public world has no epistemological relevance for the people who have primary delusion, hence the incorrigibility. Third, since the reality ascribed within primary delusional claim is the reality concerning one's own quasi-solipsistic world, one does not act on it, hence the inconsequentiality.

A similar argument has been provided to accommodate the revelatory feature of primary delusion. It goes as follows. First, delusional mood involves a disturbance in the self-world

structure. Second, this disturbance makes explicit the general ontological framework of reality of conscious experience (e.g., temporality, spatiality, intersubjectivity, intentionality, affection). Third, one becomes explicitly aware of such an ontological framework of perceptual reality and feels as though one is tapping into the deeper layer of reality, hence the revelatory theme of primary delusion. Clarifying this characteristic of primary delusion with respect to its content, Parnas and et al. claim that primary delusions generally concerns "respectively the essence of Being or existence (i.e., the schizophrenia cosmology is often of a magical character, consisting of a struggle between good and evil forces, or is penetrated by energies, rays, waves and so forth) and ultimate issues such as universal peace or the end of the world." (Parnas et al., 2020, p.3). Correlatively, "patients may feel to have a central position, to be chosen for a special mission where the meaning of their life reveals itself to them" (Parnas et al., 2020,p.3).

If this strand of argument is concerned with the question of why it is that the content of primary delusion exhibits a revelation-like (eschoatolgoical, metaphysical, or charismatic ("divine gift", literally) theme, another strand of argument has been provided to emphasis its immediately felt, almost revelation like, quality. "Such revelation", Parnas and et al., suggest, is "originally an affective, pathic, experience with only vague meaning, but carries with itself an absolute affective conviction" (Parnas et al., 2020, p.3). Although the authors do not clarify the term "affection" or "affective conviction[88]", their point is the following. The revelation-like experience of primary delusion originates from an 'immediately-felt' experience of delusional mood, or to be precise, the impending sense of "something is happening" which carries itself with absolute certitude.In the researchers' words, "the patient is convinced that something is happening, but he is not aware of what is happening. This is the essence of the delusional mood." The experience of which, in turn, gets "gradually transformed into a standard subject-object structure." (Parnas et al., 2020, p.3).

In sum, the revelatory theme of primary delusion has been explained as follows. Delusional mood involves the self-world structure disturbance. This disturbance makes explicit the

[88] Whether they mean 'generalised emotions' (happiness, frustration, euphoria, etc.), or the sense of self being affected by itself (immanent self-affection or "auto-affection") and the conviction in the mine-ness of experience, or the sense of self affected by the (pre-given) world (affection as discussed in the previous chapter, in technical term hetero-affection) and the conviction in the mine-ness of experience and in the existence of the world.

ontological framework of perceptual reality. Correlatively, a person becomes acutely aware of such formal aspects of reality, leading to the ideation that one is tapping into the deeper layers of reality. The end result of which is, according to the researchers, primary delusions wherein one believes that one is endowed with a special gift and that one is not, at the very least, like 'other humans'. Regarding the felt quality of delusional mood, its implication for the development into primary delusions is that delusional mood is an immediately felt-experience whose elaboration into delusional content does not require a cognitive effort or a reflection.

§6.1.1. Is Delusional Mood Experience That Simple?

The gist of the above discussed phenomenological research is that delusional mood involves a global shift in the way one experiences oneself and the world, i.e., the self-world structure, and this alteration leads to the formation of the distinctive features of primary delusions: double bookkeeping and revelatory themes. Here I do not concern myself with the structural claim. I do not question whether by the alteration in the self-world structure, or "the shift in the natural ontological certitude[89]", the researchers mean 'the disintegration in Urdoxa' (as I have done so in the previous chapter). Nor do I question whether by the change in the way one experiences oneself the researchers mean "the breakdown in the structure of inner time consciousness" (as I have critically assessed in detail in chapter 4). I concern myself with this question: What happened to other features of delusional mood?

In the previous chapter, I have discussed characteristic features of the delusional mood. To recall, they were: the bewildering enigmatic manifestation of the world, the loss of the determinate, familiar meaning of an object, and intoxicated anticipation. By gestalt psychologists,

[89]The authors characterise the natural-ontological certitude as a natural attitude. Natural attitude is not Urdoxa. So, I do not repeat my objection here. Laying particular emphasis on the term "ontological", however, the authors often claim that the natural-ontological certitude is taken-for-granted belief *in* the existence of the world and oneself. If this claim is intended to mean that the natural-ontological attitude is Urdoxa, then the objection I raised in the previous chapter stands. Had it been that it is Urdoxa that is distrubed, nothing should have been affirmed/doubted. This does not accord with the delusional mood experience, to be specific, as the researchers themselves have noticed, the "affective *conviction*" of the delusional mood, i.e., the immediate feeling wherein one is *certain* that something has changed. I do not entertain this possibility any further.

namely Mattusek and Conrad, those characteristic features were respectively coined as apophany and anastrophe, decontextualisaion, and trema. All of which are, in one way or another, considered as the generative experience that leads to primary delusions. Given that these experiential features are constitutive of delusional mood and the proposed contemporary phenomenological account posits delusional mood as the original experience from which primary delusion arises, it follows that their proposal would, at least, remain incomplete if those features are left unconsidered. For the proposed self-world structure disturbance account to count as a generative account, the following questions would have to be addressed. Do decontextualization, anastrophe, apophany, and trema play any role in bringing about primary delusion? Let me be exact here. Do those experiences have any relation to the identified self-world structure disturbance, or do they not? Are those features of delusional mood indicative of such a disturbance? Or is it the other way around, such that the self-world structure disturbance is indicative of decontextualization, apophany, anastrophe, and trema? Or is it the case that they are all reflective of one core disruption from which they arise? In anticipatory summary, there is an answer, specifically, to the last question. It is this: yes, and the core disruption is ipseity disturbance. In the following, I review the ipseity disturbance account and challenge its claim regarding ipseity-disturbance playing a generative role in the emergence of delusional mood and primary delusion.

§6.2. From Ipseity Disturbance to Delusional Mood

Anticipating the above-raised kind of question, Sass and Byrom write: "One may wonder whether these constitute heterogeneous features [decontextualisation, apophany, anastrophe, and trema], and to what extent they derive from or reflect some central disruption. The notion of ipseity disturbance (Sass, 2010, Sass & Parnas, 2003, and Sass et al., 2011) is one hypothesis regarding such a *trouble générateur* [generative disturbance] (see Sass, 2014 and Parnas & Henriksen, 2014)" (Sass & Byrom, 2015, p. 167; italics original). Ipseity refers to the pre-reflective and immediate sense of existing as a self-identical, vital subject of one's own experience. Its disturbance, according to Sass and many other proponents of this model, implicates two types of experience particular to schizophrenia: hyper-reflexivity and diminished sense of self-affection. Hyper-reflexivity refers to the kind of experience where a person involuntarily becomes explicitly

conscious of the tacit, taken-for-granted aspect of one's experience; most notably, for the case of schizophrenia, one becomes hyper-aware of the temporal, first-personal and embodied aspect of experience. Diminished sense of self-affection is a complementary aspect of hyper-reflexivity. As one can no longer live through one's experience but becomes explicitly conscious of it, one experiences a pervasive sense of detachment from one's own experience and the world that correlates to it. In the analysis of the delusional mood, the proponents of the ipseity disturbance model specifically focus on hyper-reflexivity and demonstrate that such an experience may underpin the constitutive features of the delusional mood. Take Sass' and Byrom's account of apophany, anastrophe, decontextualisation, and trema as an example.

Apophany refers to the experience of the bewildering, enigmatic manifestation of the world-- as discussed in detail in the previous chapter. In this state, a person experiences that the world is telling oneself indefinable "something" significant. In Sass' and Byrom's terms, it is an "abnormal, sometimes crucial sense of meaningfulness [...] The patient attributes these changes to the external world and searches for clues to render the new unpredictable changes more comprehensible" (Sass & Byrom, 2015, p.166). If apophany, in essence, pertains to the altered world experience, anastrophe pertains to altered self-experience. Anastrophe refers to the kind of experience whereby a person becomes acutely aware of oneself as the "passive middle point of the world" (Mishara, 2009, p.11). Directly quoting Conrad, Sass and Byrom write: "Conrad uses the term *anastrophe* (literally: turning-back or turning-inward) to capture this self-referential, introversive, or self-observing quality – *what could be termed a form of "hyper-reflexivity*"" (Sass & Byrom, 2015, p. 166; italics added). The researchers then proceed to claim that "*Apophany* and *anastrophe* are two sides of a coin." Their rationale is as follows: "Changes in perceived environment (e.g., sense of things being oddly significant, false, or planned) [or apophany] elicit reflection and inhibit spontaneous engaged activity; yet these changes themselves can only occur in the presence of a veritable "spasm of reflexion" [anastrophe] (Conrad, 1958, p. 167,199)" (Sass & Byrom, 2015, p.166). In short, the gist of the ipseity disturbance argument for apophany and anastrophe is the following. Apophany and anastrophe are two sides of the same coin: they are internally constitutive of each other. Anastrophe is hyper-reflexivity. Anastrophe is such that its identity is dependent on apophany, and vice versa. Given the ipseity disturbance underpins hyper-reflexivity, it follows that ipseity disturbance underpins both apophany and anastrophe.

In contrast to the above analysis wherein the researchers identify a certain experiential abnormality involved in delusional mood as hyper-reflexivity (e.g., the spasm of reflexion or anastrophe as 'hyper-reflexivity'), a slightly different analysis is provided for the decontextualisation. As discussed in the previous chapter (in §5.3.1. and §5.3.2.), decontextualisation refers to the kind of experience where a person no longer perceives a given object in its surrounding context but in itself, as an atomistic, individual thing (Matussek,1987, p.90). In its analysis, Sass and Byrom specifically emphasise "a distinctive combination of passivity with activity" involved in this experience. They write: "the patient experiences a rigid gaze, feeling "held captive" (Matussek, 1988, p.94) by the object or objects. Yet he also has an exaggerated "ability" to "focus his attention on such isolated details" (Matussek, 1987, p.93) and may indeed take "pleasure" in this "fixing [of attention]" (Matussek, 1987, p.94), thereby further transforming the perceptual field via a "prolonged gazing" difficult for normal individuals to sustain" (Sass & Byrom, 2015, p.165). The researchers then identify this "prolonged gazing" as another instance of hyper-reflexivity. In other words, in contrast to the above analysis wherein hyper-reflexivity is identified as one of the constitutive features of delusional mood (hyper-reflexivity *as* anastrophe), in the analysis of decontextualisation, hyper-reflexivity is posited as a correlative side of decontextualisation phenomenon. That is to say, hyper-reflexivity is construed as a subjective side abnormality (perceptual intentionally alteration) that is present together with the decontextualization phenomenon (i.e., the perceived environment and object alteration). Summarising their view with respect to the prolonged gazing and the spasm of reflexion, the researchers claim: "these mutations [spasm of reflexion and prolonged gazing] have been formulated recently as an alteration of minimal or core self or *ipseity* (the basic sense of existing as a unified and vital *subject* of experience) " (Sass & Byrom, 2015, p. 166).

If the above two strands of argument generally focus on searching for specific experiential abnormalities found in the characteristic features of delusional mood as 'hyper-reflexivity', a somewhat different argument is provided for trema (a term of art for "stage fright", denoting the general nervousness an actor may experience before the play). The difference is that a mediating term is introduced: the natural-ontological certitude alteration. To be exact, the argument is that the ipseity disturbance destabilises the natural-ontological certitude in the mind independent existence of the world, and this disturbance, in turn, gives rise to trema. To fully quote the above-

used quote, Sass and Byrom write: "*Self disturbance "destabilise[s]* the natural ontological attitude and may throw the patient into a new ontological-existential perspective, an often solipsistic framework, no longer ruled by the 'natural' certitudes concerning space, time, causality, and noncontradiction" (Parnas & Henriksen, 2014, p. 544), thereby facilitating experiences of the world as staged or mind-dependent, and a grandiose sense of gaining access to deeper layers of reality." (Sass & Byrom, 2015, p. 166; italics added).

Let me summarise. For the analysis of apophany, anastrophe, and decontextualisation, the aforementioned researchers, firstly, search for specific experiential abnormalities found in their characteristic instance (e.g., "the spasm of reflexion" in anastrophe and "the prolonged gazing" in decontextualisation) and identify it as hyper-reflexivity. Secondly, they proceed to claim that either a.) the identified hyper-reflexivity *is* the specific feature of delusional mood (i.e., anastrophe) that is internally constitutive of other feature of delusional mood (i.e., apophany) or b.) the identified hyper-reflexivity (i.e., the prolonged gazing) is present with the target phenomenon as its correlative side (for the case of decontextualization). For the analysis of trema, the researchers introduce a mediating term 'natural-ontological certitude' destabilised by the ipseity disturbance. Given that ipseity disturbance underpins hyper-reflexivity and destabilises the natural-ontological certitude, on the researchers' account, it follows that the aforementioned features, either directly or indirectly, arise from the ipseity disturbance. As such, Sass and Byrom posits ipseity disturbance as the "central disruption" or "trouble *générateur*", simply put, generative disturbance for delusional mood.

§6.2.1. Can It All Be Ipseity Disturbance?

Focusing on the specific aspect of each constitutive features of the delusional mood (e.g., "the spasm of reflexion" in anastrophe and "the prolonged gazing" in decontextualisation) and identifying such an aspect as hyper-reflexivity is necessary to posit ipseity disturbance as the central, generative disturbance for delusional mood. However, this approach comes at the cost of overlooking the most characteristic aspect of each feature of the delusional mood in its generative analysis, and, most problematically, providing no account regarding how it is that such aspects of delusional mood arise from ipseity disturbance. Let me detail this claim.

Consider the above analysis of decontextualization. This phenomenon, as Sass and Byrom would agree with Matussek, is most notably characterised by the perceptual field and object

disintegration experience. However, the central focus of the analysis was not on how such a perceptual abnormality comes about, nor was it regarding how it is that hyper-relativity can underpin such an experience. Instead, the investigation geared towards searching for a hyper-reflexivity like experience, i.e., the prolonged gazing, and demonstrating it as a correlative side of perceptual field and object disintegration experience. However, to say that the prolonged gazing (or hyper-reflexivity like experience) is the correlate of the perceptual field and object disintegration experience is to say that, at most, they are necessarily present together. It is not to say that hyper-reflexivity, and by implication, ipseity disturbance, gives rise to the perceptual field and object disintegration experience. A similar approach is used for the analysis of anastrophe and apophany. As seen above, Sass and Byrom acknowledge that the "Changes in perceived environment (e.g., sense of things being oddly significant, false, or planned) [apophany] elicit reflection and inhibit spontaneous engaged activity; yet these changes themselves can only occur in the presence of a veritable "spasm of reflexion". However, apart from identifying that "the spasm of reflexion" present in the instance of anastrophe as "a form of hyper-reflexivity", no account is provided regarding how it is that the "changes in perceived environment" (apophany) come about, or how it is that such an abnormality can be conceived as "reflective of" or "derives from" the ipseity disturbance. Lastly, for the analysis of the trema whose experiential abnormality cannot be easily identified as hyper-reflexivity, another mediating term is introduced that can be linked back to the ipseity disturbance claim. That is, as mentioned above, the natural ontological certitude that is supposedly destabilised by the ipseity disturbance.

To cut to the core, throughout the analysis, the nature of delusional mood is already construed as a kind of experience that has to be, in one way or the other, involved with the ipseity disturbance. As such, its justification centres on searching for the experiential abnormality derivative of ipseity disturbance (be it hyper-reflexivity or natural-ontological certitude alteration). This is, again, all to conclude that ipseity disturbance is, in the final analysis, the generative disturbance for delusional mood. However, it should be made clear here that it is one thing to say that the experiential abnormalities derivative of the ipseity disturbance are present in the delusional mood, and it is another thing to say that, *as such,* hyper-reflexivity or the natural ontological certitude alteration (by implication, ipseity disturbance) *gives rise* to delusional mood. Unless it is demonstrated how it is that the ipseity disturbance underpins the above-mentioned features of the delusional mood and how exactly it is that such a disturbance destabilises the natural-ontological

certitude, there is no legitimate reason to posit ipseity disturbance as the central generative disturbance for delusional mood. Given the claim has been that it is nothing but the delusional mood from which primary delusion arises, it also follows that there is no legitimate reason to posit ipseity disturbance as the generative disturbance for primary delusion either.

To be clear, I do not here dispute that ipseity disturbance and its derivative experience (be it hyper-reflexivity or the natural-ontological certitude alteration) are present in the delusional mood. The target of my objection is the generative claim, i.e., the claim that ipseity disturbance brings about delusional mood and primary delusion. My argument is the following: the ipseity disturbance account fails to demonstrate how it is that ipseity disturbance underpins the constitutive features of the delusional mood. Therefore, it cannot be counted as a generative account. My argument is not the following: the ipseity disturbance account fails to demonstrate how it is that ipseity disturbance gives rise to the constitutive features of the delusional mood. Therefore, the experience derivative of ipseity disturbance is not present in the delusion mood. To be exact, insofar as the proponents of the ipseity disturbance hypothesis fail to demonstrate the generative role the ipseity disturbance plays in bringing about decontextualization, apophany, anastrophe, and trema, the generative claim regarding ipseity disturbance has to be retracted. If the generative claim can be retracted, that is to say, if the claim that ipseity disturbance is the *trouble genérateur* can be retracted, then this follows: there is no reason to justify the generative role ipseity disturbance plays in the emergence of the delusional mood and primary delusion. This implies the following: the ipseity disturbance account should not be accepted as a generative account. As argued above, the ipseity disturbance account fails to be one. Therefore, the ipseity disturbance account should not be accepted as a generative account.

Now that I have established the above claim let me lay my cards on the table. Accept the ipseity disturbance account as an experiential account, as an account that claims hyper-reflexivity like experience is present in the delusional mood. The acceptance of the ipseity disturbance account as an experiential account entails the acceptance of the following. Hyper-reflexivity like experience (e.g., “prolonged gazing” in decontextualization and “spasm of reflexion” in anastrophe and apophany) is present in the delusional mood but does not give rise to delusional mood. Given that I aim to link the ipseity disturbance account with the affective account I provide in the previous chapter, what’s at stake is this: demonstrate a.) how the affective repression

dysfunction brings about hyper-reflexivity like experience and b.) how such a disruption can contribute towards the formation of primary delusion. Let me proceed.

§6.3. Delusional Mood, Affection, and Primary Delusions: Inexplicable "Something" New

In the following, I link the affective account I provided in the previous chapter to the ipseity disturbance account. To cut to the chase, particular to delusional mood, I argue that hyper-reflexivity can be best understood as the complementary aspect of affective repression dysfunction. Should the generative claim be made, it is the affective dysfunction that underpins hype-reflexitivty like experience. I justify this claim throughout the analysis of decontexsualisation, apophany, anastrophe, and trema. Afterwards I bring attention to a particular mode of understanding that has been mentioned only in passing in the contemporary phenomenological discussion regarding primary delusion formations, i.e., "thematization". I detail how the affective dysregulation experience underpins such a mode of understanding crucial to the articulation of full blown primary delusions. In so doing, I aim to provide a coherent and detailed phenomenological account on how it is that primary delusion arises from delusional mood. Let me begin by reminding ourselves what we have learned from the previous chapter.

In the previous chapter, I emphasised that in the state of delusional mood, the perceived surroundings and objects acquire a peculiar prominence and grab hold of one's attention. By employing Husserl's account of affection, I have termed such a prominence as affective prominence. I then identified the affective repression failure as the determining factor that underpins such an experience whereby a person's attention is drawn into every insignificant detail of one's surrounding and/or that of a perceived particular object — viz. affective dysregulation experience. To recall, its characteristic instance was the following: "I developed a greater awareness of … my senses were sharpened. I became fascinated by the little significant things around me"; "Sights and sounds possessed a keenness that he had never experienced before", "It was as if parts of my brain awoke, which had been dormant" or "my senses seem alive.. Things seemed clearcut, I noticed things that I had never noticed before" (Kapur, 2003, p.74). With this in mind, let me proceed into the analysis of decontextualisation and hyper-reflexivity.

§6.3.1. Decontextualisation and Hyper-reflexivity

As mentioned-above, decontextualisation refers to the kind of an experience where a person no longer perceives a given object in its natural perceptual context but as an isolated, individual object. Matussek terms this phenomenon as the loosening of the natural perceptual context and describes it specifically as "the splitting of individual perceptual components from their natural context" (Matussek, 1987, p.90). Consider the following self-reports I discussed briefly in the previous chapter:

> I was surrounded by a multitude of meaningless details. Once in a such a moment, I found myself walking to the University. When I was on the street, everything seemed as dull and uninteresting as at home. I did not see things as a whole. I only saw fragments: a few people, a dairy, a dreary house. To be quite correct, I cannot say that I did see all that, because these objects seemed altered from the usual. They did not stand together in an overall context, and I saw them as meaningless details. (Mattusek, 1987, p. 91)

As Mattusek notes, the defining feature of decontextualization experience is that a person can only "see in fragments" and "only details in meaningless background". In the previous chapter, I have argued that in the usual, everyday life case when a given object comes to grab hold of attention it does so by repressing the prominence of its surrounding object. As such, in everyday life case, when one perceives an object, say, a cup sitting on one's desk, one can just see the cup without having to have one's attention all drawn into every feature of its surrounding objects, say, a ketchup bottle, a pringles can, a pile of books, etc. that are all on the desk. To recall, I detailed this phenomenon by appealing to Husserl's account of primordial association and termed it as 'affective repression'. As the self-reports indicate, in the instance of decontextualization, it seems to be that the usual affective repression fails, such that the prominence of one particular object no longer represses the prominence of its surrounding objects. As a result, the surrounding context of a perceived particular object is no longer perceived as that, as a background context, but as a set of particular objects that all equally attracts one's attention; hence, the reports: "I did not see things as a whole. *I only saw them as fragments: a few people, a dairy, a dreary house.* To be quite correct, I can't say that I did see all that, because these objects seemed altered from the usual. *They did not stand together in an overall context, and I saw them as meaningless details*." Another

patient of Mattusek writes: “I may look at the garden, but I don’t see it as I normally do. *I can only concentrate on details.* For instance I can lose myself in looking at a bird on a branch, but then I don’t see anything else.” (Matussek, 1987, p.92)

If such is the case, if in the instance of decontextualisation, there occurs affective repression failure, such that every individual object of one’s surrounding attracts one’s attention, then it is not a mystery that hyper-reflexivity like experience is present . The passive, involuntary form of reflection, the “prolonged gazing”, the “rigid gaze, feeling “held captive” (Matussek, 1987, p.94) “by *object or objects*” identified by the proponents of the ipseity disturbance model, is just a person experiencing intensified affective prominence of object or objects. The reason that a person can sustain this “prolonged gazing” more so than “normal individuals” is not because such is the intrinsic nature of hyper-reflexivity, nor is it because such hyper-reflexivity like experience is underpinned by ipseity disturbance. One can sustain such a prolonged gazing and such an experience arises because, simply put, things just look weird. In a little bit more detail, as discussed in the previous chapters, the affective prominence exercised by a given object denotes, in the most general sense, the inseparable relationship between consciousness and the world. Therefore, its disturbance or exaggeration does not implicate an alteration at one end, the perceived object, but also, by necessity, the perceiving subject, or perceptual intentionality. For the case of decontextualization, the changed aspect of the perceived object is its exaggerated affective prominence and the correlating changed aspect of the perceptual intentionality is the attention that is “held captive” by such prominence: prolonged gazing and decontextualization are interdependent moments. They are two sides of the same coin. If the decontextualization phenomenon can be understood as an affective one, then no recourse to the ipseity disturbance claim is needed. Hyper-reflexivity like experience is present in the instance of decontextualisation as a correlate of that decontextualization phenomenon itself. As a correlate, prolonged gazing does not bring about decontextualization.

§6.3.2. Apophany, Anastrophe and Hyper-reflexivity

As briefly mentioned above, apophany refers to the kind of experience where a person experience as though the world is telling one self ‘something’ significant is happening, experiencing “tantalizing but typically unidentifiable” meaningfulness. Referring to his case study, Conrad describes this state as follows “every component of his experiential field appears to stand

in special relation to him,e.g.,the instructions given to others about how to behave in front of him; the preparations, the being staged. His 'world' transforms itself into a singular field specifically meant to 'test' him [...] the patient often interprets the course of events as if a film were being made or a theatre-piece performed" (Conrad, 1958, p. 53; as translated in Mishara & Fusar-poli, 2013, p.283). Consider the following self-reports by Susan Weinss (2003) I briefly discussed in the previous chapter (Chapter 4). Recounting the beginning of her psychosis, she writes:

> Schizophrenia is a disease of information. And undergoing a psychotic break was like turning on a faucet to a torrent of details, which overwhelmed my life. In psychosis, nothing is what it seems. Everything exists to be understood beneath the surface. A bench remained a bench but who sat there became critical. Like irony, the casual exchange of words between a stranger or a friend meant something more than was being said. The movies, TV, and newspapers were alive with information for those who knew how to read. Without warning my world became suffused with meaning like light. (Weinss, 2003, p.877).

Anastrophe refers to the experience where a person feels as though one has become the passive centre of the universe (e.g., "I have a feeling that everything turns around me"). In this instance, the everyday life, innocuous behaviour of other people or simply objects themselves all to convey special meaning to one self, feeling as though the world revolves around oneself. Susan continues:

> In response, I felt as if I had been only half conscious before, as ignorant of reality as a small child. Although my sense of perception remained unaffected, everything I saw and heard took on a halo of meaning that had to be interpreted before I knew how to act. An advertising banner revealed a secret message *only I could read*. The layout of a store display conveyed a clue. A leaf fell and in its falling spoke: nothing was too small to act as a courier of meaning. (Weinss, 2003, p.877; italics added)

As suggested by Sass and Byrom, apophany and anastrophe seem to be closely related to each other. One feels as though one has become the middle point of the universe because everything one perceives seems to tell one self something significant is happening or "changes in perceived environment". Further, if anastrophe can be identified as a form of hyper-reflexivity, that is, as an involuntary form of reflection characterised by "self-referential" quality, as Sass and

Byrom do, it follows that hyper-reflexivity and apophany are "two side of the same coin": they are internally constitutive of each other.

Here I do not dispute the claim that apophany and anastrophe are closely related to each other. Nor will I repeat the objection that ipseity disturbance gives rise to such features of delusional mood. Regardless of the acceptance of the ipseity disturbance generative claim, however, a more detailed analysis of apophony is required to justify the claim that hyper-reflexivity and apophony are internally constitutive of each other. Consider the following argument.

As Sass and Byrom would agree, in the instance of apophany, it is not simply that one's perceived environment takes on a.) a peculiar prominence but also b.) a tantalising sense of meaningfulness. The experience of a.) alone, however, does not lead to anastrophe. The prominence of one's perceptual field can be exaggerated such that one's attention is drawn into its insignificant details, say, to the general acoustic of this room, to the shape of this laptop, to the brightness of this screen etc. However, this experience does not directly imply that one will therefore experience that one has become the centre of the universe [anastrophe]. One can, in principle, dismiss such an experience as an unusual occurrence or simply take it to mean that one is not well and seek medical help. In essence, what justifies the claim regarding the implication between apophany and anastrophe (or hyper-reflexivity, if one accepts Sass' and Byroms' identification) is the b.): the tantalising meaningfulness one experiences from the perceived environment. As the perceived environment all seems to insinuate a *hidden, indefinable meaning* only one can read, one feels as though the world has turned towards one self, as if one has become the passive middle point of the universe. Given the experience of affective prominence itself does not directly imply anastrophe, the following question has to be addressed to justify the claim that hyper-reflexivity and apophany are internally constitutive of each other: how does one go from noticing every insignificant detail of one's surroundings (or the exaggerated affective prominence of perceived environment) to feeling as though the world is trying to tell one self something significant (or the experience of tantalising meaningfulness)?

In the previous chapter, I have argued that in everyday life perception, our past experiences and the commonsensical, everyday life knowledge acquired therein constantly informs and constrain the present perception. Appealing to Husserl's account of reproductive association, I

have argued that the sedimented past experience provides a framework of determinate sense and familiarity to the present perception. I have specifically focused on the associative connection between the present experience and the past experience and suggested that what actually establishes such a connection is the affective force that propagates from the present consciousness to the past similar experience. For instance, the affective prominence of a given object that is strong enough to grab hold of one's attention, say, this laptop, travels towards the similar past experience where I perceived and interacted with a laptop before. This propagation, in turn, awakens the past perceptual knowledge (that it is an object I can use to type with, go on websites, read books, listen to music, watch movies, etc.) and impart a determinate, articulate sense to the present perception. I termed such a phenomenon whereby the present affective prominence travels towards similar past experience as "affective propagation". With this reminder in mind, let me go back to the self-reports.

As the above-self reports indicate, in the instance of apophany and anastrophe, one's past experiences are still implied in the present perception. Despite the peculiar affective prominence Susan experiences, she can still identify what it is that she is perceiving, e.g, leaf, bench, advertising banner, etc. She can still recognise her surroundings and also notes the novelty of her experience. Meaning, the affective force of the present perception still propagates towards similar past experience whereby one perceived and interacted with such objects before and informs the present perception, such that she can notice the novelty of her perceptual environment against the backdrop of its familiarity. However, as discussed in the previous chapter, this affective propagation is exactly the problem. The problem is that this awakened past experiences cannot adequately accommodate her present perceptual environment. To be precise, the peculiar affective prominence one experiences from one's environment, say, the exaggerated prominence a mundane bench exercises, cannot be accounted for by that 'such is so because it is an object to sit on'. The awakened everyday life knowledge cannot explain just exactly why it is that the falling leaf, the advertising banner, the bench that she has come across, perceived, interacted with, and talked about numerous occasions, all of a sudden, acquires such a prominence and attracts her attention. Susan simply perceives inexplicable 'something' new, hence the remark "*nothing is what it seems*" and "*everything exists to be understood beneath the surface.*" This experience of perceiving inexplicable something new may further underpin the grandiose ideation that one has gained a special insight. To go back to Susan's case, she writes: "In response [to her changed perceived

environment], I *felt as if I had been only* half conscious before, *as ignorant of reality as a small child* (italics added)." Against the backdrop of the implied past experiences, she comes to be aware that her changed perceived environment is an entirely new and revelatory experience, in that the world is trying to tell her something, an indefinable, significant something that cannot be accommodated by commonsencial-- or at this point of psychosis-- 'banal, human knowledge[90]'.

My points are as follows. a.) The affective repression failure intensifies the affective prominence of the perceived environment, drawing one's attention to its every insignificant detail (e.g., "Schizophrenia is a disease of information. And undergoing a psychotic break was like turning on a faucet to a torrent of details, which overwhelmed my life"). b.) This affective repression failure does not inhibit affective propagation: the past experiences are still implied in the present perception. Susan can identify the object of perception, she can recognise her surroundings, and she is aware of the novelty of her experience. c.) Against the backdrop of the implied past experiences, the affective prominence of the perceived environment can take on the quality of novelty and tantalising sense of meaningfulness: a person knows what it is that one is perceiving, a bench as a bench, a leaf as a leaf, etc., but the implied past experience cannot account for its exaggerated affective prominence, eliciting the feeling that one is perceiving inexplicable something new (e.g., "nothing is what it seems" and "everything exists to be understood beneath the surface. an advertising banner revealed a secret message only I could read. The layout of a store display conveyed a clue. A leaf fell and in its falling spoke: nothing was too small to act as a courier of meaning." and "I felt as if I had been only half conscious before, as ignorant of reality as a small child"). In short, affective repression failure adds alien inexplicable, something more to the present perception.

If c.) can be accepted, then the peculiar affective prominence of the perceived environment implies the tantalising sense of meaningfulness, constituting the apophony experience. Meaning, the peculiar affective prominence experienced against the backdrop of the implied past experiences elicit the sense of meaningfulness, or the feeling that a hidden, indefinable *something more* is weighted by the familiar, mundane perceptual environment[91]. And as one's perceived environment

[90]I detail this claim soon.

[91] In the previous chapter, I detailed this claim in the meaning disturbance analysis of delusional mood. The only reason that I did not use the term 'apophany' or 'anastrophe' in the previous chapter was because my interlocutors, Fuchs and Wiggins and et al., do not use such terms. As the argument I proposed in the

takes on such a tantalising sense of meaningfulness and beckons one's attention to its every insignificant detail, one experiences that the world is trying to tell one self something significant and "turned towards one self", leading to anastrophe. If anastrophe can be identified as a form of hyper-reflexivity, then apophany and hyper-reflexivity are two sides of the same coin. They come together.

Going back to the dialectic of the argument, if one aims to justify the claim that hyper-reflexivity is co-present with apophany, a more detailed analysis of apophany is required. Such an analysis, as demonstrated above, does not need recourse to the ipseity disturbance generative claim. The general point of the above analysis is the following: if it can be accepted that apophany is an affective experience, that is, a kind of experience that implies an alteration in the affective prominence of one's surroundings and, correlatively, in the way one perceives the world, then it becomes intuitive why it is that hyper-reflexivity is present in the instance of apophany. This hyper-reflexivity-- or the involuntary form of reflection characterised with self-referential quality, wherein one immediately feels that the world revolves around oneself without the mediation of reflective consciousness -- is present with apophany because it is a response to the altered affective prominence of one's surroundings. To put it simply, regarding delusional mood, if apophany denotes the changed aspect of the perceived environment, hyper-reflexivity denotes the changed aspect of the correlating perceptual intentionality. As a correlate, hyper-reflexivity does not bring about apophany.

§6.3.3. Trema

As mentioned, trema refers to the type of experience where a person experiences oppressive tension that 'something' is going to happen[92]. Although Conrad notes the various emotional qualities trema can take on (anxiety, depression, joy, euphoria, excitement, etc), he considers its "state of tension" as its core feature (Conrad, 2002, p.42). His point is that in the state of trema it is not that one feels joyous, depressed, anxious, or excited about some particular event that might happen in the future. Instead, a person immediately knows that "something" is going to

previous chapter was that approaching delusional mood from its affective dimension can help us better understand the type of experience my interlocutors deem important, I had to stick with the terms they use to describe such experience, hence "the loss of the determinante, familiar meaning of an object".

[92]In the previous chapter, I discussed this experience in general under the heading of 'intoxicated anticipation'.

happen but cannot pinpoint exactly what it is that is going to happen, hence the heightened state of tension. As Sass puts it, in the state of trema, "patients feel *something* is in the offing". Consider the following vignette offered by Conrad, regarding his patient Rainer.

> He later joined the RAD ("Reich Arbeits-Dienst", i.e., the national workforce) and was deployed in southern France [...] From the very moment he was deployed, he felt under pressure, as if an extraordinary work effort was expected from him. *For some time, he had the impression that "something was in the air", but he couldn't tell what it was.* The others looked strangely at him and acted all but friendly toward him [...] From the creaking of the floorboards and the bed, he could clearly hear how they tried to sneak up on him. He jumped out of bed to attack his opponent but there was none. As soon as he lay down, they started to sneak up on him again, and all the time he had to jump up [...] Even his best friend asked him, "quite innocently", what was wrong. Everybody was dissembling. Undoubtedly, they wanted to see how he reacted (Conrad, 2002, p.22-24; as translated in, Parnas and Henriksen, 2019, p.748).

This enveloping sense of non-finality, that something is going to happen, has been described in detail by Jaspers in General Psychopathology-- albeit under the general heading of delusional mood[93]. In this state, Jaspers writes: "[...] a living-room which formerly was felt as neutral or friendly now becomes dominated by some indefinable atmosphere. Something seems in the air which the patient cannot account for, a distrustful, uncomfortable, uncanny tension invades him". One of his patients claims: "Something is going on; do tell me what on earth is going on [...] how do I know, but I am certain something is going on" (Jaspers, 1913/1997, p.98). To recall, the vignette offered by Jaspers was the following.

> Everything in the street was so different, something is bound to be happening [...] Something must be going on; the world is changing, a new era is starting [...] The house-signs are crooked, the streets look suspicious; everything happens so quickly. The dog scratches oddly at the door. "I noticed particularly" is the constant remark

[93]For the sake of distinguishing this type of experience from other types, I termed this experience as 'intoxicated anticipation'.

these patients make, though they cannot say why they take such particular note of things nor what it is they suspect.

As mentioned in the previous section, this kind of experience has been viewed as a result of the natural-ontological attitude shift. To recall, its argument was the following. The natural-ontological attitude is the passive, taken-for-granted certitude in the mind-independent existence of the world constrained "by the principles of space time, causality, and noncontradiction, essentially making it reliable, predictable and ontologically secure." In everyday life, this certitude is stable. In the case of schizophrenia, due to the ipseity disturbance, such a certitude is destabilised, leading to the experience characteristic of delusional mood such as trema.

I do not here dispute that trema like experience can be, in principle, understood as an alteration in the natural-ontological certitude. However, if we do so, the following questions would have to be addressed. Given one accepts the ipseity disturbance generative claim: a.) How does the ipseity disturbance lead to the disturbance in the natural-ontological certitude? and b.) How exactly is it that the alteration in the natural-ontological certitude brings about the oppressive tension that "something" is going to happen? Answering these questions could help understand trema as (another) manifestation of ipseity disturbance-- in a more detailed and clear manner. There, however, can be another way of understanding trema other than posting it as another experiential abnormality underpinned by the ipseity disturbance. Let us go back to the self-reports.

As Rainer reports, in the state of trema, not only does he experience that 'something' is in the air, that something is going to happen, but also he becomes acutely aware of his immediate surroundings. He senses that something is going to happen *and* things start to look strange. He notices that "others looked strange at him", perhaps hiding their hostile intentions towards him. The creaking of the floorboards and beds, which would have simply gone unnoticed or heard as innocuous noise, constantly captivates his attention and is heard as the footsteps of his enemy, to the extent that he had to stay up all night. In Conrad's terms, in this state, "everything becomes conspicuously salient (auffällig)" (Conrad, 1987, p.53; as translated in Mishara & Fusar-poli, 2013, p.279). For the patient considered by Jaspers, one not only experiences the oppressive tension of non-finality ("something is bound to be happening", "something must be going on") but also the strangeness of one's surroundings ("Everything in the street was so different ; "The house-signs are crooked, the streets look suspicious; everything happens so quickly"; "The dog scratches

oddly at the door"). In other words, the affective prominence of one's immediate surroundings is exaggerated, drawing one's attention into its insignificant details.

This experience of strangeness one senses from one's immediate surroundings seems to be closely related with the experience of affective prominence, in that the latter leads to the former. Let me detail this claim. Rainer knows the object of his perception and recognises it (his best friend as best friend, the sound of floor bed and beds as that, etc.). Rainer knows what the 'usual', 'friendly' behaviour of others is like-- without such a knowledge implied in the present perception he would have not perceived the behaviour of his colleague and his friends as "dissembling". The patient considered by Jaspers can also still recognize one's surroundings and identify and recognise the object of one's perception (e.g., house sign, dog, candle, etc). One knows what it all usually looks like-- without such a knowledge still implied in the present perception one would not be able to find "everything so different". Against the backdrop of this implied past experiences, the affective prominence one experiences from one's surrounding can take on the quality of strangeness and oddness. What makes a dog scratching at the door, the house-signs, the behaviour of others and of close friends look so strange is just that the prominence one experiences comes from the exact same environment, people, and objects one *perceives and knows* to be mundane and familiar. One perceives inexplicable something more in the mundane, familiarity of life: one experiences inexplicable something new.

In the previous chapter, I have discussed how our past experiences not only inform our present perception (such that one can identify and recognize the object of perception) but also condition its anticipatory aspect. In perceiving this laptop, I do not simply see it as an object I can take up and use it for whatever purpose I have in mind but also anticipate that it will exist as it has been, as an object with its determinate, practical significance. In its perception, I do not have to inspect this laptop to acquire or justify such a certainty. I know what this object is, what it is for, and how it behaves. Nor I do not have to determine its function or property any more closely: I have used a laptop before. When opening the door to my room, I do not simply perceive a door opening but also anticipate that I will be presented with the same room I have been living in, not a hotel room, or a basketball court, or the edge of a cliff. I do not have to assure myself that it will be my room that I will see once I open the door: I have been living in this house for many years. To put it otherwise, the anticipatory aspect of perception takes on the form of 'habitual certainty',

that is, the certainty that the given familiar object (be this an object or objects or environment) will exist *in the way it always has been*[94]. Appealing to Husserl's account of anticipatory association, I have argued that such an anticipatory certainty, the certainty *that* such and such will exist in the way it has been-- to be exact, the determinate sense perceptual anticipation has--is the one imparted from the similar past experiences. To put it very simply, the reason that I anticipate with certainty that this laptop will continue to exist as it has been, as an object I can simply take up and use to write with as I have been, is because I have done so before for so many years. With this reminder in mind, let me go back to the discussion of trema.

Given the past experiences are implied in the perception via the affective propagation that emanates from the present to the similar past experience, its implication is as follows. In the moment the affective propagation awakens similar past experiences and informs the present perception it also conditions the anticipatory aspect of perception, such that one can not only perceive a familiar given object and its environment as that, as familiar, but also anticipate with certainty that they will continue to exist just as they have been. If in the instance of trema, one experiences *inexplicable something new*, to be exact, if one experiences the exaggerated affective prominence from the environment one already knows and perceives to be familiar and mundane, then it follows that: the past experiences and the commonsensical, everydaylife knowledge acquired therein are already implied in the present perception *and* the intensified affective prominence one experience in the present has no other set of similar past experiences to propagate towards. The implication being: one's anticipatory aspect of perception, to be precise, the perception of the exaggerated affective prominence coming from the mundane, familiar environment will lack the determinate, articulate sense. If in everyday life context one can anticipate with certainty *that*, say, one's room will be presented as it has been upon opening its door, in this state, *one will be uncertain with respect to just what is going to happen* if one opens the door-- that exact same door that one has been seeing for many years and thought nothing of thus far but, for some unknown reason, all of a sudden, constantly captivate one's attention and seeming to tell one self something significant. As I discussed in the previous chapter, something is anticipated but just as that, as indeterminate, unspecific 'something'. Given, in the instance of trema, this intensified affective prominence is not coming from a particular individual object but

[94] Emphasis is on the mode of existence, not the existence itself.

from everywhere one's glance lay hold of, it is not simply that one is uncertain with respect to the future moment of perceived object but one's entire perceived environment, hence the experience of trema that "Everything in the street was so different, something is bound to be happening [...] Something must be going on", "something" is going to happen."

Going back to the dialectic of the argument, let us entertain this question: Is trema a result of the disturbance in the natural-ontological attitude? Does one experience that "something" is going to happen because the usually stable, taken-for-granted certitude in the mind-independent existence of the world is disturbed? If the natural-ontological attitude can be specified[95] and can be identified with habitual certainty, then, yes, in the final analysis, it is. However, the conclusion of such an analysis would still not be enough to justify that the ipseity disturbance gives rise to trema. For the trema to be counted as a result of ipseity disturbance, the proponents of the ipseity disturbance would have to first clarify how exactly it is that ipseity disturbance leads to the natural-ontological certitude alteration particular to the delusional mood. That is, the specific kind of alteration that underpins the sense of non-finality that "something is going to happen".

To be clear, the point of the above analysis was not to contest the claim that the natural-ontological certitude is disturbed. In effect, it was detailing what such a disturbance might exactly amount to, specifying which aspect of perception could have been altered by remaining close to the reported experience of trema. The concepts, such as "affective repression" and "affective propagation", and its derivative expressions, were the tools I use to articulate the almost-ineffable characteristic of the delusional mood, i.e., the experience of perceiving something inexplicable new from the mundane, familiar environment, and the possible implication such an experience may have with respect to the way one experiences one self and the world. In doing so, I hope to have shown that there is a plausible way to accommodate trema experience without having to appeal to the ipseity disturbance generative claim.

§6.3.4. Summary

Let me summarise the above analyses. I have brought attention to the affective dimension of the delusional mood experience, i.e., the exaggerated affective prominence one experiences from the mundane, familiar environment. This was to show that, in part, in the instance of

[95] Its scope has to be better delimited.

delusional mood, hyper-reflexivity like experience exists as a correlate of the characteristics features of delusional mood, i.e., decontextualisation, apophany and anastrophe. If the generative claim has to be made, it has to be predicated on the changed perceived environment. One immediately feels that everything seems to turn towards oneself (i.e., anastrophe or spasms of reflexion) and/or one's attention is captivated by objects and objects (i.e., prolonged gazing) without having to think as such, *because,* simply put, things start to look weird. By employing Husserl's account of affection, I have identified the structural underpinning of this 'things-looking-weird' experience -- or to be precise, the experience of perceiving inexplicable something new from the mundane, familiar environment -- as affective repression failure and clarified its implication. In the analysis of trema, I have further demonstrated how the affective dysregulation experience could alter the anticipatory aspect of perception. To be clear, the experiential abnormalities derivative of ipseity disturbance (be it hyper-reflexivity like experience or natural ontological certitude alteration) are present in the stage of delusional mood. My point is that the presence of such an experiential abnormality does not justify that the ipseity disturbance gives rise to the constitutive features of delusional mood. At the risk of sounding crude but for the sake of simplicity, not everything can be a manifestation of ipseity disturbance. This emphasis on the self-disorder, or the attitude to link various aspects of the target phenomenon to the ipseity disturbance, could have made researchers overlook other possible modal alterations involved in the delusional mood experience. I have shown such a possibility by zeroing in on the experience of exaggerated affective prominence and identifying its underpinning alteration as the affective repression failure.

Grant that the above affective account is somewhere along the right lines, that, yes, in the stage of delusional mood, things start to look weird, and one starts to feel weird about it. But how exactly does such an experience contribute to the formation of primary delusions? If not with the ipseity disturbance claim, then with what can one explain the double bookkeeping and revelatory features of primary delusions? The short answer: Delusional mood experience itself. In the following, I first argue that the experience of perceiving something inexplicable new from the mundane, familiar environment is solipsistic and revelatory in nature. Afterwards, I argue that such an experience underpins the particular mode of understanding oneself and the world that underpins the formation of primary delusions. With this account, I explain the defining features of the primary delusions: double-bookkeeping and revelatory themes.

§6.4. Revelation and Solipsism

Given the above affective account is somewhere along the right lines, the experience of perceiving something inexplicable new from the mundane, familiar environment carries the following implications. First, the sedimented past experiences and the commonsensical, everydaylife knowledge acquired therein are implied in the present perception, hence the perception and recognition of familiarity and mundaness of one's environment. Second, the affective prominence of the present perception cannot be accommodated by the implied past experiences, hence the experience of inexplicable something new from the mundane, familiar environment. To translate these implications at an experiential level, it is the following. A person knows what a given object is and what it is for, a cup as a cup to drink from, and recognise one's surroundings as a familiar environment, one's room as just that, the familiar room one has been living in for some time, etc. That same environment and that same object, one knows and perceives to be familiar, however, solicits, beckons, allures, and captivates one's attention. This exaggerated affective prominence is immediately felt as an entirely new experience (recall: "*Sights and sounds possessed a keenness* that he had never experienced before", "It was as if parts of *my* brain awoke, which had been dormant*"*; "*my senses seemed alive...* Things seemed clear cut, I noticed things that I had never noticed before"). This alien experience of exaggerated affective prominence is revelatory and solipsistic in nature. Let me unpack this claim as it will be important in characterising the mode of understanding contributing to the formation of primary delusions.

It is revelatory in the sense that the correlating end of the experience of exaggerated affective prominence is the entire world *seeming to tell oneself there is something more than what meets one's eyes* (e.g., "nothing is what it seems" and "everything exists to be understood beneath the surface".) To recall, Susan reports that "undergoing a psychotic break was like turning on a faucet to a torrent of details, which overwhelms mylife" and claims that everything she "sees and hears" took on a "halo of meaning [...] the movies, TV, and newspapers were alive with information for *those who knew how to read* […] an advertising banner revealed a secret message only *I could read*." Scherber (1988) similarly writes in his memoir that he has gained a "*deeper insight than [that available to] all other human beings*' p.7) and 'I have come infinitely closer to the truth *than human beings who have not received divine revelation*' [p.41]). Regarding such a revelation, Kepinski writes in his vignette: "It seems as if the patient discovers the essence of

reality-- Kant's "Ding an sich". According to the patient, other people are ignorant and only aware of the Kantian phenomenon." (Kepinski, 1974, p. 118-119; as translated in Parnas, 1993, p.592). Similarly, Sass writes: "Every detail and event takes on an excruciating distinctness, specialness, and peculiarity – *some definite meaning that always lies just out of reach, however, where it eludes all attempts to grasp or specify it*" (Sass, 1992, p. 52). In short, the alien experience of exaggerated affective prominence is revelatory in the sense that the world of conscious experience presents itself in its uncanny indeterminacy, as if everything is there for one to determine ever more closely its indefinable, hidden meaning.

This alien experience of exaggerated affective prominence is 'solipsistic' in the following specific sense. One knows that it is only one self who is having such an alien experience and no one else, or from one's perspective, revelatory experience. Susan, as discussed above, is well aware that other people cannot see what she perceives ("the movies, TV, and newspapers were alive with information for *those who knew how to read";* "*only I could read"*), so is Schreber (he is aware that other humans do not have the insight he has). Meaning, in the stage in the delusional mood, one perceives the other people as actually existing people endowed with the similar perceptual capacity one has, albeit limited. Against the backdrop of this awareness, one can know that it is only one self *and no one else* who is having the revelatory experience. A patient considered by Freyer's et al., reports:

> At the steps of a catholic convent, a dog was waiting for me in an upright position, watching me seriously. As I approached, it lifted its paw. *By chance, another man was walking a meter from me. I quickly caught up with him and asked if the dog had also introduced itself to him. An astonished 'no' made me certain that I was here dealing with a plain revelation.* (Feyaerts et al., 2021, p.3; italics added)

In sum, the experience of perceiving something inexplicable new from the mundane, familiar environment is revelatory and solipsistic. The correlating end of the world of experience that presents itself in its uncanny indeterminacy (revelatory). The other end is the self experience in which one immediately senses that one has become the passive middle point of the universe, feeling as though everything is turned towards one self (solipsistic).

Both experience, that of solipsism and revelation, may elicit the pressing need to find a new framework of understanding the world and one self. Expressing such a need, a patient

considered by Møller and Husby (2002) reports that in the early state of her psychosis "I *had to* define and analyze everything I was thinking about; *needed new concepts for the world and human existence;* absorbed by new ideas or interests, gradually taking over my way of life and thinking" (Møller and Husby, 2000, p.22). C.D.B., a 27-year-old man, a patient considered by Giovani Stanghellini, reports that "nothing is obvious" to him and "everything can be *uncanny*". Stanghellini notes that his patient expressed "the need for a general theory that makes the world understandable and his actions possible" (Stanghellini, 2000, p.777). Another patient of his, V.V., a 22 year-old university student, reported that she planned to remove herself from what she calls, "heteronomia" (i.e., depending on the rules established by others). This is to find the "original and eccentric view on the human condition" (Stanghellini, 2000, p.778). Stanghelli accordingly concluded that "They [the people living with schizophrenia] seem to lack, or sometimes to reject, common sense categories that are normally used to typify everyday experiences. In short, people with schizophrenia are hypoconnected to common sense" (Stanghellini, 2000, p.778). This tendency to reject or ignore everydaylife, a commonsensical assumption of the world and its replacement with a new framework has been also reported by traditional psychopathologists. Regarding such a tendency, Blankenbrug writes that the people living with schizophrenia "try to replace the 'natural successiveness or consistency of experience that rests on common sense with what are sometimes more, and sometimes less ingenious logical constructions [...] There follows a rigidity and consistency which is maintained with painstaking efforts." (Blankenburg, 2001, p.306). The phenomenon of which has been coined as "morbid rationalism".

To characterise this new framework of understanding the world and oneself, its thematic objects are: a.) the world that presents itself in its uncanny indeterminacy and b.) the correlating experiential I that immediately senses that something significant is going on, or the 'I' called upon by the world. The end result of this mode of understanding is the content in which the "somethingness" one has thus far perceived is thematized into specific delusional meaning. How exactly so? Why is it that the delusional mood experience is not simply dismissed as an unusual experience but elaborated into a delusional content? Short answer: because common sense doesn't cut it anymore. In Sophie's term, the problem is "rather the dissolution of the (common sense) assumption of certain metaphysical premises, that, as John [her friend also diagnosed with schizophrenia], any philosopher knows (knows but unironically cannot, unlike schizophrenic, *believe*) is fundamentally unsubstantiable." (Sass, 2014, p. 143) To clarify its implication, the

implied past experiences and commonsensical knowledge that, say, a glass is an object to drink from, cannot explain away the tantalising vivacity it exercises one self and captivates one's attention. If pushed by one's therapist or friend, that there is nothing more to the glass than it just being an everyday life object, one may articulate that one knows all that. Sophie writes: "I cannot count the number of times I've been told 'but Sophie, X is impossible' and all I ever want to say in response is *'yes, I am perfectly capable of appreciating why you think X is impossible, but your conceptual or metaphysical constraints are simply not mine*" (Sass, 2014, p.144; italics added). In other words, one just perceives inexplicable "something" new from, to stick to the example, the glass one knows and perceives to be mundane and familiar, and one is acutely aware that it is only one self who is having such an experience. Sophie characterises this alien exaggerated intensity she experiences as "*increases* in metaphysical dynamism, universal animism, emotional resonance, human and/or divine purposiveness [...] the common factor is not *a loss of dynamism or vitality, but simply radical change."* She terms this experience as 'derealization' and suggests that it is "the single most pervasive, enduring, and destabilising 'world-disturbance' in schizophrenia" (Sass, 2014, p.130). As indicated by Sophie's characterization, what seems to exacerbate this situation is that it is not simply a perceived individual object or an individual other that exercises such an intensified affective prominence but one's entire environment. Norma McDonald most vividly describes such an experience as follows:

> At first, it was as if parts of my brain *"awoke" which had been dormant, a*nd *I became interested in a wide assortment of people, events, places, and ideas which normally would make no impression on me.* Not knowing that I was ill, I made no attempt to understand what was happening, but felt that there was some overwhelming significance in all this produced either by God or Satan. *I felt that I was duty-bound to ponder on each of these new interests,* and the more I pondered, the worse it became. The walk of a stranger on the street could be a "sign" to me which I must interpret. Every face in the windows of a passing streetcar would be engraved on my mind, all of them concentrating on me and trying to pass me some sort of message. (McDonald, 1960, p.218; italics added).

To cut to the core, one does not dismiss the delusional mood experience as an unusual experience because it is revelatory and solipsistic, not pathological. One finds oneself in the

position to justify and determine ever more closely the bewildering, enigmatic manifestation of the world, just exactly why it is that everything seems to turn towards one self and seeming to tell one self (and no one else) that "something" significant is going on-- hence the pressing need to find a new way of understanding the world and oneself not the need to go see a doctor. The end product of this mode of understanding is the delusional content whose content reflects the specified inexplicable "something" new with respect to its thematic object: the bewildering, indeterminate world and the called-upon I. The world appeared so *because* it has been warning oneself of the inevitable emergence of the evil dictator, and only one self had that experience *because* one is the only one that stands in his way. The world appeared so *because* it has been trying to tell oneself one's origin is of the extraterrestrial being, and only one self who had that experience *because* one is the chosen one. The world appeared so *because* it has been foretelling its end, and only one self who had that experience *because* one is gifted with divine revelation. "Somethingness" is specified into determinate content. The oppressive tension that "something" is going to happen gets relaxed. One knows what this is all about. One knows what's coming. Delusion sets in.

In short, the experience of perceiving something inexplicable new from the mundane, familiar environment involved in the delusional mood stage brings about primary delusions. One does not dismiss such an experience because it is revelatory and solipsistic in nature. What enables the thematization of the delusional mood experience into delusional content is the particular mode of understanding in which one determines ever more closely the existential status of the world and one self, relaxing the oppressive tension that "something" is going to happen. With this in mind, let me discuss the double-bookkeeping and revelatory features of primary delusions.

§6.4.1. Double Bookkeeping and Revelation

To recall, the double-bookkeeping feature of primary delusions refers to the seemingly contradictory attitude one holds towards one's delusional content. To be precise, a person does not act on their belief despite their unshakable certitude, exhibiting both incorrigible and inconsequential attitude. In the above, I argued that the experience of perceiving something inexplicable new from the mundane, familiar environment (call this alien experience, AE) is solipsistic. The AE is solipsistic in the specific sense that one knows that it is only one self who is having AE and no one else. The implication being, in the stage of delusional mood, one is aware that a.) there exists other people inhabiting the same world one exists in, b.) those others perceive

the same object and world one perceives, and c.) the others do not have the same kind of experience the one is having. If the AE is solipsistic and if this AE is thematized into delusional content, then what that content articulates is the world of one's experience that other people have no access to. From one's perspective, the world one sees and understands in its full lucidity is the world other people are not even aware of despite perceiving and living in the same world one exists in. Meaning, one is aware of the separation between the world that only one self has an access to and the public world of others, and the delusional content is a theme reflective of such a world. Consider Sophie's case studied most extensively by Sass.

> Finally, both John and I agree that it is generally quite easy (except during periods of what John calls "extreme self-indulgence") to act "normal" precisely *because the non-coincidence of the delusional and the consensual/intersubjective is so obvious. I have never once, for example, when talking to my therapist, ever expected her to actually agree with me, or express some kind of shared sense of my alter-realities* [...] Both of us [John and Sophie herself], at any rate, have, on any number of occasions both pretended to believe in things we don't actually believe in *(or to believe in and insist on them to clinicians without acknowledging how self-consciously subjectivistic we felt them to be)* AND pretended not to believe things we actually did [...] *Last week I spent an entire hour trying to convince my therapist, for example, that one could be simultaneously convinced of two competing "realities" (and thus that insight should not be understood as something that simply increases only as delusional conviction decreases)* and yet I clearly failed to get this point through to her. (I will undoubtedly have to resort to my usual strategies [showing full conviction] in the future). John (who, I should emphasize, clearly was and is quite "crazy") describes the whole thing repeatedly as "performance" and "theatre" (Sass, 2014, p.136; italics added; capitalization original).

Another patient, considered by Parnas and et al. (2020), reports:

> I have always known that this was my place, this was my reality. Away from other people's reality. I live in the shared world just like all humans. And then I also have my own reality. Of course, I know that there is not a man standing there talking to

> me… It all takes place in my head. I know that. And I am completely aware of that. But to me it is my reality. I have lived like that for years. I really feel that I live in two worlds (Parnas et al., 2020, p.5).

In short, a person does not act on one's primary delusion despite one's certitude because one knows that it is about one's own reality that has nothing to do with the world of others. For that same reason, primary delusion is epistemologically immune to counter evidence/counter arguments, hence its appearance of incorrigibility to others. To make this point more intuitive, it may be comparable to the following situation. Imagine your friend, A, wrote a poem. You have another friend, B. B reads through A's poem and checks its logical consistency. B shows that the poem includes a set of propositions that contradict one another. B goes on to clarify the implication of having such a contradiction, that any proposition can follow from the poem. B accordingly advises A to revise the poem or stop writing such an irrational piece of work. In response, A claims "... okay, cool story bro." in a dismissive attitude, to mean that B is missing the point of a poem. In this case, the A's poem is epistemologically immune to the B's argument in the sense that the A cannot care any less about the logical consistency of the poem and that, as such, from the A's perspective, the B's argument does not constitute a good argument for the revision of a poem. In this case, A is not incorrigible. From the A's perspective, no "counter argument" is provided to be even incorrigible to. A and B are not playing the same game.

This situation may be comparable to the one in which a person living with primary delusions does not change one's mind despite overwhelming counter evidence and arguments. From one's perspective, the evidence and arguments proposed by others (e.g., friends and therapists) may not even amount to "evidence" or "arguments". The content of primary delusion pertains to the other worldly realm other people have no access to, and its justification, so to say, rests on one's own private, solipsistic understanding of such a world. In this regard, Saks writes: "[...] I was *choosing*, eg, to hold certain beliefs *even though* the evidence was not what would classically constitute 'good' evidence—*I had a special premium on the truth* (Saks, 2009, p.973; italics added)." To recall, Schreber described this access as having "*deeper insight than [that available to] all other human beings*' and 'I have come infinitely closer to the truth *than human beings who have not received divine revelation*' and explicitly claimed that "I could even say with

Jesus Christ: 'My Kingdom is not of this world'; my so-called delusions are concerned solely with God and the beyond;". This experience, or the solipsistic nature of the AE, could be the reason that primary delusion seems "incorrigible" to counter arguments and disconfirming evidence to others, when, in actual fact, it is immune to it.

As discussed above, the revelatory feature of primary delusions refers to, firstly, that primary delusion reflects eschatological, metaphysical, or religious themes and, secondly, that it immediately reveals its delusional meaning, without any cognitive efforts. Let me begin by addressing its first feature.

The AE (or the alien experience of the exaggerated affective prominence from the mundane, familiar environment), I have argued, is revelatory. It is revelatory in the sense that it presents the entire world -- the exact same world one knows and perceives to be mundane and familiar -- in its uncanny indeterminacy, seeming to insinuate hidden meaning or concealed "something" only one can perceive. Given the AE is solipsistic (in the specific sense discussed above), it follows that one knows that it is only one self and no one else who is having such a revelatory experience. If the AE is revelatory and solipsistic and if it is the AE that is thematized into determinate content, then what this thematization entails is the specification of that "something" into determinate content. Given that this "something" is the indeterminate, concealed meaning only one can perceive from the world, its specification entails the clarification with respect to just exactly why it is that it has been *only one self* who had such an experience and no one else: one had such a revelatory experience because one is the part of the good resistance, is a savior, is the chosen one, is a supernatural entity, etc., and, at the very least, not the kind of being other people are, i.e., human -- hence the bizarreness of the primary delusions.

As discussed above, primary delusions are revelatory in another sense that it articulates its delusional meaning immediately, without any cognitive efforts. To recall, as Parnas and Henriksen suggested:

> the delusional meaning [in the case of primary delusion] is revealed to the patient in an imposing manner rather than being grasped through cognitive efforts [...] This

> crystalisation is not a product of step by step inferential reasoning or reflection, but possesses a character of immediacy and revelation.

In the above, I have argued that the formation of primary delusions is involved with a particular mode of understanding in which one determines ever more closely the "somethingness" one perceives from the perceived environment. This claim seems to be in conflict with the established view that primary delusion appears out of nowhere. This largely stems from the Jaspers' incomprehensibility thesis. According to which, primary delusion does not arise "comprehensively from other psychic events and which can be traced back psychologically to certain affects, drives, desires and fears" (Jaspers, 1913/1963, p. 106–107). In Chapter 3, I termed this strand of argument as 'psychological irreducibility argument' and contested it. However, for the present purpose of the argument, let me render it relevant to the current discussion. It goes as follows:

> Primary delusion is a kind of mental state, such that if delusion, D, at tn originates from a prior "cognitive efforts" (e.g., "reflection" and "step by step inferential reasoning"), in short, C at tn-1, then the D at tn is, by definition, not primary delusion.

If, as I argued above, a.) a person determines every more closely the "somethingness" of one's experience and if b.) this mode of understanding is a type of cognitive efforts, then it follows that the product of such a mode of understanding, by definition, is not primary delusions. A quick way of preempting this kind of objection would be to retract the a.) or revise b.). I choose neither. The rejection of the a.) would amount to saying that in the state of delusional mood one does not make sense of the anomalous experience. This does not accord with the trainstory stage into psychotic stage (I justify this claim shortly). The revision of the b.) would amount to claiming that the mode of understanding I talk of has nothing to do with "reflections" and "step by step inferential reasoning." Before detailing my response any further, let me first point out a somewhat contradictory attitude held by contemporary phenomenologists regarding 'primary delusions'. This will help make a target appropriate response and assist in characterising the particular mode of understanding important to the formation of primary delusions.

In the contemporary discussion, there has been a constant unclarity regarding the use of the concept "primary delusions". In the analysis where researchers have to show that there is a kind of delusion that is not based on cognitive deficits, the "revelatory" feature of primary delusions or its appearing-out-of-nowhere characteristic has been emphasised (Frayers et al., 2021a; Frayers et al., 2021b; Parnas et al., 2020, Parnas & Henriksen, 2016). In this context, primary delusion is used to specifically mean delusional meaning experience. This use has been largely to contest the predominant neuropsychological model that posits delusions as a cognitive reaction (be this rational[96] or irrational[97]) to anomalous perceptual experience. However, in the discussion where researchers have to demonstrate how it is that delusional mood experience leads to primary delusions, its 'appearing-out-of-no-where' characteristic has been constantly underemphasized. Instead, primary delusion is used to denote a fully crystalised belief-like state or "quasi-belief" that originates from the delusional mood experience itself and/or its postulated underpinning, e.g., ipseity disturbance. It is in this context, a somewhat puzzling point is proposed, that is, delusional mood experience "is thematized" or "becomes thematized" (Sass & Parnas, 2002, p.112,113; Parnas et al., 2020, p.6) into primary delusions, or that delusional mood

[96]I specifically mean one factor theory originally proposed by a french psychiatrist de Clerambault (1942; as cited in Klee, 2004) and popularised by Brendan Maher (1974).This theory views delusion as a "hypothesis designed to explain unusual perceptual phenomenon and developed through the operation of normal cognitive processes" (Maher, 1974) These cognitive processes, Mahelr argues, are "indistinguishable from employed by non-patients, by scientists and by people generally". In simple terms, according to this theory, what goes wrong in the case of delusion is the perceptual experience, not the cognitive processes. Delusion is a product of normal cognitive processes making sense of anomalous perceptual experience.

[97]I specifically mean the two-factor theory of delusions. In brief, two major challenges have been posed to the one-factor theory. The first is a theoretical one which motivated researchers to identify additional factors of delusional formation. Klee writes that it is questionable "[...] indeed whether conceptually coherent-- to posit that raw perceptual experience contains its own thematic content (one stage) or whether, instead, thematic content is always supplied by a distinct stage of cognitive interpretation (two stage) (Klee, 2004; Cf. Chadwick & Birchwood, 1994). In simple terms, for a raw perpetual experience to be turned into belief content it has to be interpreted and appraised by some kind of cognitive process. The second challenge is an empirical one. One factor theory cannot account for the cases where a person does not develop delusion despite having anomalous perceptual experience akin to the delusional experience (specifically, that of capgras) (Elis & Young, 1996, Ellis, 1998). So came the two factor theory (Connors, 2020; Garety et al., 2001; Coltherart, 2011). This theory postulates that anomalous perceptual experience as the first factor that explains the unusual content of delusion and a disturbance in the cognitive process (i.e., belief evaluation deficit or bias) as the second factor that explains why a delusional belief is adopted as a legitimate one instead of being discarded.

experience is followed by "cognitive and metaphysical elaboration of this experience [delusional mood] into "various delusional explanations" (Parnas et al., 2020, p.6). With this in mind, let me go back to the above objection. It was as follows:

> Primary delusion is a kind of mental state, such that if delusion, D, at tn originates from a prior "cognitive efforts" (e.g., "reflection" and "step by step inferential reasoning"), in short, C at tn-1, then the D at tn is, by definition, not primary delusion.

If "primary delusion" here is used to mean the delusional meaning experience, then I agree with the above-mentioned researchers. The particular mode of understanding the world and one self I detailed above does not bring about the delusional meaning experience. To be precise, one immediately feels that one is an existentially different being than other people and the world presents itself in uncanny indeterminacy without any conscious cognitive efforts. This experience is not brought on by a reflection or step-by-step inferential process. One immediately feels so. However, if, in the above objection, "primary delusion" is used to mean a belief-like state that originates from the delusional mood experience as the aforementioned researchers themselves do, then I do not agree. If such is the case, if the cognitive efforts in trying to elaborate and make sense of delusional mood experience implies that its result[98] cannot be counted as an instance of primary delusion, then what licences such an inference has to be rejected on the following ground: the content of primary delusion always reflects the *clarified* existential status of one self and the world. Once delusion sets in, it is not that one simply feels that one has some significant role to play in this world or is just existentially different from other people in some vague sense[99]. Instead, one *knows specifically what that role is and what kind of being one is*. If the emergence of primary delusions has nothing to do with the cognitive efforts wherein one, at the very least, specifies the uncanny indeterminacy of the world and the I called-upon by such a world, then primary delusion

[98]As the researchers themselves put it, "cognitive and metaphysical elaboration" of delusional mood

[99] To put it in the empiricist account of delusion formation, the content of the delusional mood experience is not identical to the content of fully crystallised primary delusion. Thus, endorsement account is not a suitable candidate for explaining primary delusion formation.

should not have the specific type of content it has -- viz. the *clarified* existential status of oneself and the world. Yet it does.

My claim here is not that the reflection or inferential reasoning must be involved in formation of primary delusion, such that if delusional mood experience at tn-1 is not "reflected upon" or "consciously inferred" into delusional content, then the delusion at tn is not primary delusion. In some cases, such a conscious cognitive effort may contribute to the formation of primary delusions. In some cases, it may not. Consider Susan's case. In the early stage of schizophrenia, she frequented the movies to gather as much "data" as possible, which only she can decode and perceive from the movie screens. After months of "putting pieces together", she realised (in her words "a sense of clarity dawned on me") that "there was a secret history of the world to which I now became attuned [...] An evil dictator was gathering power to himself, and he meant to perpetrate a holocaust on the Nation" (Weinss, 2003, p.878). Consider Peter's case. At the onset of schizophrenia, he initially experienced that "strange change is affecting him", feeling that he has "lost contact to himself" and became increasingly "preoccupied with existential themes and Indian philosophy" (Parnas, 2000, p.130). As the illness progressed (after seven months from the initial experience of "strange change" affecting him), he felt that some fundamental change was happening, claiming that "something in me became inhuman", and expressed the need to "find a new path" in his life (Parnas, 2000, p.130). In the final stage (psychotic stage), he understood what this change was all about. He was convinced that his role was to assist the Indians in their salvatory mission and that he was brought to his place every day from another planet to carry out his mission (Parnas, 2000, p.131). For both cases, both individuals do consciously make sense of one's anomalous experience, either by directly engaging with one's reality or by appealing to an entire branch of philosophy. In other cases, primary delusion appears without conscious cognitive efforts. A patient of Henriksen and et al. at the onset of schizophrenia "suddenly got a thought that he was perhaps a saviour, destined to bring peace in the world. This ideation was followed not by any conscious cognitive efforts but "a global feeling of intense happiness." Meaning, there is no principled reason to understand the thematization of delusional mood experience only as *either* conscious cognitive efforts *or* (supposedly) non-conceptual, pathic delusional mood experience.

To stay with the dialectic of the argument, I am here targeting a certain attitude held by contemporary researchers specifically in the discussion of primary delusions. That is, a.) a somewhat misleading attitude that views the cognitive mechanisms involved in the formation of primary delusion as only "conscious cognitive efforts" (be this reflection or inferential reasoning, or natural deductive reasoning deficit, belief evaluation deficit, negative attributional style, or jumping to conclusion) and b.) a somewhat contradictory attitude (unless clarified otherwise) that postulates primary delusion is not a result of conscious cognitive efforts *and* primary delusion is a result of cognitive elaboration or thematization of delusional mood experience.

In correction to the a.), I suggest the following: the cognitive mechanisms involved in the formation of primary delusion need not be curtailed into conscious cognitive efforts. To be precise, the mode of understanding I discussed above need not be identified as "reflection" or "inferential reasoning". As a *mode* or as a way one understands the world and oneself present in the stage of delusional mood, it refers to the background context for a certain style of reasoning. In the above, I have characterised such a mode of understanding in relation to the AE. By demonstrating that the AE is solipsistic and revelatory, I emphasised that in the instance of the AE, firstly, one perceives indeterminate something more in a mundane, familiar environment that cannot be easily explained away by appealing to the past experiences and, secondly, that one experiences one self as the called-upon-I that has to specify such an indeterminacy. I have argued that this experience elicits the pressing need to find a new conceptual framework to understand one self and the world. By suggesting that the past experiences are still implied in the present perception, I have pointed out that it is not that in the instance of the AE one forgets or is completely oblivious that there is a plausible, commonsensical explanation for the 'odd' experience one is having. This everyday life explanation may simply not matter anymore. It cannot account for just exactly why it is that it is only one self and no one else who is having this experience wherein everything that constitutes one's environment beckons, allures and solicits attention to its every detail. If this is somewhere along the right lines, then the particular styles of reasoning involved in the formation of primary delusion can be *provisionally* specified as follows:

Type 1: One takes A to mean improbable (or impossible) B (inference 1), while being aware that the A can mean highly probable C as it has been taken to mean (inference 2) yet does not dismiss the inference 1.

Type 2: One immediately perceives A as (improbable or impossible) B (perception 1), while being aware that A can be perceived as (highly probable) C as it has been perceived (perception 2) yet does not dismiss the perception 1.

The type 1 would accommodate the above discussed Susan's and Peter's case, to be precise, the type of primary delusion followed by a conscious cognitive effort, whereas the type 2 would accommodate the case considered by Henrisken and et al., or the type of primary delusion that seems to immediately originate from the delusional mood experience. These types may closely correspond to the type of cognitive bias identified by the two factor neuropsychological model of delusion, i.e., the bias towards observational (or explanatory) adequacy. Briefly, as a type of cognitive bias, it refers to the tendency wherein a person forms a belief that accommodates perceptions "as if ignoring the relevant prior probabilities of candidate hypothesis" (McKay, 2012, p.347) (e.g., accepting the inference 2/ the perception 2 despite their implausibility/impossibility). I am aware that the postulated types have to be clarified further and that there can be other types that may contribute to the formation of primary delusions. These types and their distinction are only provisional. However, what has to be brought to attention here is the altered existential orientation, or to be specific, the general dismissive attitude towards the habitual, everydaylife understanding of oneself and the world. It is against the backdrop of such an attitude wherein one dismisses the everydaylife explanation that, say, one is falling ill, one can bother going to the movies to make sense of one's reality, to determine closely just exactly why it is that the world is trying to tell oneself something significant is on going. Against the backdrop of such an attitude, one can seriously entertain the idea that one has become the saviour of the world after having an intense feeling of happiness. The particular mode of understanding oneself and the world I discussed above in detail in relation to the AE is just that attitude.

In correction to the b.), that is, a somewhat contradictory attitude that primary delusion is not a result of conscious cognitive efforts *and* primary delusion is a result of cognitive elaboration

or thematization of delusional mood experience, I suggest the following. Given primary delusions sometimes originate from the 'conscious cognitive efforts' and that, sometimes, it doesn't, it is reasonable to retract a somewhat dogmatic attitude that licences the inference "if cognitive efforts then no primary delusion". Given primary delusions always have determinate conceptual content that reflects the specified existential status of oneself and the world, it is reasonable to postulate that the formation of primary delusion involves the specification of "somethingness" one has experienced in the stage of delusional mood. If the above account of the mode of understanding is somewhere along the right lines, then it can be further postulated that such a specification of somethingness need not be solely construed as 'conscious' cognitive efforts. Even if it is, such cognitive efforts can be taken to be reflective of the general orientation one takes towards the world and others. Acceptance of this claim may open up the possibility to fruitfully engage with the neuropsychological model of delusions.

§6.4.2. Summary

Let me summarise. In the above, I have discussed the double bookkeeping and revelatory features of primary delusions by focusing on the alien experience of perceiving something inexplicable new from the mundane, familiar environment, or the AE. I have first suggested that the AE is revelatory and solipsistic, in the following specific sense. It is revelatory in that in the instance of the AE, the world of experience presents itself in its uncanny indeterminacy, as if telling oneself there is something more than what meets one's eyes. It is solipsistic in the sense that one immediately feels that one has become the passive middle point of such a world-- the world that constantly beckons, allures, solicits one's attention-- and one knows that it is only oneself who is having such an experience and no one else. Afterwards, I have demonstrated how the thematization of such an experience could lead to the formation of primary delusions. By highlighting the solipsistic characteristic of the AE, I have pointed out that in its instance one is aware of the separation between the public, everydaylife world and that of one's conscious experience and, further, that the delusional content pertains to the quasi-solipsistic world, leading inconsequential attitude. In so doing, I brought attention to the possibility that the incorrigibility of primary delusion is its apparent feature, when, in fact, it is epistemologically immune to counter

evidence and arguments. By highlighting the revelatory features of the AE, I have demonstrated how the thematization of such an experience might lead to the formation of the bizarre content that elaborates one is, at the very least, not the kind of being other is. In addressing the revelatory experiential feature of primary delusion, I have identified a somewhat misleading and contradictory attitude held by contemporary researchers. That is, primary delusion is not a result of cognitive efforts *and* primary delusion is a result of thematization or cognitive elaboration of delusional mood experience. I have argued that there is no principled reason to suggest that for a mental state to count as an instance of primary delusion it must not be followed by a cognitive elaboration of delusional mood experience. Appealing to the particular mode of understanding the AE elicits, I have specified two provisional general types of inference and perception that may contribute to the emergence of primary delusions.

§6.5. Conclusion

In this chapter, I have discussed the formation of primary delusion from delusional mood experience. I began by critically reviewing the ipseity disturbance model. I argued that the ipseity disturbance generative claim has to be retracted as it fails to be one and suggested that it should be taken as an experiential claim. This meant the following: the ipseity disturbance, or to be precise, hyper-reflexivity like experience, is present in the delusional mood but does not give rise to it. I justified this claim throughout the analysis of the constitutive features of the delusional mood, i.e., decontextualisation, apophany, anastrophe, and trema. In so doing, I highlighted the possibility that the overemphasis on the self-disorder in the investigation of schizophrenia could have made overlook researchers the perhaps most common experience that transpires through various constitutive features of the delusional mood: the alien experience of perceiving something inexplicable new from the mundane, familiar environment. As opposed to considering such an experience just another manifestation of ipseity disturbance, I zeroed in on this experience and clarified the implication it might have for the way one experiences oneself and the world. By approaching it from its affective dimension, I argued that the experience of perceiving something new from the mundane, familiar environment is revelatory and solipsistic in its nature. I then showed how such an experience may elicit the pressing need to find the new conceptual framework

to determine ever more closely just exactly why it is that it is only oneself who is having such an experience and no one else, leading to the specification of the 'somethingness' one experience into determinate delusional content, or in accepted terms, leading to the crystallisation of primary delusion from delusional mood. I then provided a more detailed account that can accommodate the defining features of primary delusions, i.e., its double-bookkeeping and revelatory feature, without taking recourse to the ipseity disturbance generative claim but by remaining close to the delusional mood experience itself.

Let me conclude by addressing the relevance of the affective centred phenomenological account I propose here in relation to the important development in the neurobiological research of delusion formation, i.e., prediction error model. Prediction error model starts from postulating that perception and belief are intimately related with each other such that our perception always-already makes informed inferences about the likely future states based on empirical priors (e.g., past experiences and beliefs). To be specific, the prediction error model postulates that the brain functions in a hierarchically organised manner. At the cortically lower level, neuronal activity rapidly assesses the incoming stimuli with respect to the context information and empirical priors, while, at the higher level, abstract thoughts (or beliefs) actively shape those information into a set of probable predictions. These predictions or predictive signals cascades down to the lower level, making the most probable explanation for the incoming stimuli. Predictions often do not match with the incoming stimuli. When this occurs, prediction error is generated. Depending on its precision, the prediction error either gains saliency or gets ignored. If the error is salient enough, it is fed forward to the next higher-up hierarchical level, recalibrating the previous prediction into a more accurate one. In other words, depending on its precision, some prediction errors acquire saliency and drive new learning mechanisms, while some don't. According to the proponents of the prediction error model, what goes wrong in the case of delusion formation is that the brain[100] overly estimates the precision of certain prediction errors when they should have been simply ignored (Adams et al., 2013; Corlett et al., 2018)

Appealing to the associative learning models of delusions, Corlett et al. detail the inappropriate precision estimation and its implication at an experiential level as follows:

[100] Due to hyperactivity of dopamine or hypoactivity of glutamate.

> […] during the earliest phases of delusion formation aberrant novelty, salience or prediction error signals drive attention toward redundant or irrelevant environmental cues, the world seems to have changed, it feels strange and sinister, such signals and experiences provide an impetus for new learning which updates the world model inappropriately, manifest as a delusion (Corlett *et al.*, 2009a; Corlett et al., 2007a; Gray, 2004, 1991; Hemsley, 1994; Kapur, 2003).

The affective centred account I propose shares some overlap with the prediction error model, with respect to its focus on the aberrant saliency experience and clarifying its implication for delusion formation. Here I do not dispute the empirical justification for the neurobiological underpinning of inappropriate prediction error signals. However, it is noteworthy that the researchers often appeal to the classic phenomenological psychopathology literature for a personal-level explanation of delusion formation. For instance, after identifying the dysregulation of dopamine signalling as the neurobiological underpinning of inappropriate prediction errors, the researchers go on to write that, referencing *General Psychopathology,* "If persistent, this imprecision may ultimately lead to the formation of a new explanatory prior, or delusion, that consolidates the misrepresentation allowing it to pervade the deluded individual's future perception and action (Jaspers, 1963)[101]"-- (arguably) referring to the delusional mood in general. In other places, after identifying the neurobiological underpinning of the "sensory overload" experience, the researchers go on to suggest that "such a deficit could *conceivably* alter the sense of background and foreground that permeates normal perception" (Conrad, 1958a; italics added), referring to the above discussed 'decontextualized' phenomenon.

The affective centred phenomenological account I proposed here may help provide a more detailed account regarding how the inappropriately signalled prediction errors-- or sensory overload experience and aberrant novelty experience-- could lead to delusion formation. Albeit,

[101] We should be cautious here that Jaspers did not appeal to the contemporary prediction error model to explain delusion formation. Nor did he appeal to the classic Bayesian model. *General Psychopathology* was originally published in 1913. Further, only a part of *General Psychopathology* is dedicated for the description of delusional mood. The researchers should clarify whether it is the delusional mood they are referring to in the footnoted claim and, if so, they should further specify which aspect of delusional mood they are targeting in their analysis. Without this clarification and specification, the link they wish to establish between the identified neurological dysfunction and the target prodrome experience remains unclear.

this would require the translation of certain key neuropsychological terms, i.e., prediction error signals, and its derivative expressions, i.e., sensory overload and aberrant novelty, into a phenomenological term, i.e., affective dysregulation experience or AE. However, if this translation is possible, the researchers may need not be satisfied with making a set of "conceivable" postulations when it comes to the personal-level explanation of delusion formation. To be precise, with respect to the prodrome stage of schizophrenia, the proposed affective centred account may help explain how it is that the inappropriately signalled prediction error could manifestes in the form of experience the proponents of the prediction error model constantly refer to. This can help diffuse the worry that the changes in intensity of perception are not the only characteristic features of the early stage of schizophrenia and that such an aberration is not enough to explain delusion formation. With respect to delusion formation, the proposed account may complement why it is that the inappropriately signalled prediction error in the instance of schizophrenia leads to the formation of delusion, not everyday life hypothesis. The prediction error model, in turn, could help identify the neurobiological correlates for the affective repression failure. Further, with its neurobiological evidence for the role of empirical priors (e.g., past experiences and beliefs) in regulating the distribution of salience, the model could help motivate differentiating various types of memorial act involved in perceptual field constitution and its alteration in delusional mood. This can help specify the kind of 'affective propagation' I argued to be present in the delusional mood and the role of 'affective past horizon' in regulating the affective distribution of the living present. In such a way, both neurobiological and phenomenological approaches can help enrich each other's research. This will be the task of future research.

Conclusion

The aim of this thesis was to provide a systematic phenomenological account of primary delusion formation. Although there has been almost a century old phenomenological research tradition that targets self-disturbance and delusional mood as the precursor experiences for primary delusion formation, I have argued that their underlying affective dimension has been largely overlooked. Employing Husserl's account of affection, I clarified the nature of such an aspect of experience and termed it as 'affective dysregulation experience'. For the analysis of self fragmentation experience, I identified its structural underpinning as 'affective modification dysfunction'. For the analysis of the affective dysfunction experience present in the instance of delusional mood, I identified its underpinning as 'affective repression failure'. In this thesis, these concepts functioned as a conceptual scheme with which one can understand otherwise seemingly chaotic experience features present in both of the target experiences in their coherent unity. Zeroing in on the solipsistic and revelatory nature of the affective dysregulation experience, I demonstrated how such an experience could globally alter the way one experiences oneself, time, and world, ultimately leading to the emergence of primary delusion. In developing this affective centred account, I critically assessed and refined prevailing phenomenological accounts of self-fragmentation, delusional mood, and primary delusion. I have further charted out a possible way whereby phenomenologically oriented research and neurobiological research can enriche one another. Let me conclude by summarising this thesis and clarifying its future research directions.

In Chapter 1, I clarified the theoretical orientation of current research. I oriented this thesis with philosophical phenomenology. With this, I clarified the nature of schizophrenia predicated as a particular object of this thesis research. In this thesis, schizophrenia has been studied as a particular form of subjectivity whereby the object, space, time, mood, oneself, others, and events acquire and articulate their (albeit unusual) meaning. The specific focus of current research was the altered temporal and affective modes of experience, and its aim was to show how their alteration could contribute towards the formation of primary delusion. I further detailed how this kind of phenomenologically oriented research could provide two specialised types of understanding: nosographic understanding and structural understanding. If the nosographic one can be used to chart out the taxonomic order of schizophrenic experience, the structural

understanding, I argued, can be used to understand how it is that the individual features of schizophrenia are interrelated with each other, contributing towards its systemic understanding. Drawing on contemporary phenomenological research, I have articulated how such an understanding may benefit the nosographic and neurobiological inquiry into schizophrenia.

The affective centred account I provided in this thesis is a structural understanding. In Chapter 5 and Chapter 6, I have briefly shown how such an account could help complement the neurobiological inquiry into delusion formation. However, the proposed account may further aid a nosographic inquiry. In contemporary research context, researchers have accentuated the presence of the time fragmentation experience present in schizophrenia. Partly, this has been to highlight and describe in detail the core experiential feature that differentiates schizophrenia from other types of disorder, such as bipolar disorder and depression (Sass & Pienkos 2013 ab). However, Bowden has argued that the fragmentation experience is not only present in schizophrenia but also in mania (Bowden, 2013). Further, the time stop experience I discussed in Chapter 4 is known to be also present in depression (Neemeh & Gallagher, 2020). In short, recent findings suggest that both the unity and the velocity of temporal experience are altered across schizophrenia, bipolar disorder, and depression. Given this, it can be reasonably argued that the thus far targeted aspects of temporal experience (i.e, unity and velocity) are not good enough markers for differentiating anomalous temporal experiences implicated in those disorders. Another aspect of temporal experience researchers may focus on is its affective aspect. Given the affective centred account (Ch.4) is somewhere along the right lines, it can be initially hypothesised that in the case of schizophrenia the unusual attraction or pull one experiences originates from the temporal *modes* of experience itself: past, present, and future. Whereas, for instance, in the case of depression, it can be hypothesised that the pull or attraction one experiences originates from the content of temporal experience, viz. specific events one experienced in the past and specific events one expects to happen to oneself in the future. The expected result would be the following. For the case of schizophrenia, researchers will see a cluster of reported experiences whereby one describes unspecified something affecting, attracting, or coming towards oneself *but with a clear reference to the temporal modes of experience*. In the instance of depression, one will see a cluster of reported experiences whereby one describes *specific content* of past or expected future events, perhaps, expressed in the form of depressive ruminations and hopelessness. If the empirical findings suggest

otherwise, the initial hypothesis would have to be revised. Carrying out such a task goes over the scope of current research. This will be the task of future research.

In Chapter 2, I critically assessed two most notable methods proposed, employed, and clarified by various researchers in the phenomenological study of mental disorder: ideal type approach and essential type approach. I assessed both and chart out a possible way whereby both approaches can complement one another. In short, I advanced a mutual complementarity thesis. My argument went as follows. First, I focused on the aim of the ideal type approach: constructing a type that exemplifies the "unified conceptual whole" with which one can understand various features of a given disorder in their conceptual unity. Following Jasper's adaptation of the ideal type, the proposed method in making such a type was by "synthesising" or "grouping together" individual features into an analytic construct (Schwartz et al., 1995, p.426). Second, I contested this claim with the following: unless one already presupposes a certain relationship between the target features, grouping them together will only produce a cluster-like type that shows they are present in a given disorder, not how they are related to each other. Third, I appealed to the essential type approach to resolve this issue. I demonstrated how this approach, with its emphasis on clarifying the necessary, ideal connection between various types of experience, could help construct the unified conceptual whole the ideal type aims to exemplify, and thereby complementing the ideal type approach. Fourth, I argued that complementarity has to go both ways. Essential types can very easily grow reluctant to a falsification process. The process of which would be crucial to identify and isolate the features the essential type aims to exemplify: the essential ones that confer a particular type to a given disorder. I argued that the findings of the ideal type complemented by the essential type can help continually revise and refine an essential type in use and pushed for a mutual complementarity thesis. Applied in the current research, this mutual complementarity thesis amounted to the following. First, as an ideal type analysis, the subject matter of this thesis was not the concrete totality of the formative stage of primary delusion nor its essential features. The target experiences are the types of experience that have been deemed characteristic/typical to the formative stage of primary delusion: self-fragmentation experience and delusional mood experience. Second, as an ideal type analysis, the set of claims I made with respect to their underlying structure (i.e., "affective modification dysfunction" and "affective repression failure") is an analytic construct. It is a conceptual scheme that helps one to better understand

otherwise seemingly disparate features of the pre-delusional experience in their coherent unity. Third, as an ideal type analysis complemented by the essential type approach, I employed phenomenological concepts that articulates the basic, essential structure of temporality and mood to clarify the nature of target experiences.

An interesting line of development for the proposed mutual complementarity thesis would be to clarify its implication with respect to the recently developed psychiatric classificatory scheme: dimensional approach. Recently, dimensional classificatory approach has been put forward for both clinical and research purposes, e.g., the Hierarchical Taxonomy of Psychopathology (2017) and the Research Domain Criteria (2010). As opposed to the currently prevailing categorical approach whereby a person *either* has a mental disorder *or* does not, the recently proposed dimensional approaches suggest that a person falls on the broad spectrum of experience, behaviour, traits, and neurobiology that can alter across populations (be it "healthy" or otherwise) and various types of clinical categories. This dimensional approach aims to a.) do away with a somewhat arbitrary categorical distinction between 'the normal' and 'the pathological', b.) resolve comorbidity issues, and c.) provide categories useful for neurobiological researches. In tandem with this recent development, Fernandez (2016, 2019) argued that phenomenologists should also adopt a broad dimensional outlook in their study of mental disorder. Briefly, his proposal is that phenomenological concepts that denote the basic dimension of subjectivity (e.g., temporality, intentionality, affection, selfhood, understanding, etc.) should function as the "general domain" in a phenomenological psychopathological study. This helpfully orients a phenomenological research to the clearly distinguished structural features of subjectivity. Having this orientation established, researchers can zero in on the particular mode of experience that belongs to its correlating general domain (or "subconstructs"). For instance, targeting the temporality general domain, researchers can compare and contrast the particular mode of temporal experience present in, say, schizophrenia and depression. This type of research will be useful for making a clear distinction (or identifying overlap) between different clinical categories (for this case, that of schizophrenia and depression). Or, researchers can focus on the particular mode of experience present in a single disorder. This will be useful for clearly articulating diverse psychopathological profiles present in the instances of the target clinical category *and* organising

them with respect to the common modal alteration. The result of these types of dimensional research will be extremely valuable for revising and refining current clinical categories.

Though, here, I cannot clarify the importance of this newly proposed dimensional approach in relation to the history of phenomenological psychopathology, I agree with this new proposal and the motivation behind it. The nosographic understanding I briefly sketched out in Chapter 1 owes much of its inspiration to Fernandez's dimensional approach. However, I have some worries with respect to its use in a psychopathological study. The dimensional approach may come in direct conflict with a (somewhat) essentialist phenomenological psychopathological research into mental disorder. Specifically, it may come in conflict with the long standing research tradition that aims to identify the 'basic disorder' (or "grundstörung", Blankenburg 1971/1997), 'generative disturbance (or "trouble genérateur" (Minkowski, 1927/1997)), or, in contemporary terms, 'core disturbance' of the mental disorder in question. As discussed in Chapter 1 and Chapter 2, those concepts refer to the underlying core gestalt alteration that defines and provides specificity to the disorder under investigation. For the case of schizophrenia, phenomenological psychopathologists have identified its various underlying gestalt alterations, e.g., minimal self disturbance, the loss of vital contact with reality, the global crisis of common sense, false-self system, disembodied existence, etc. These have been often deemed as the basic or core features of schizophrenia. For the sake of brevity, let me term a phenomenological psychopathological account that identifies the underlying core disturbance that defines and provides specificity to the disorder under investigation as an "essentialist account". Now, if a researcher orient their dimensional research with such essentialist accounts, the researcher has to accept that some particular mode or subcontructs (e.g., minimal self, basic attunement towards the world, synchronicity with the social world, etc.) can be altered only in the case of schizophrenia *even prior to an actual investigation.* This will defeat the purpose of the dimensional approach: systematically examining the heterogeneity of mental disorders and the alterations present the basic dimension of subjectivity across the norm and the pathological.

One way of pre-empting this issue would be the following. At least, for a dimensional research, researchers should not orient their research with the essentialist accounts. However, this will come at some cost. As Fernandez would agree, phenomenological psychopathological

accounts systematically organise the lived experience of the target disorder *in relation to* the identified core disturbance. The essentialist accounts, or to be precise, a set of claims regarding the underlying structural disturbance of the disorder in question, is *structurally linked* to the self-reports, memoirs, interviews, case histories, and clinical vignette — such that the organisation of the latter (which expresses the particular theme of the disorder in question) makes no sense without the former and vice versa. As such, foregoing the essentialist accounts in a research context does not simply entail rejecting some essentialist claims but also the systematic organisation of the experience that is linked to such claims. Further, as correctly noted by Fernandez, although it is true that phenomenological psychopathologists do not make a clear distinction between the general domain (or structure) and the subconstructs (or particular mode), their research generally identifies a general structural alteration involved in a target disorder and demonstrates how such a general alteration could manifest in the form of particular experience typical of the disorder in question. Given this, for a dimensionally oriented phenomenological research, the essentialist accounts can be used to helpfully identify the general domain and its correlating subconstructs that have been deemed crucial for understanding the disorder in question (albeit, this will take the procedure of clearly distinguishing the structural claims from the particular modal claims). However, as mentioned above, this will come at the cost of presuming that some modes are particular only to some disorder and that that mode can be only altered in the case of that specific disorder. This, again, will come in direct conflict with the dimensional approach.

Another way of addressing this issue would be to accept the proposal I made in Chapter 2. That is, at least, in the initial stage of investigation, take the essential type as a useful conceptual tool, as a heuristic device, that can sketch out the organising principles of the mental disorder in question. Given this proposal can be accepted, researchers can, for instance, appeal to the minimal self disturbance model in the dimensional study of schizophrenia and initially accept that the minimal self disturbance and its derivative experiences, e.g., hyper-reflexivity and diminished self-affection, are *present in* (not, present *particular to*) schizophrenia. This can helpfully clarify the target domain and subconstructs of the dimensional research as follows: selfhood (domain), minimal self and operative intentionality (subconstructs). In other words, by orienting the dimensional research to the specific domain and subconstructs of the disorder in question, the essentialist accounts can aid the research design stage of dimensional phenomenological research.

Having the target domain and subcontructs clarified, the researchers may carry out a comparative investigation between schizophrenia and, say, dementia. If the empirical findings suggest that minimal self disturbance is present in both disorders but hyper-reflexivity and diminished self-affection are present only in the case of schizophrenia, this will provide a strong reason for the proponents of the minimal self model to clarify and revise the implicatory relationship they postulated between minimal self disturbance and its derivative experiences. In such a way, the essentialist approach of phenomenological psychopathology and the dimensional approach can stand in a mutually informative relationship. This is only a provisional outline. I hope to develop this line of inquiry in future research.

In Chapter 3, I addressed the enduring challenge in providing a phenomenological account of primary delusion. The challenge was this: primary delusion is, in principle, un-understandable, and it indicates the end of a phenomenological research. I termed this point as 'the incomprehensibility thesis' and critically assessed it. I systematised Jaspers' argument into two strands: a.) closed-to-empathy argument and b.) psychological irreducibility argument. I rejected both. I argued that, in an attempt to cleanly circumscribe primary delusion, Jaspers raises the bar of empathetic understanding way too high, such that not only does primary delusion (easily) fail to satisfy such a requirement also so do almost all or all ment states of others. I then replaced Jaspers' account of empathy with radical empathy in support of the contemporary view that considers Jasper' incomprehensibility thesis as an ethical precept. Taken in such a manner, the incomprehensibility thesis amounts to that the otherness one finds in primary delusion indicates not the end but only the beginning of its phenomenological inquiry. The inquiry in which a researcher, I have argued, firstly, clarifies the altered structure of primary delusion to render it understandable and, secondly, constantly refines, develops, or rejects the proposed structural account with respect to the lived experience of primary delusion. Having this incomprehensibility thesis in mind, I critically assessed the prominent phenomenological accounts of self-fragmentation, delusional mood and primary delusion and highlighted its often overlooked aspect, i.e., affective dimension. I started from the self-fragmentation experience.

In Chapter 4, I turned my attention to the specific target phenomenon that has been known to be involved in the formation of primary delusion: self-fragmentation experience. I highlighted

its much-neglected aspect in the contemporary phenomenological analysis of schizophrenic temporal experience. That is, its non-emotional, affectively prominent experience whereby one experiences pervasive 'attraction' or 'pulls' coming from different temporal modes of experience: the past, present, and future. I argued that this kind of experience is not yet another experience that happens to be present in the case of schizophrenia but indicative of the core disturbance that underpins schizophrenic temporal experience. I began by reviewing one of the most systematic phenomenological accounts proposed by various prominent figures using Husserl's account of inner time consciousness (Fuchs, 2007, 2010, 2013, 2017, Fuchs and Van Duppen, 2017, Sass and Pienkos, 2013, Stanghellini et al., 2016). The account according to which the total breakdown, fundamental disintegration, or collapse in the structure of inner time consciousness underpins the self-fragmentation experience (in short, 'structural account'). I rejected it on the grounds of radlicaity. The structural breakdown does not implicate self-fragmentation experience. It implicates the impossibility in having any first-personal, subjective experience. After contesting this structural account, I proposed a provisional account that details the structure of schizophrenia temporal experience with respect to its affective dimension. As opposed to its total breakdown, in the case of schizophrenia, I argue that the structure of inner time consciousness no longer modulates the affective intensity of the retained just-past consciousness. I termed this malfunction as the "affective modification dysfunction" and employed it as a core concept with which I organise and synthesise heterogeneous components of schizophrenic anomalous temporal experience in their coherent unity — not limited to the self-fragmentation experience but also its closely related temporal experiences, i.e., time stop, ante-festum, déjà vu/vecu, and time fragmentation. I concluded by demonstrating how this affective centred approach can further help us illuminate the nature of the pre-psychotic phase known to precipitate primary delusion, i.e., delusional mood.

An interesting line of development for the proposed account would be to consider its application for the thought insertion symptom of schizophrenia. Recently, Mishara et al. (2016) argued that the self-disturbance in schizophrenia, specifically, the fragmentation involved in the "inner connected of thoughts and experiences" (p.5), is closely related to the thought insertion experience. Appealing to the traditional psychopathological accounts, the researchers suggest that the distinctive feature of thought insertion symptom is the loss of the 'sense of ownership'

regarding one's thought. The researchers employ the integration deficit hypothesis (Martin & Pacherie, 2013) to explain such a loss. Very briefly, this hypothesis suggests that the sense of ownership of a thought is produced by the coherent integration of an occurring thought with its relevant casual-context information. An occurring thought is judged to be well integrated into its relevant casual-context information if it is generated and/or constrained by the following factors: 1.) perceptual constraints, 2.) situational constraints, 3.) doxastic background constraints, 4.) immediate internal constraints, 5.) memory constraints, 6.) emotion constraints, and 7.) volitional constraints. The postulated hypothesis is that, in the case of schizophrenia, an occurring thought is not so well integrated into its relevant causal-context information, leading to the loss of the sense of ownership of a thought. Linking this hypothesis to prediction error model, Mishara and his colleagues argue that the thought that is not so well integrated into its relevant causal-context information acquires saliency (Mishara et al., 2016, p.7). This saliency attracts a person's attention, leading to the attribution of alien agency to the given thought.

For now, I do not concern myself with Mishara et al.'s proposal for connecting the integration deficit hypothesis with the prediction error model. However, one concern I have with respect to Mishara et al.'s (and, by implication, Martin's and Patcheri's) explanation is that the integration deficit hypothesis seems to presuppose what it is trying to explain. To be precise, the successful integration of the episodes of thinking into its relevant causal-context information presupposes that the mental states involved in such an integration already possess the sense of ownership. Consider the "immediate internal constraints". If the content of a thought at tn+1 depends on the content of the thought at tn-1, then the integration process involved in the thought at tn+1 is said to be constrained by the immediate internal constraints. Say, if I think "I should find the washing liquids" after thinking "I should do the dishes", then the "I should find the washing liquids" thought is said to be constrained by the immediate internal constraints. This integration is, *inter alia*, responsible for the generation of the sense of ownership. My wager is the following. If the thought at tn-1 lacks the sense of ownership (i.e., the implicit sense that obviously it is me who has a thought that goes "I should do the dishes"), I wouldn't have been able to think that "I should find the washing liquids". As the self-reports regarding such a self-disturbance experience indicate, in such a case, it will be much more likely that one will question if it is oneself who is having one's thought as one's own, and not, at least, think "I should find the washing liquids". In

other words, in the case where the thought tn-1 lacks the sense of ownership, the thought at tn +1 will not be successfully integrated into its preceding thoughts. This violates the internal immediate constraint. The same goes for other constraints. If the mental states (be it thought, beliefs, perception, memory, or volition) so constrained by the above listed 7 factors lack the sense of ownership, an occurring thought will not be constrained by or generated by such a set of states. This will violate the above mentioned constraints. In other words, the successful integration of the episodes of thinking into its relevant causal-context information requires that the mental states involved in such an integration process already possess the sense of ownership. To be precise, the sense of ownership of mental states is the necessary condition for the successful integration of an occurring thought into its relevant casual-context information. Given a.) the proposed hypothesis is that it is such an integration process that generates the sense of ownership and given b.) that the necessary condition for such an integration is that the mental states involved such a process already possess the sense of ownership, it follows that the causal-context information integration process does not generate the sense of ownership. It presupposes it.

I am aware that the integration deficit hypothesis is much more complicated than what I have presented above. And *even if* the above objection goes through, this hypothesis will still be extremely useful for explaining symptoms that exhibit disturbances in semantic coherence (i.e., disordered thought patterns) — not, however, for the thought insertion experience. One way of addressing the identified issue would be to supplement the model with a more robust account of the sense of ownership. In Chapter 4, appealing to Husserl's account of inner time consciousness, I sketched out what such an account might look like. I argued that retention plays an essential role in the constitution of the temporal unity of an experience and its first-personal presentation across time. This can provide a systemic account on the "causal coherence" of temporal experience, that is, the aspect of temporal experience the proponents of the integration deficit hypothesis argues to be missing in the instance of the thought insertion experience. In Chapter 4, I have further demonstrated how a dysfunction in the retentional element of time consciousness could seriously endanger the sense of self ownership regarding one's experience. This theoretical postulate may help interpret the neurobiological evidence that indicates the working memory impairment involved in the thought insertion symptom (Martin and Patcherie, 2013). In so doing, the proposed

affective centred account may help strengthen the explanatory power of the integration deficit hypothesis. This is only a provisional outline. I hope to carry out this task in future research.

In Chapter 5, I sustained my focus and developed an affective centred account for delusional mood. I began by reviewing its contemporary accounts. The accounts according to which the structural disturbance in the inner time consciousness and urdoxa underpins the delusional mood experience. I contested it on the charge of radicality. After raising this objection, I appealed to Husserl's account of affection and affective syntheses (Husserl, 2001b). From the discussion of affection and affective syntheses, I gleaned two conceptual tools necessary for providing an alternative account of the delusional mood: affective repression and affective propagation. The former regulates the prominence of a perceived object and its encompassing context, and the latter enables the past experiential life of a subject to provide a framework of determinate sense and familiarity to the present experience. Employing those concepts, I identified the structural underpinning of delusional mood as "affective repression failure". I argued that this structural alteration underpins the above mentioned experience whereby every insignificant detail of one's familiar surroundings attracts one's attention and termed this kind of experience as 'affective dysregulation experience'. I demonstrated how such an experiential abnormality could implicate the notable characteristics of the delusional mood. Afterwards, I related the above finding to the aberrant salience hypothesis (Kapur, 2003, 2005) and advanced a mutual enlightenment thesis. I tentatively suggested that the neurobiological hypothesis can complement the proposed phenomenological account by identifying the neurobiological correlate of the affective repression failure. In turn, the proposed phenomenological account can complement the hypothesis by illuminating how exactly it is that the peculiar affective saliency experience, or in neurobiological terms, aberrant salience phenomenon, can give rise to the delusional mood experience, and thereby resolving its issue concerning the mind-level explanation of the delusional mood.

One interesting line of development for the proposed account is the specification of the affective propagation operative in the delusional mood. In Chapter 5, I briefly mentioned Hemsely's cognitive model of schizophrenic delusion to clarify the nature of the affective propagation present in the delusional mood. To recall, I argued that in the case of delusional mood,

it is not that the past experiences no longer contextualise the present perception. The past experience and the knowledge acquired therein (i.e., affective past horizon) are still implied in the living present. To be precise, the affective force of the present perception that presents a given object still propagates towards the affective past horizon and awakens the similar past experience and the knowledge acquired therein, thereby enabling one to perceive it as a familiar object whose name one can recall and articulate its practical significance. The problem, I argued, however, is that the affective force of the *same* perception that presents the *same* object *at its intense vivacity* has no similar past experience to propagate towards. Within the affective past horizon, there just is no similar past experience in which every experienced feature of an object had become prominent and imposed its tantalising vivacity on the subject. This disturbance, I argued, underpins the feeling that 'something more' is indicated by a given familiar object, engendering a somewhat paradoxical experience wherein one experiences unfamiliarity from a familiar object. This process may closely correspond to the 'low latent inhibition' process hypothesize to be implicated in the formation of delusions. Latent inhibition refers to the process whereby the pre-exposed, familiar stimuli is "marked as insignificant and not worthy of further attention". This process is mediated by the activation of appropriate context material (past experiences and beliefs) for processing the current sensory input. Importantly, Hemsely writes: "The LI (latent inhibition) does not simply represent a form of habituation. There is a major difference between the two: *LI is disrupted by a change of context, whereas habituation is not*" (1993, p.638). Given this, it can be reasonably argued that the affective repression failure (which amplifies the affective vivacy of one's surroundings and perceived objects) may take a temporal precedence over affective propagation in the development of delusional mood. This line of inquiry, so aided by the cognitive psychological model, could help further clarify how affective repression failure could globally alter various modes of experiences present in the instance of delusional mood. This will be the task of future research.

In Chapter 6, I focused on the affective dysregulation experience and provide a detailed account on how such an experience could contribute to the formation of primary delusions. I began by critically reviewing the ipseity disturbance model. In its assessment, I highlighted the possibility that the overemphasis on the self-disorder in the investigation of schizophrenia could have made overlook researchers the perhaps most common experience that transpires through various

constitutive features of the delusional mood: the alien experience of perceiving something inexplicable new from the mundane, familiar environment, i.e., affective dysregulation experience. As opposed to considering such an experience just another manifestation of ipseity disturbance, I zeroed in on this experience and clarified the implication it might have for the way one experiences oneself and the world. By approaching it from its affective dimension, I argued that the affective dysregulation experience is revelatory and solipsistic in its nature. I then showed how such an experience may elicit the pressing need to find the new conceptual framework to determine ever more closely just exactly why it is that it is only oneself who is having such an experience and no one else, leading to the specification of the 'somethingness' one experience into determinate delusional content, or in accepted terms, leading to the crystallisation of primary delusion from delusional mood. I then provided a more detailed account that can accommodate the defining features of primary delusions, i.e., its double-bookkeeping and revelatory feature, without taking recourse to the ipseity disturbance generative claim but by remaining close to the delusional mood experience itself.

I concluded this chapter by demonstrating the relevance of the affective centred account I proposed in relation to the significant development in the neurobiological research of delusion formation, i.e., prediction error model. I argued that the proposed affective centred account could help explain how it is that the inappropriately signalled prediction error could manifest in the form of experience the proponents of the prediction error model constantly refer to (delusional mood, specifically, decontextualization and apophany) in their attempt to link their neurobiological findings to the early stage of delusion formation. This, I suggested, could help diffuse the worry that the changes in intensity of perception are not the only characteristic features of the early stage of schizophrenia and that such an aberration is not enough to explain delusion formation. With respect to delusion formation, the proposed affective centred account can complement why it is that the inappropriately signalled prediction error leads to delusion formation, not everyday life hypothesis. The prediction error model, in turn, could help identify the neurobiological correlates for the affective repression failure. Further, with its neurobiological evidence for the role of empirical priors (e.g., past experiences and beliefs) in regulating the distribution of salience, the model could help motivate differentiating various types of memorial act involved in perceptual field constitution and its alteration in delusional mood. This can help specify the kind of 'affective

propagation' I argued to be present in the delusional mood and the role of 'affective past horizon' in regulating the affective distribution of the living present. In such a way, both neurobiological and phenomenological approaches can help enrich each other's research. I hope to develop this line of inquiry in future research. For now, I end my inquiry here.

References

Adams, R. A., Stephan, K. E., Brown, H. R., Frith, C. D., & Friston, K. J. (2013). The computational anatomy of psychosis. *Frontiers in Psychiatry, 4*, 47.

Aftab, A. (2021). Phenomenology, Power, Polarization, and Psychosis. *Psychiatric Times*, *38*, (4).

Allardyce, J., Gaebel, W., Zielasek, J., & van Os, J. (2007). Deconstructing Psychosis conference February 2006: the validity of schizophrenia and alternative approaches to the classification of psychosis. *Schizophrenia bulletin*, *33*(4), 863–867. https://doi.org/10.1093/schbul/sbm051

American Psychiatric Association. (1987). *The Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi-org.ezproxy.frederick.edu/10.1176/appi.books.9780890425596

American Psychiatric Association. (2013). In Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.dsm05

American Psychiatric Association (1980). *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. Washington, D.C.

Ames, D. (1984). Self shooting of a phantom head. *British Journal of Psychiatry* 145(2): 193–194.

Andreasen, N. (1997). What shape are we in? Gender, psychopathology, and the brain. *Am JPsychiatry,* 154: 1637–1639

Andreasen, N. Flaum, M. (1991). Schizophrenia: The Characteristic Symptoms. *Schizophrenia Bulletin*. (17): 1

Andreasen N. (2007). DSM and the death of phenomenology in america: an example of unintended consequences. *Schizophrenia Bulletin*, 33(1), 108–112. https://doi.org/10.1093/schbul/sbl054

Bayne, T. and Pacherie, E. (2005). In Defence of the Doxastic Conception of Delusions. Mind & Language, 20: 163-188. doi:10.1111/j.0268-1064.2005.00281.x

Bayne T. (2010). Delusions as doxastic states: contexts, compartments and commitments." Philosophy, Psychiatry and Psychology, 17(4), 329-36.

Berrios, E. (2002). “Conceptual Issues”. In D’haenen H, den Boer JA, Willner P (eds.), *Biological psychiatry*. New York: Wiley; p. 3–24.

Berrios, G.E. (1991). Delusions as ‘wrong beliefs’: a conceptual history. British Journal of Psychiatry 159 (suppl. 14): 6–13.

Binswanger, L. (1946). Über die daseinsanalytische Forschungsrichtung in der Psychiatrie. *Schweizer Archive Für Neurologie Und Psychiatrie*, 57, 209–225.

Binswanger, L. (1958). “The Existential Analysis School of Thought.” In May, R., Angel, E., and Ellenberger, H.F. (Eds.), *Existence: A New Dimension in Psychology and Psychiatry*: 191–213. New York: Basic Books

Blankenburg, W. (2001). First steps toward a psychopathology of "common sense". Trans. Mishara, A. *Philosophy, Psychiatry, & Psychology, 8*(4), 303–315. https://doi.org/10.1353/ppp.2002.0014

Blankenburg W. (1971). *Der Verlust der Natürlichen Selbstverständlichkeit: Ein Beitrag zur Psychopathologie Symptomarmer Schizophrenien.* Stuttgart: Ferdinand Enke Verlag.

Bleuler, E. (1924). *Textbook of Psychiatry.* Transl. by A. Brill. New York (NY): Macmillan.

Bleuler, E. (1950). *Dementia Precox, or the Group of Schizophrenias.* New York (NY).

Blount, G. (1986). *Dangerousness of patients with Capgras syndrome.* Nebraska Medical

Bortolotti, L. (2010). *Delusions and other Irrational Beliefs.* Oxford: OUP.

Bovet, P. & Parnas, J. (1993). Schizophrenic Delusions: A phenomenological approach. *Schizophrenia Bulletin,* 19 (3), 579-597. https://doi.org/10.1093/schbul/19.3.579

Bowden, M.H. (2013). *A Phenomenological Study of Mania and Depression.* [Doctoral Thesis]. Durham University Research Repository.

Breen, N., Caine, D., and Coltheart, M. (2000). Models of face recognition and delusional misidentification: A critical review. *Cognitive Neuropsychology, 17* (1–3): 55–71.

Broome, M.R. (2006). Taxonomy and Ontology in Psychiatry: A Survey of Recent Literature. *Philosophy, Psychiatry, & Psychology*, *13*(4), 303-319. https://doi:10.1353/ppp.2007.0026.

Carr V, Wale J. (1986). Schizophrenia: an information processing model. *Aust N Z J Psychiatry*, 20(2):136-55. doi: 10.3109/00048678609161327.

Cermolacce, M., Naudin, J., Parnas, J. (2007). The "minimal self" in psychopathology: Re-examining the self-disorders in the schizophrenia spectrum, *Consciousness and Cognition*, 16 (3): 703-714

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices. A cognitive approach to auditory hallucinations. *British Journal of Psychiatry, 164*: 190-201.

Chapman, J. (1966). The early symptoms of schizophrenia. *British Journal of Psychiatry*, 112, 225-251. https://doi.org/10.1192/bjp.112.484.225

Coltheart, M., Langdon, R., & McKay, R. (2011). Delusional belief. *Annu Rev Psychol*., *62*: 271–298.

Connors, M.H. & Halligan, P.W. (2020) Delusions and theories of belief. *Conscious Cogn, 81*.

Conrad K. (1959). Gestaltanalyse und Daseinsanalytik. *Nervenarzt*. 30, 405–410

Conrad K. (1958/2002). *Die beginnende Schizophrenie: Versuch einer Gestaltanalyse des Wahns. Bonn: Edition Das Narrenschiff im Psychiatrie-Verlag*

Cooper, J.E., Kendell, R.E., Gurland, B.J., Sartorius, N., & Farkas, T. (1969). Cross-national study of diagnosis of the mental disorders: some results from the first comparative investigation. *The American Journal of Psychiatry, 125* (10): 21–9. https://doi:10.1176/ajp.125.10s.21.

Cooper, J.E., Kendell, R.E., Gurland, B.J.,Sharpe, L., Copeland, J.R.M., & Simon, R. (1972). *Psychiatric Diagnosis in New York and London*. Maudsley Monograph. Oxford University Press: Oxford.

Corlett, P. (2018). Delusions and Prediction Error. In: Bortolotti, L. (eds.) Delusions in Context. Palgrave Macmillan, Cham.

Corlett, P. R., Taylor, J. R., Wang, X. J., Fletcher, P. C., & Krystal, J. H. (2010). Toward a neurobiology of delusions. *Progress in neurobiology, 92*(3), 345–369. https://doi.org/10.1016/j.pneurobio.2010.06.007

Coulter, C., Baker, K., Margolis. R. (2019). Specialized Consultation for Suspected Recent-onset Schizophrenia: Diagnostic Clarity and the Distorting Impact of Anxiety and Reported Auditory Hallucinations, *Journal of Psychiatric Practice, 25*(2): 76-81

Crowell, S. (1990). Husserl, Heidegger, and Transcendental Philosophy: Another Look at the Encyclopaedia Britannica Article. *Philosophy and Phenomenological Research, 50*(3), 501-518.

Currie, G. (2000). Imagination, delusion and hallucinations. In Coltheart, M. and Davies, M. (Eds.) *Pathologies of Belief* (167–182). Oxford: Blackwell.

Currie, G. & Jureidini, J. (2001). Delusions, rationality, empathy. *Philosophy, Psychiatry and Psychology, 8* (2–3), 159–162.

Currie, G. & Ravenscroft, I. (2002). Recreative Minds: Imagination in Philosophy and Psychology. New York (NY): Oxford University Press.

Dastur, F. (2011). "Dasein". In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology*. Hoboken: Routledge.

Davies, M. and Stone, T. (Eds.) (1995). *Folk Psychology*. Oxford: Blackwell.

Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science, 243*: 4899.

Durham RC, Chambers JA, Power KG, et al. (2005). Long-term outcomes of cognitive behaviour therapy clinical trials in central Scotland. *Health Technol Assess, 9* (42):1–174

Ellenberger, H.F. (1958). "A Clinical introduction to psychiatric phenomenology and existential analysis". In R. May, E. Angel, & H.H. Ellenberger (Eds.) *Existence: A new dimension in psychiatry and psychology.* New York: Basic Books

Ellis, H.D. (1998) Cognitive neuropsychiatry and delusional misidentification syndromes: An exemplary vindication of the new discipline. *Cognitive Neuropsychiatry,* 3: 81-90.

Ellis, H.D. & Young, A.W. (1996). Problems of person perception in schizophrenia. In C. Pantelis, H. Nelson, T.Barnes (Eds.). *Schizophrenia: a neurological perspective.* Chichester: Wiley.

Eugene, Kelly. (2011). "Ch.3 Max Scheler". In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology.* Hoboken: Routledge.

Fernandez, A.V. (2017) The Subject matter of phenomenological research: existentails, modes, and prejudices. *Synthese, 194,* 3543-3562

Fernandez, A. V. (2016). 'Phenomenology, Typification, and Ideal Types in Psychiatric Diagnosis and Classification', In Bluhm, R. (ed.) *Knowing and Acting in Medicine*, Lanham, MD: Rowman & Littlefield International.

Fernandez, A. V. (2019). "Phenomenological Psychopathology and Psychiatric Classification." In Stanghellini G., Broome M, Fernandez A, Fusar-Poli P., Raballo A., and Rosfort R. (Eds.),. *The Oxford Handbook of Phenomenological Psychopathology*. Oxford, UK: Oxford University Press.

Feyaerts, J., Henriksen, M.G., Vanheule, S., Myin-Germeys, I., & Sass, L.A. (2021) Delusions beyond beliefs: a critical overview of diagnostic, aetiological, and therapeutic schizophrenia research from a clinical-phenomenological perspective. *Lancet Psychiatry, 8* (3):237-249.

Fuchs, T., & Van Duppen, Z. (2017). Time and Events: On the Phenomenology of Temporal Experience in Schizophrenia (Ancillary Article to EAWE Domain 2). *Psychopathology*, 50(1): 68–74.

Fuchs, T. (2002). The Challenge of Neuroscience: Psychiatry and Phenomenology Today. *Psychopathology*, (35) 319-326.

Fuchs, T. (2005a). Delusional Mood and Delusional Perception—A Phenomenological Analysis. *Psychopathology,* 38 (3), 133-139

Fuchs, T. (2005b). Implicit and explicit temporality. *Philosophy, Psychiatry & Psychology*, 12, 195–198.

Fuchs, T. (2007). The temporal structure of intentionality and its disturbance in schizophrenia. *Psychopathology*, 40, 229–235.

Fuchs, T. (2013). Temporality and psychopathology. *Phenomenology and the Cognitive Sciences, 12*, 75–104. https://doi.org/10.1007/s11097-010-9189-4

Fuchs T, Van Duppen Z. (2017). Time and Events: On the Phenomenology of Temporal Experience in Schizophrenia (Ancillary Article to EAWE Domain 2). *Psychopathology*, 50(1), 68-74.

Fuchs T. (2010). "Phenomenology and psychopathology", in Schmicking D. and Gallagher

S.(Eds.) *Handbook of Phenomenology and Cognitive Science*, Dordrecht: Springer Netherlands.

Fusar-Poli, Paolo & Meyer-Lindenberg, Andreas. (2016). Forty years of structural imaging in psychosis: Promises and truth. *Acta Psychiatrica Scandinavica*. 134.

Gallagher, S. (2009). "Delusional realities." In Broome, M.R. and Bortolotti, L. (Eds.) *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*. Oxford: Oxford University Press.

Garety, P.A., Kuipers, E., Fowler, D., Freeman, D., Bebbington, P.E.. (2001) A cognitive model of the positive symptoms of psychosis. *Psychol Med.* 31;189–95.

Ghaemi S. N. (2007). Feeling and time: the phenomenology of mood disorders, depressive realism, and existential psychotherapy. *Schizophrenia bulletin*, *33*(1), 122–130. https://doi.org/10.1093/schbul/sbl061

Gold, I. (2009). Reduction in Psychiatry. *The Canadian Journal of Psychiatry*, *54*(8), 506–512.

Gold, J. M., Robinson, B., Leonard, C. J., Hahn, B., Chen, S., McMahon, R. P., & Luck, S. J. (2018). Selective Attention, Working Memory, and Executive Function as Potential Independent Sources of Cognitive Dysfunction in Schizophrenia. *Schizophrenia bulletin*, *44*(6), 1227–1234. https://doi.org/10.1093/schbul/sbx155

Goldman, A. (2006). *Simulating Minds: The Philosophy, Psychology, and Neuroscience of Mindreading.* Oxford: Oxford University Press.

Gray, J., Feldon, J., Rawlins, J., Hemsley, D., & Smith, A. (1991). The neuropsychology of schizophrenia. *Behavioral and Brain Sciences*, *14*(1), 1-20. doi:10.1017/S0140525X00065055

Gray, J.A., Feldon, J., Rawlins, J.N.P., Smith, A.D., (1991). The neuropsychology of schizophrenia. *Behavioural and Brain Sciences*, *18*: 617–680.

Guze, S.B. (1978). Nature of psychiatric illness: Why psychiatry is a branch of medicine. *Comprehensive Psychiatry*, 19(4), 295-307. https://doi.org/10.1016/0010-440X(78)90012-3.

Haug E., Øie M., Melle I., Andreassen O. A., Raballo A., Bratlien U., et al. (2012). The association between self-disorders and neurocognitive dysfunction in schizophrenia. *Schizophr. Res, 135*: 79–83.

Heidegger, M. (1996). *Being and Time*. Trans. J. Stambaugh. Albany, NY: SUNY.

Hempel, C. G. (1994). "Fundamentals of taxonomy". In Sadler, J.S., Wiggins, O.P., and Schwartz, M.A. (Eds.) *Philosophical Perspectives on Psychiatric Diagnostic Classification*, 315–31. Baltimore, MD: Johns Hopkins University Press.

Hemsley, D. R., & Garety, P. A. (1986). The formation of maintenance of delusions: a Bayesian analysis. *The British journal of psychiatry: the journal of mental science,* 149, 51–56. https://doi.org/10.1192/bjp.149.1.51

Hemsley, D. R. (2005b). The Schizophrenic Experience: Taken Out of Context? *Schizophrenia Bulletin*, 31(1) ,43–53. https://doi.org/10.1093/schbul/sbi003

Hemsley D. R. (2005a). The development of a cognitive model of schizophrenia: placing it in context. *Neuroscience and biobehavioral reviews*, *29*(6), 977–988. https://doi.org/10.1016/j.neubiorev.2004.12.008

Hemsley, D. (1993) A Simple (or simplistic?) cognitive model for schizophrenia. *Behaviour Research and Therapy,* (31): 7, 633-645

Hemsley, D.R. (1975). A two-stage model of attention in schizophrenia research. *Br J Soc Clin Psychol.* 14(1):81-9. doi: 10.1111/j.2044-8260.1975.tb00152.x. PMID: 1122350.

Hengartner Michael P., Moncrieff Joanna. (2018). Inconclusive Evidence in Support of the Dopamine Hypothesis of Psychosis: Why Neurobiological Research Must Consider Medication Use, Adjust for Important Confounders, Choose Stringent Comparators, and Use Larger Samples. *Frontiers in Psychiatry, (9)*: 174-175

Henriksen, M.G. & Parnas, J. (2019). Delusional Mood. In Stanghellini, G., Broome, M., Raballo, A., Fernandez, V. A., Fusar-Poli, P., Rosfort, R. (Ed.) *The Oxford Handbook of Phenomenological Psychopathology.* Oxford: Oxford University Press.

Henriksen, M.G. & Parnas, J. (2014) Self-disorders and schizophrenia: a phenomenological reappraisal of poor insight and noncompliance. *Schizophr Bull, 40*(3):542-7.

Hobson, J. A., & Hobson, R.P. (2007). Identification: The Missing Link between Joint Attention and Imitation? *Development and Psychopathology, 19*: 411-431.

Hodges, S. & Biswas-Diener, R. (2007). Balancing the empathy expense account: Strategies for regulating empathic response. *Empathy in Mental Illness.* 389-407.

Hohwy, J., & Rosenberg, R. (2005). Unusual experiences, reality testing and delusions of alien control. Mind and Language, 20, 141-162.

Horsfall, J., Clearly, M., Hunt, G.E., & Walter, G. (2009) Psychosocial treatments for people with co-occurring severe mental illness and substance use disorders (dual diagnosis): a review of the empirical evidence. *Harv Rev Psychiatry*, *17*(1):24–34.

Howes, O.D. & Kapur, S. (2009).The Dopamine Hypothesis of Schizophrenia: Version III—The Final Common Pathway. *Schizophrenia Bulletin, 35*(3), 549–562. https://doi.org/10.1093/schbul/sbp006

Husserl, E. (1925/1977). *Phenomenological Psychology: Lectures, Summer Semester*. Trans. S, John. The Hague: Martinus Nijhoff.

Husserl, E. (1927/1971). Article for the Encyclopaedia Britannica (1927). Trans. Palmer E. Richard, *Journal of the British Society for Phenomenology*, 2:2, 77-90.

Husserl, E. (1939/1973). *Experience and Judgment. Investigations in a Genealogy of Logic*. Ed L. Landgrebe, Trans. S. Churchill and K. Americks. London: Routledge.

Husserl, E. (1913/1983). *Ideas Pertaining to a pure phenomenology and to a phenomenological Philosophy*, first book. (F. Kersten.Trans.) The Hague: Martinus Nijhoff.

Husserl, E. (1991). *On the Phenomenology of the Consciousness of Internal Time (1893-1917).* (Brough, J.B. Trans). Husserliana: Edmund Husserl – Collected Works, Springer.

Husserl, E. (2001a). Logical Investigations, vol. 2. Trans. Findlay, J.N. London: Routledge

Husserl, E. (2001b). *Analyses concerning passive and active synthesis: Lectures on transcendental logic.* Trans. Steinback, A.J. Springer.

Husserl, E. (2003). Transzendentaler Idealismus. Texte aus dem Nachlass (1908–1921). Husserliana 36. R. Rollinger (Ed.). Dordrecht: Kluwer Academic Publishers.

Hyler, S. E., Williams, J. B., & Spitzer, R. L. (1982). Reliability in the DSM-III field trials: Interview v case summary. *Archives of General Psychiatry, 39* (11): 1275–1278. https://doi.org/10.1001/archpsyc.1982.04290110035006

Hyman, S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Annual review of clinical psychology, 6,* 155–179. https://doi.org/10.1146/annurev.clinpsy.3.022806.091532

Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., Sanislow, C., & Wang, P. (2010). Research domain criteria (RDoC): Toward a new classification framework for research on mental disorders. *The American Journal of Psychiatry, 167*(7), 748–751.

Insel, T. R., & Quirion, R. (2005). Psychiatry as a clinical neuroscience discipline. *JAMA, 294*(17), 2221–2224. https://doi.org/10.1001/jama.294.17.2221

Jaspers, K. (1913/1997). *General Psychopathology*, Trans. J. Hoenig, M.W. Hamilton. Baltimore, MD: Johns Hopkins University Press

Jaspers, K. (1913/1963). *General Psychopathology,* Trans. J. Hoenig and M.W. Hamilton. Manchester: University of Manchester Press.

Jaspers, K. (1968). 'The phenomenological approach in psychopathology', British Journal of Psychiatry, 114: 1313–1323. (Original work published in Zeitschrift fur die gesamte Neurologie und Psychiatrie, 1912; 9: 391–408.)

Jaspers, K. (1971). *Philosophy of Existence.* Philadelphia, PA: University of Pennsylvania Press.

Jaspers, K. (2003). *Way to Wisdom.* New Haven, CT: Yale University Press

Jauhar S, Nour MM, Veronese M, Rogdaki M, Bonoldi I, Azis M, et al. (2017). A test of the transdiagnostic dopamine hypothesis of psychosis using positron emission tomographic imaging in bipolar affective disorder and schizophrenia. *JAMA Psychiatry, (74)*:1206–13.

Kapur, S., Romina M., Ming L. (2005). From dopamine to salience to psychosis—linking biology, pharmacology and phenomenology of psychosis. *Schizophrenia Research,* 79 (1), 59-68. https://doi.org/10.1016/j.schres.2005.01.003

Kapur, S. (2003). Psychosis as a state of aberrant salience: a framework linking biology, phenomenology, and pharmacology in schizophrenia. *Am J Psychiatry*, 160(1), 13-23. https://doi.org/10.1176/appi.ajp.160.1.13

Kapur, Shitij & Phillips, Anthony & Insel, T.R.. (2012). Why Has It Taken So Long for Biological Psychiatry to Develop Clinical Tests and What to Do about It?. *Molecular psychiatry,* 17. 10.1038/mp.2012.105.

Kean, C. (2009). Silencing the self: schizophrenia as a self-disturbance. *Schizophrenia bulletin*. 35 (6): 1034-6. doi:10.1093/schbul/sbp043

Kendell, R.E. (1975). *The Role of Diagnosis in Psychiatry*. Oxford, Blackwell.

Kendell, R.E. (1983). DSM-III: A major advance in psychiatric nosology. In Spitzer R,L. and WIlliams J.B.W. and Skodol, A.E. (Eds). *International Perspectives on DSM-II*. Washington American psychiatric.

Kepinski, A. (1974). *Schizofrenia*. Warsaw, Poland: Panstwowy Zaklad Wydawnictw Lekarskich.

Keshavan, M. S, Henry A. N., & Tandon, R. (2011). Moving Ahead with the Schizophrenia Concept: From the Elephant to the Mouse. *Schizophrenia Research,* 127 (1-3): 3–13.

Kimura , B. (1992). Écrits de psychopathologie phénoménologique. Trad. Bouderlique, J . Paris : PUF.

Kirk, S. A. & Kutchins, H. (1994). The Myth of the Reliability of DSM. *Journal of Mind and Behavior*. 15 (1&2): 71–86.

Klee, R. (2004) Why Some Delusions Are Necessarily Inexplicable Beliefs. *Philosophy, Psychiatry, and Psychology, 11*: 25-34.

Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M.,…Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology,* 126(4), 454–477.

Kraus A. (1983). Schizo-affective psychoses from a phenomenological anthropological point of view. *Psychiatria clinica, 16*:265-274.

Kunzman, K. (2019, April 23). Patients Are Commonly Misdiagnosed with Schizophrenia. HCPLive. https://www.hcplive.com/view/patients-misdiagnosed-schizophrenia

Laing, R., (1965/2010). The Divided Self. London: Penguin.

Lanei Rodemeyer (2003). Developments in the Theory of Time-Consciousness: An Analysis of Protention, in Donn Welton (ed), *The New Husserl: A Critical Reader.* Bloomington and Indianapolis: Indiana University Press, 2003.: 125-154; 131.

Lieberman, P. (1989). "Objective" methods and "subjective" experiences" *Schizophr Bulletin*, 15 (2): 267-275.

Livesley, W. J. (1985) The classification of personality disorder: II. The problem of diagnostic criteria. *Can J Psychiatry, 30*:359-362.

Lopez-Silva, P. (2015). On the Architecture of Psychosis: Thoughts and Delusions of Thought Insertion. Phd Thesis. School of Social Sciences. University of Manchester. UK.

Luft, S., & Overgaard, S. (2011). "Introduction". In S. Luft & S. Overgaard (Eds.), *The Routledge companion to phenomenology.* Hoboken: Routledge.

MacLean, P. (1970). The limbic brain in relation to the psychoses. In:Black P.ed.Physiological Correlates of Emotion. New York: Academic Press.

MacLean, P. (1970). "The limbic brain in relation to the psychoses". In:Black P. (Ed). *Physiological Correlates of Emotion*. New York: Academic Press.

Maher, B A. (1974) Delusional thinking and perceptual disorder. *J. Individ Psychol, 30* (1):98-113.

Maj, M. (1998). Critique of the DSM-IV operational diagnostic criteria for schizophrenia. The British journal of psychiatry. *The journal of mental science*, 172, 458–460. https://doi.org/10.1192/bjp.172.6.458

Maj, M. (2011). Understanding the pathophysiology of schizophrenia: Are we on the wrong or on the right track? *Schizophrenia Research,* 127: 20-21 https://doi.org/10.1016/j.schres.2011.01.002.

Maj M. (2013). Karl Jaspers and the genesis of delusions in schizophrenia. *Schizophrenia bulletin*, *39*(2), 242–243. https://doi.org/10.1093/schbul/sbs190

Marková S., Berrios, E. (2009). Epistemology of mental symptoms. *Psychopathology, 42*(6):343-9.

Matarazzo, J. D. (1983). The reliability of psychiatric and psychological diagnosis. *Clinical Psychology Review*, *3*(1), 103–145. https://doi.org/10.1016/0272-7358(83)90008-9

Matussek, P. (1987). *The clinical roots of the schizophrenia concept.* Cambridge University Press.

Matussek P. (1987). "Studies in delusional perception." In: Cutting, J. & Shepherd, M. (Eds). *The clinical roots of the schizophrenia concept.* Cambridge: Cambridge University Press.

McCarthy-Jones, Simon et al. (2013) "Stop, look, listen: the need for philosophical phenomenological perspectives on auditory verbal hallucinations." *Frontiers in human neuroscience,* 7: 127-129.

McDonald, N. (1960). Living with schizophrenia. *Canadian Medical Association journal*, 82(4), 218–221.

McEwen BS, Bowles NP, Gray JD, Hill MN, Hunter RG, Karatsoreos IN, et al. (2015). Mechanisms of stress in the brain. *Nat Neurosci, 18*:1353–63. doi: 10.1038/nn.4086

Merleau-Ponty, M. (2012). *Phenomenology of Perception,* trans. D. A. Landes. London: Routledge.

Minkowski, E. (1923). Étude psychologique et analyse phénoménologique d'un cas de mélancolie schizophrénique,. *Journal De Psychologie Normale Et Pathologique*, 20, 543–558

Minkowski, E. (1927/1997). La schizophrénie: Psychopathologie des schizoïdes et des schizophrènes. Paris: Payot

Minkowski, E. (1933/1970). *Lived Time.* Trans. Metzel, N. Evanston, US: North Western University Press.

Mishara, A. L., & Fusar-Poli, P. (2013). The phenomenology and neurobiology of delusion formation during psychosis onset: Jaspers, Truman symptoms, and aberrant salience. *Schizophrenia bulletin*, *39*(2), 278–286. https://doi.org/10.1093/schbul/sbs155

Mishara, A.L., Lysaker, P.H., & Schwartz, M.A. (2014). Self-disturbances in schizophrenia: history, phenomenology, and relevant findings from research on metacognition. *Schizophr Bull, 40*(1):5-12.

Mishara, A. L. (2007). Is minimal self preserved in schizophrenia? A subcomponents view. *Consciousness and Cognition, 16*(3): 715–721.

Mishara, A.L. (2010) Klaus Conrad (1905–1961): Delusional Mood, Psychosis, and Beginning Schizophrenia, *Schizophrenia Bulletin, 36* (1): 9–13.

Mishara, A. L. & Fusar-Poli, P. (2013) The phenomenology and neurobiology of delusion formation during psychosis onset: Jaspers, Truman symptoms, and aberrant salience. *Schizophr Bull, 39* (2):278-86.

Mishara A. L. (2010). Klaus Conrad (1905-1961): delusional mood, psychosis, and beginning schizophrenia. *Schizophrenia bulletin*, *36*(1), 9–13. https://doi.org/10.1093/schbul/sbp144

Moskowitz, A., & Heim, G. (2011). Eugen Bleuler's Dementia praecox or the group of schizophrenias (1911): a centenary appreciation and reconsideration. *Schizophrenia bulletin*, *37*(3): 471–479. https://doi.org/10.1093/schbul/sbr016

Müller-Suur H. (1950). Das Gewissheitsbewusstsein beim schizophrenen und beim paranoischen Wahnerleben. Fortschritte der Neurologie, Psychiatrie, und ihrer Grenzgebiete, 18(1), 44–51.

Møller, P. & Husby, R. (2000) The Initial Prodrome in Schizophrenia: Searching for Naturalistic Core Dimensions of Experience and Behavior. *Schizophrenia Bulletin, 26* (1): 217–232, https://doi.org/10.1093/oxfordjournals.schbul.a033442

Neemah, Z. A. and Gallagher, S. (2020). "The Phenomenology and Predictive Processing of Time in Depression". In Dina Mendonça, Manuel Curado & Steven S. Gouveia (eds.), *The Philosophy and Science of Predictive Processing*. London, UK: 187-207

Nelson, B., Parnas, J., & Sass, L. A. (2014). Disturbance of Minimal Self (Ipseity) in Schizophrenia: Clarification and Current Status, *Schizophrenia Bulletin,* 40 (3): 479–482,

Nordgaard, J., & Parnas, J. (2014). Self-disorders and the schizophrenia spectrum: a study of 100 first hospital admissions. *Schizophrenia bulletin*, *40* (6): 1300–1307. https://doi.org/10.1093/schbul/sbt239

Owen, M. J. (2014). New approaches to psychiatric diagnostic classification. *Neuron*, *84*(3): 564–571. https://doi.org/10.1016/j.neuron.2014.10.028

Pankow, A., Knobel, A., Voss, M., & Heinz, A. (2012). Neurobiological correlates of delusion: beyond the salience attribution hypothesis. *Neuropsychobiology*, *66*(1), 33–43. https://doi.org/10.1159/000337132

Parnas, J., & Sass, L. A. (2001). Self, Solipsism, and Schizophrenic Delusions. *Philosophy, Psychiatry, Psychology, 8*(2), 101–120. https://doi.org/10.1353/PPP.2001.0014

Parnas, J., & Zahavi, D. (2002). "The role of phenomenology in psychiatric diagnosis and classification." In M. Maj, W. Gaebel, J. J. López-Ibor, & N. Sartorius (Eds.), *Psychiatric diagnosis and classification*. John Wiley & Sons Inc. https://doi.org/10.1002/047084647X.ch6

Parnas, J., Handest, P., Jansson, L., & Saebye, D. (2005). Anomalous subjective experience among first-admitted schizophrenia spectrum patients: empirical investigation. *Psychopathology, 38*(5), 259–267. https://doi.org/10.1159/000088442

Parnas, J., Handest, P., Saebye, D., & Jansson, L. (2003). Anomalies of subjective experience in schizophrenia and psychotic bipolar illness. *Acta psychiatrica Scandinavica, 108*(2), 126–133. https://doi.org/10.1034/j.1600-0447.2003.00105.x

Parnas, J., Møller, P., Kircher, T., Thalbitzer, J., Jansson, L., Handest, P., & Zahavi, D. (2005). EASE: Examination of Anomalous Self-Experience. *Psychopathology, 38*(5), 236–258. https://doi.org/10.1159/000088441).

Parnas, J., Sass, L. A., & Zahavi, D. (2013). Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object. *Schizophrenia bulletin, 39*(2), 270–277. https://doi.org/10.1093/schbul/sbs153

Parnas, J., Urfer-Parnas, A. & Stephensen, H. (2020). Double bookkeeping and schizophrenia spectrum: divided unified phenomenal consciousness. *Eur Arch Psychiatry Clin Neurosci.* https://doi.org/10.1007/s00406-020-01185-0

Parnas, J. (2000). "The self and intentionality in the pre-psychotic stages of schizophrenia: A phenomenological study." In Zahavi, D. (Ed.), *Exploring the self: Philosophical and psychopathological perspectives on self-experience.* John Benjamins Publishing Company.

Parnas, J. (2011). A Disappearing Heritage: The Clinical Core of Schizophrenia. *Schizophrenia Bulletin, 37*(6), 1121–1130. https://doi.org/10.1093/SCHBUL/SBR081

Parnas, J. (2013). “On psychosis: Karl Jaspers and beyond.” *In One Century of Karl Jaspers' General Psychopathology*. Oxford, UK: Oxford University Press.

Parnas, J. (2015). Differential diagnosis and current polythetic classification. *World Psychiatry,* 14(3):284–287. https://doi:10.1002/wps.20239

Parnas, J. & Bovet, P. (2014) “Psychiatry made easy: operation(al)ism and some of its consequences.” In Kendler, K.S. & Parnas, J. (eds.) *Philosophical issues in psychiatry III: The nature and sources of historical change.* Oxford: Oxford University Press.

Parnas, J. & Gallagher, S. (2015). “Phenomenology and the interpretation of psychopathological experience.” In Kirmayer, L. Lemelson, R. & Cummings, C.C. (Eds.), *Revisioning Psychiatry Integrating Biological, Clinical and Cultural Perspectives*. Cambridge: Cambridge University Press.

Parnas, J. & Henriksen, M.G. (2014) Disordered self in the schizophrenia spectrum: a clinical and research perspective. *Harv Rev Psychiatry, 22*:251–65.

Parnas, J. & Bovet, P. (1995). Research in psychopathology: epistemological issues. *Compr Psychiatry. 36*: 167–181

Parnas, J. & Handest, P. (2003). Phenomenology of anomalous self-experience in early schizophrenia. *Compr Psychiatry, 44*(2):121-34. doi: 10.1053/comp.2003.50017. PMID: 12658621.

Parnas, J., Raballo, A., Handest, P., et al. (2011). Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen Prodromal Study. *World Psychiatry, 10*:200–204.

Parnas, J., Handest, P., Saebye, D., & Jansson, L. (2003). Anomalies of subjective experience in schizophrenia and psychotic bipolar illness. *Acta Psychiatr Scand, 108:* 126–133.

Pérez-Álvarez, M., García-Montes, J. M., Vallina-Fernández, O., & Perona-Garcelán, S. (2016). Rethinking Schizophrenia in the Context of the Person and Their Circumstances: Seven Reasons. *Frontiers in psychology*, *7*: 1650. https://doi.org/10.3389/fpsyg.2016.01650

Pienkos, E. & Sass, L. (2012). Empathy and Otherness: Humanistic and Phenomenological

Approaches to Psychotherapy of Severe Mental Illness. *Pragmatic Case Studies in Psychotherapy, 8,* 10.14713/pcsp.v8i1.1119.

Pincus, H. A,. & McQueen, L. (2002) "The limits of evidence-based classification of mental disorders", in Sadler, J.Z. (Ed.), *Descriptions and prescriptions: Values, mental disorders, and the DSMs.* Baltimore: The Johns Hopkins University Press.

Raballo, A., & Parnas, J. (2012). Examination of anomalous self-experience: initial study of the structure of self-disorders in schizophrenia spectrum. *The Journal of nervous and mental disease, 200* (7): 577–583. https://doi.org/10.1097/NMD.0b013e31825bfb41

Raballo A., Sæbye D., & Parnas J. (2011). "Looking at the schizophrenia spectrum through the prism of self-disorders: an empirical study". *Schizophrenia Bulletin, 37* :344–351.

Ratcliffe, M. (2012). Phenomenology as a Form of Empathy. *Inquiry: An Interdisciplinary Journal of Philosophy, 55* (5):473-495.

Ratcliffe, M. (2015) *Experiences of Depression: A Study in Phenomenology*. Oxford: Oxford University Press.

Robins, E. & Guze, S.B. (1970). Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. *Am J Psychiatry., 126* (7): 983-7.

Rossi, M. & Giovanni, S. (2014).Pheno-phenotypes: A holistic approach to the psychopathology of schizophrenia. *Current Opinion in Psychiatry, 27* (3): 196-204.

Rümke, H. C., & Neeleman, J. (1990). The nuclear symptom of schizophrenia and the praecoxfeeling. *History of psychiatry, 1*(3 Pt 3), 331–341. https://doi.org/10.1177/0957154X9000100304

Saks, E. R. (2007). *The center cannot hold: My journey through madness.* New York: Hyperion.

Saks, E.R. (2009) Some thoughts on denial of mental illness. *Am J Psychiatry, 166*: 972–973

Sartre, J.P. (1970). Intentionality: A fundamental idea of Husserl's phenomenology. *Journal of the British Society for Phenomenology, 1* (2):4-5.

Sass, L.A. & Parnas, J. (2003). Schizophrenia, Consciousness, and the Self, *Schizophrenia Bulletin*, *29* (3): 427–444,

Sass, L.A. (2001). Self and World in Schizophrenia: Three Classic Approaches. *Philosophy, Psychiatry, & Psychology*, *8* (4): 251-270. doi:10.1353/ppp.2002.0026.

Sass, L.A., Parnas, J., & Zahavi, D. (2011). Phenomenological Psychopathology and Schizophrenia: Contemporary Approaches and Misunderstandings. *Philosophy, Psychiatry, & Psychology, 18*(1): 1-23. doi:10.1353/ppp.2011.0008.

Sass, L. A., & Byrom, G. (2015). Self-Disturbance and the Bizarre: On Incomprehensibility in Schizophrenic Delusions. *Psychopathology*, 48, 293-300. https://doi.org/10.1159/000437210

Sass, L. A., & Pienkos, E. (2013a). Delusion: The Phenomenological Approach, In K.W.M. Fulford (ed.), *The Oxford Handbook of Philosophy and Psychiatry.* Oxford University Press.

Sass, L. A., & Pienkos, E. (2013b). Space, time, and atmosphere: A comparative phenomenology of melancholia, mania, and schizophrenia, part II. *Journal of Consciousness Studies*, 20 (7-8), 131-152.

Sass, L. A., Parnas, J, & Zahavi, D. (2011) Phenomenological psychopathology and schizophrenia: contemporary approaches and misunderstandings. *Philos Psychiatr Psychol, 18* :1–23.

Sass, L.A. (2010) "Phenomenology as description and as explanation: the case of schizophrenia." In: Schmicking, D. & Gallagher, S. (Eds). *Handbook of phenomenology and cognitive science.* Dordrecht: Springer.

Sass, L. A. (2013), "Jaspers, Phenomenology, and Ontological Differences". In Stanghellini, G. and Fuchs, T. (Eds.), *One Century of Karl Jaspers' General Psychopathology.*

Sass, L. A. (2014). "Delusion and double bookkeeping." In T. Fuchs, T. Breyer, C. Mundt (Eds.). *Karl Jaspers' Philosophy and Psychopathology.* New York & Heidelberg:Springer.

Sass, L. A. (2014). Explanation and description in phenomenological psychopathology. *Journal of Psychopathology*, *20*(4), 366-376.

Sass, L. A. (2014). Self-disturbance and schizophrenia: structure, specificity, pathogenesis (current issues, new directions). *Schizophr Res.*, *152:*5–11.

Sass, L. A. & Byrom, G. (2015) Phenomenological and neurocognitive perspectives on delusions: A critical overview. *World Psychiatry*, *14* (2):164-173. doi:10.1002/wps.20205

Sass L.A., Pienkos, E., Skodlar, B., Stanghellini, G., Fuchs, T., Parnas, J., & Jones, N. (2017). EAWE: Examination of Anomalous World Experience. *Psychopathology.* 50(1):10-54. Doi: 10.1159/000454928. Epub 2017 Mar 8. PMID: 28268224.

Schneider, K. (1959). *Clinical Psychopathology.* Trans. M.W. Hamilton. New York, NY: Grune & Stratton

Schreber, D.P. (1903/1988) *Memoirs of my nervous illness.* Trans. Macalpine, I. & Hunter, R. Harvard University Press, Cambridge MA.

Schutz, A. (1967). *Phenomenology of the Social World*. Evanston, IL: Northwestern University Press).

Schwartz, M. A., Wiggins, O. P., & Norko, M. A. (1995). 'Prototypes, ideal types, and personality disorders: The return to classical phenomenology', in Livesley, W.J. (ed.), *The DSM-IV personality disorders* (pp. 417–432). Guilford Press. (Reprinted in modified form from "*Journal of Personality Disorder*s," *3*, 1989, pp. 1–9)

Schwartz, M.A., Wiggins, O.P., & Norko, M.A. (1989). Prototypes, Ideal Types, and Personality Disorders: The Return To Classical Psychiatry. *Journal of Personality Disorders, 3,* (1), 1-9.

Schwartz, M. A. & Wiggins, O.P. (1987a) Typifications: The first step for clinical diagnosis in psychiatry. *The Journal of Nervous and Mental Disease, 175* (2): 65-77.

Schwartz, M.A. & Wiggins, O. P. (1987b) Diagnosis and ideal types: A contribution to psychiatric classification. *Comprehensive Psychiatry, 28*(4), 277-291, https://doi.org/10.1016/0010-440X(87)90064-2.

Schwartz, M.A. & Wiggins, O.P. (1988) Psychiatric Diagnosis and the Phenomenology of Typification." In L.Embree (Ed.) *Wordly Phenomenology: The Continuing Influence of Alfred Schutz on North American Human Science.* University of Press of America.

Sechehaye, M. (1970). *Autobiography of a Schizophrenic Girl.* Signet. New American Library.

Seeman M. V. (2015). On delusion formation. *Canadian journal of psychiatry, 60*(2), 87–90. https://doi.org/10.1177/070674371506000206

Seeman P. (2014). Clozapine, a fast-off-D2 antipsychotic. *ACS Chem Neurosci, 5*:24–9. https:// doi: 10.1021/cn400189s

Skre, I., Onstad, S., Torgersen, S., & Kringlen, E. (1991). High interrater reliability for the Structured Clinical Interview for DSM-III-R Axis I (SCID-I). *Acta psychiatrica Scandinavica*, *84*(2), 167–173. https://doi.org/10.1111/j.1600-0447.1991.tb03123.x

Sparrow, T. (2014). *The End of Phenomenology: Metaphysics and the New Realism*. Edinburgh: Edinburgh University Press.

Spiegelberg, H. (1981). *The phenomenological movement: A historical introduction.* Dordrecht: Springer.

Spitzer, R. L. & Fleiss, J. L. (1974). A re-analysis of the reliability of psychiatric diagnosis. *British Journal of Psychiatry, 125* (4): 341–347. https://doi:10.1192/bjp.125.4.341.

Spitzer, R.L. & Williams, J. B.W. (1985) "Classifications of mental disorders", in Kaplan H.I. and Sadock, B.J. (Eds). *Comprehensive Textbook of Psychiatry,* Baltimore Wilkins.

St. Stoyanov, D., Borgwardt, S. J., & Varga, S. (2015). "Translational validity across neuroscience and psychiatry." In P. Zachar, D. St. Stoyanov, M. Aragona, & A. Jablensky (Eds.), *Alternative perspectives on psychiatric validation: DSM, ICD, RDoC, and beyond*. Oxford: Oxford University Press

Stanghellini, G., & Raballo, A. (2015). Differential typology of delusions in major depression and schizophrenia. A critique to the unitary concept of 'psychosis'. *Journal of affective disorders, 171:* 171–178.

Stanghellini, G., & Rosfort, R. (2013). Schizophrenia as a Disorder of Mood. In Fulford, (K.W.M) B., Morris, K., Sadler, Z. J., Stanghellini, G. (Ed.) *Emotions and Personhood: Exploring Fragility - Making Sense of Vulnerability.* Oxford: Oxford University Press.

Stanghellini, G., Ballerini, M., Presenza, S., Mancini, M., Raballo, A., Blasi, S., & Cutting, J. (2016). Psychopathology of lived time: Abnormal time experience in persons with schizophrenia. *Schizophrenia Bulletin,* 42(1), 45–55.

Stanghellini, G., Broome, M., Fernandez, A., Fusar-Poli, P., Raballo, A., & Rosfort, R. (2019). *The Oxford Handbook of Phenomenological Psychopathology*. Oxford, UK: Oxford University Press.

Stanghellini, G. (2000). Vulnerability to schizophrenia and lack of common sense. *Schizophrenia Bulletin, 26*(4), 775–787. https://doi.org/10.1093/oxfordjournals.schbul.a033493

Stanghellini, G. (2013). "Karl Jaspers' General Psychopathology in the framework of clinical practice." In Stanghellini, G. and Fuchs, T. (Eds). *One Century of Karl Jaspers' General Psychopathology*. Oxford, UK: Oxford University Press.

Stanghellini, G. (2016). Abnormal time experience, bizarre delusions and verbal-acoustic hallucinations in schizophrenia, *European Psychiatry,* 33: S32.

Straus, E. (1967). "Aesthesiology and hallucinations". In May, R., Angel, E., and Ellenberger, H.F. Ellenberger (Eds.) *Existence: A new dimension in psychiatry.* New York: Simon and Schuster.

Sulzer, D., Sonders, M.S., Poulsen, N.W., & Galli, A. (2005) Mechanisms of neurotransmitter release by amphetamines: a review. *Prog Neurobiol, 75*:406–33. doi: 10.1016/j.pneurobio.2005.04.003

Svenaeus, F. (2016). The phenomenology of empathy: a Steinian emotional account. *Phenom Cogn Sci*, *15*, 227–245.

Taipale, J. (2016). From Types to Tokens: Empathy and Typification. In Szanto, T. and Moran, D. (Eds.): *Phenomenology of Sociality. Discovering the We*. London: Routledge.

Thaker, G.K. (2008). Neurophysiological endophenotypes across bipolar and schizophrenia psychosis. *Schizophr. Bull,34* (4), 760–773.

Thompson, E. (2007). *Mind in life: Biology, phenomenology, and the sciences of mind.*Cambridge, MA: Harvard University Press.

Thornton, T. (2016). "Psychiatric diagnosis, tacit knowledge, and criteria." In Keil, G., Keuck, L., and Hauswald, R. (Eds.), *Vagueness in Psychiatry.* Oxford, UK: Oxford University Press.

Titelman, P. (1976). A phenomenological approach to psychopathology: The conception of Erwin Straus. *Journal of Phenomenological Psychology, 7*(1), 15–33. https://doi.org/10.1163/156916276X00151

Tost, H., Alam, T., & Meyer-Lindenberg, A. (2010). Dopamine and psychosis: theory, pathomechanisms and intermediate phenotypes. *Neuroscience and biobehavioral reviews, 34*(5), 689–700. https://doi.org/10.1016/j.neubiorev.2009.06.005

Uhlhaas, P. J., & Mishara, A.L. (2007) "Perceptual Anomalies in Schizophrenia: Integrating Phenomenology and Cognitive Neuroscience." *Schizophrenia Bulletin,* 33 (1): 142–156.

Varela, F. (1996). Neurophenomenology. *Journal of Consciousness Studies,* 3:330–49.

Vogeley, K., & Kupke, C. (2007). Disturbances of time consciousness from a phenomenological and a neuroscientific perspective. *Schizophrenia Bulletin, 33*, 157–165.

Weber, M. (1949) *Methodology of Social Sciences*. Finch, H.A. and Shil, E.A. (eds.) Glencoe, IL: The Free Press.

Weiner, S. K. (2003). First Person Account: Living With the Delusions and Effects of Schizophrenia. *Schizophrenia Bulletin, 29* (4), 877–879.

Wiggins, O.P., Schwartz M.A., Northoff G. (1990). Toward a Husserlian Phenomenology of the Initial Stages of Schizophrenia. In Spitzer, M. & Maher, B.A. (Eds.) *Philosophy and Psychopathology* (pp.21-34). New York: Springer.

Wiggins, O. P., Schwartz, M. A., & Naudin, J. (2003). Rebuilding reality: a phenomenology of aspects of chronic schizophrenia. *Seishin shinkeigaku zasshi = Psychiatria et neurologia Japonica*, *105*(8), 1005–1015.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin*, 34(3), 523– 537.

Young, A.W. &Leafhead, K. (1996). "Between life and death: Case studies of the Cotard delusion." In Halligan, P. and Marshall, J. (Eds.) *Method in Madness: Case Studies in Cognitive Neuropsychiatry.* Hove: Psychology Press.

Zachar P. (2015). Psychiatric disorders: natural kinds made by the world or practical kinds made by us?. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *14*(3), 288–290. https://doi.org/10.1002/wps.20240

Zahavi, D. (2003). Inner time-consciousness and pre-reflective self-awareness. In: D. Welton (Ed.) *The new Husserl: a critical reader*. Indiana University Press.

Zahavi, D. (2005). *Husserl's Phenomenology.* Stanford University Press.

Zahavi, D. (2008). Internalism, externalism, and transcendental idealism. *Synthese*, *160*: 355–374 https://doi.org/10.1007/s11229-006-9084-2

Zahavi, D. (2008). *Subjectivity and Selfhood.* Cambridge, Mass: MIT Press.

Zahavi, D. (2008). "CH.15 Phenomenology." In Moran, D. (Ed.), *The Routledge Companion to Twentieth-century Philosophy*. New York: Routledge.

Zahavi, D. (2014). *Self and Other: Exploring Subjectivity, Empathy, and Shame.* Oxford: Oxford University Press.

Zahavi, D. (2015). You, me, and we: The sharing of emotional experiences. *Journal of Consciousness Studies*, *22*(1-2): 84–101.

Zahavi, D. (2018). *Husserl's Legacy: Phenomenology, Metaphysics, and Transcendental Philosophy*. Oxford, UK: Oxford University Press.

Zahavi, D. (2021) "Ch. 26 Phenomenology and Metaphysics". in Bliss, R. and Miller, J.T.M. (Eds.): *The Routledge Handbook of Metametaphysics*. London: Routledge.