

The Ghost in the Machine: Disembodiment in Schizophrenia – Two Case Studies

Sanneke de Haan Thomas Fuchs

Department of Psychiatry, University of Heidelberg, Heidelberg, Germany

Key Words

Schizophrenia · Embodiment · Phenomenology ·
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Abstract

The notion of embodiment is central to the phenomenological approach to schizophrenia. This paper argues that fundamental concepts for the understanding of schizophrenia have a bodily dimension. We present 2 single cases of first-onset schizophrenic patients and analyze the reports of their experiences. Problems such as loss of self, loss of common sense, and intentionality disorders reveal a disconnectedness that can be traced back to a detachment from the lived body. Hyperreflectivity and hyperautomaticity are used as coping mechanisms, but reflect the same problem of the split between body and mind. It is argued that the sole focus on cognitive impairments leads to a distorted image of schizophrenia, and that the acknowledgment of its fundamental bodily roots enables one to see the coherence between the diverse symptoms. As for the practical implications of the phenomenological approach, further research is needed to investigate if and how body- and movement-oriented therapies might strengthen the embodiment of schizophrenic patients.

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Introduction

In contemporary debates on how to best understand schizophrenia, its symptoms and their coherence, we can roughly discern three different strands. Each takes a different level to be primary. The metarepresentationalist approach considers metarepresentational deficiencies as the main problem, i.e. schizophrenic symptoms such as thought insertion and experiences of alien control arising out of a failure of the patients to correctly attribute their own experiences to themselves [1]. Another approach is to explain schizophrenia in terms of so-called basic symptoms; in this view, metacognitive impairments are the result of an accumulation of more basic neurological defects [2]. In between is the phenomenological perspective, whose proponents argue that we can best understand schizophrenia as a disturbance of the basic embodied self [3–5]. The basic prereflective sense of self is weakened, which in turn shows in lower-order neurological deficits and also influences higher-order cognitive functioning.

In this article, we make a case for the phenomenological viewpoint and discuss how the embodied self is affected in schizophrenic experiences. We present two case studies of young, first-onset schizophrenic patients to exemplify the different ways in which schizophrenia can be regarded as a problem of disembodiment.

The Basic Self

Different authors [6, 7] have suggested that schizophrenia is a problem at the level of the so-called minimal or basic self – as opposed to the extended, autobiographical or narrative self. The notion of the minimal self refers to the intuition that even if all autobiographical information were to be stripped away, there would still be a sense of self left. It would still be *me* who is experiencing. Zahavi [8] calls this the inherent ‘mineness’ of all my experiences, i.e. the structure of experiencing is subjective. Experiences do not exist as objects isolated from subjects; every perception, movement or thought is the experience of at least a minimal self.

Sass and Parnas [5] argued that what unifies the so-called positive, negative and disorganization symptoms of schizophrenia is that they all express a disorder at the level of this minimal self or ‘ipseity’. The symptoms point to an altered underlying structure of experiencing: the act of awareness itself is disturbed. Sass and Parnas [5] discerned two main complementary aspects of the schizophrenic self-disorder: *hyperreflexivity* and *diminished self-affection*. These are accompanied by a disturbed hold or grip on the perceptual or conceptual field; figures and meanings do no longer stand out clearly from their background.

The concept of self-affection was developed by French phenomenology in particular (by Maurice Merleau-Ponty [9] with regard to the experience of time, by Michel Henry [10] with regard to embodiment and life). Regarding subjectivity, this concept describes the typical feature of our experience that we are always already related to ourselves in a prereflective and nonobjectifying sense. Sass and Parnas [5] specify self-affection as the ‘intensity or vitality of one’s own subjective self-presence’. ‘Hyperreflexivity’ refers to the tendency of schizophrenic patients to exaggeratedly monitor their own sensations.

The focus of this article is on the role of the body in this disturbance of the basic self in schizophrenia. The traditional notion of what it means to be a self or, perhaps more accurately put, what it means to be a person highlights the reflective abilities that are required for the autonomy and authenticity of the subject. When we look at the basic self, however, a different, more embodied, picture emerges.

From a developmental perspective, it is well before we form our rational and reflective faculties that we are selves already, in the sense of subjective, bodily experiencers. This basic self is first and foremost a bodily and social or ‘intercorporeal’ self [9]. It may sound counterintuitive to

speak of the social self, but if we look at the developmental process, it is *intersubjective* from the very start [11, 12]. An infant does not learn in a vacuum, it is constantly engaged in interactions with other people and its surrounding world. Moreover, the development of the self is to a very high degree a *bodily* process, both in the sense of getting to know and exploring the own body, and in the sense of the body as a medium of the self-world relation. It is through our bodies that these interactions are possible in the first place. Bodily expressiveness is consequently augmented by vocal or linguistic expressiveness. From a developmental perspective, one could argue that the rational and reflective abilities build on a more basic ‘*shared self*’.

If we consider schizophrenia to be a disturbance of this basic self, we should expect to find problems in the bodily, intersubjective and intercorporeal spheres. Let us take a look, then, at what the case studies show.

Case Studies

Methods

Both patients presented with first-onset schizophrenia, diagnosed according to the ICD-10. They took part in a larger study that uses the Examination of Anomalous Self-Experience, a semi-structured qualitative interview developed by Parnas et al. [13] that focuses on a phenomenological assessment of altered experiences with respect to thinking, self-awareness, bodily sensations, social and worldly interactions, and existential reorientation. The aim of this study is to enable an early detection of prodromal schizophrenia by looking at the often subtle changes in self-experience that occur before full-blown psychosis. The two patients were selected on the basis of their paradigmatic descriptions and their very different cultural backgrounds. The latter serves as an extra indication of the elementary nature of the processes at stake.

The analysis of single-case studies lends itself particularly well to research on subjective experiences. While a comparison of quantitative data may point to valuable correlations, the spontaneous descriptions of patients can reveal a meaningful coherence between otherwise isolated symptoms. Subjective experiences are of course unique, but they do share a common structure. The phenomenological investigation of these descriptions focuses on precisely this common structure.

Results

Patient S.N. is a 22-year-old man who presented with mainly physical complaints. His parents had divorced when he was 8 years old, and he chose to live with his abusive father. At the age of 15 years, he started to drink a lot with friends. He had been a good pupil, but his achievements deteriorated from then on. After 2 years of heavy drinking, he sensed that he had become addicted and abstained from drinking. He did not finish school. At the age of 18 years, he moved out and broke off contact with his father; he had already lost contact with his mother years before. Around that time he started smoking pot, which he at first experienced as an expansion of consciousness, but which increasingly led to rumi-

nations and feelings of alienation. He had stopped using marijuana 2 months prior to presentation.

Three years ago, he began to notice certain changes. He suspected that these may have started even before. The world somehow looked and felt different, and he himself experienced strange bodily sensations and mood swings. For the last 6 months, he had suffered from insomnia and inexplicable pain in his skin, bones and joints, and he had been unable to cry or laugh, or to speak to anyone. The only contact he had was with his girlfriend, with whom he lived together. He suspects that she reads his thoughts. He thought his altered experiences might be caused by a brain tumor, but a neurological examination had shown no abnormality.

S.N. was diagnosed with schizophrenia based on the following first-rank symptoms: thought insertion, thought broadcast, cenesthetic experiences and delusional perception.

Patient L.N. is a 23-year-old man who lived in almost complete isolation in his parents' house before he came to the clinic. He suffered from severe depersonalization and derealization, and was diagnosed with schizophrenia based on delusional perception and negative symptoms. He was born and raised in Iran in a family consisting of his father, mother and younger sister. The family often moved. When he was 16 years old, they moved to Germany where they lived for 2 years in an asylum-seekers hostel. He described the circumstances as humiliating: they shared one room with two families, and he had to wait in line to receive a meal. After 1 year, he was allowed to go to school. He had always been a very good student, despite his difficulty in concentrating. He had trouble connecting with his fellow students and did not make any friends. After high school, he started studying computer sciences, but rapidly switched to physics because he felt he needed more of an intellectual challenge. After a few weeks, however, he also aborted this study and, from then on, he rarely ventured outside the house.

Loss of Self

Within our interview sample, it is remarkable how pervasive the worries about the self and being a person are:

L.N.: 'I don't know [who I am]. I have difficulties to determine who I actually am, because in different situations I feel very differently and I also behave very differently. I experience myself as individual parts, not as a complete thing. Not as a person, as a whole person. I feel as parts of a whole person, but never at the same time. It is difficult to explain.'

The loss of self-coherence is obviously not something that you can easily put aside; in fact, it proves to be a persistent struggle to try to gather and frame all the separate pieces into a meaningful whole:

L.N.: 'I constantly have to ask myself "who am I really?" It is hard to explain ... most of the time, I have this very strange thing: I watch myself closely, like, how am I doing now and where are the "parts" – in quotation marks. And that occupies me so much, to think about my condition, because it is not just one condition, it is always more conditions, that is exactly what is not functioning. I think about that so much that I get to nothing else. It is not easy when you change from day to day. As if you were a totally different person all of a sudden.'

S.N. describes a similar loss of self:

S.N.: 'With everything that I do, it seems to me as if that person were not really me. Something forged. That is how it is: I am not me, like I am sitting here now.'

When asked what was lacking, he answered 'that I am again, who I am'.

He links this with his inability to initiate something, and even to want something:

S.N.: 'When you are doing well, then you just sit there, you know yourself, you know who you are, you know what you do the whole day long, and what you want to do. You can just get up and do something. And that simply is completely gone. You are sitting there ... nothing means anything to you. I simply cannot assign myself; I don't know what I want to do, what I am doing, who I am. Yes ... That's my biggest problem at the moment, that I don't know who I am, what I want.'

In depression, apathy and aboulia primarily express a lack of energy. In schizophrenia, on the other hand, those seemingly same symptoms rather appear to be a matter of a lack of knowing how to get started. This may be related to a loss of the world's physiognomy: 'nothing means anything to you', nothing stands out or invites.

The loss of self is often accompanied by a feeling of being somehow too open to the world, of having a too 'thin skin'. This, in turn, may lead to experiences of transitivity, of the permeability of boundaries between the self and others, or the self and the world. In this case, other people and the world may be experienced as intrusive, invading the personal sphere. Fuchs [14, 15] called this an 'inversion of intentionality'. Contrary to the loss of physiognomy, here an exaggerated expressiveness forces itself upon the patient.

S.N.: 'My skin is extremely thin, especially when it concerns me personally. [I feel vulnerable] like a rabbit, lying on its back.'

L.N.: 'I am too sensitive. [I feel] helpless, sometimes. I think that I cannot defend myself.'

Apart from being too vulnerable and 'open', some patients describe themselves as too closed, as if there is a wall or glass pane between them and the world.

These patients express that they do no longer know who they are, that they doubt if they are the same person, or even a person at all. Like many other patients, they see this as their biggest or core problem and often judge their other difficulties to be the results of this fundamental loss.

Alienation

Both patients described a severe estrangement from themselves, including their bodies, and from other people and the surrounding world.

S.N.: 'In general, I didn't have a sense of my body anymore; this completely vanished at some time. My face became increasingly strange to me, as it still is today. My voice, too, because I talked much less. Just an extreme self-estrangement.'

S.N.: 'The world is not really tangible anymore, the world is just ... I don't know what. If you cannot be part of it, the world automatically feels different. I cannot describe it.'

The estrangement also encompassed a distance between themselves and their own perception. They even used the same image of a camera that transmitted the perceptual data to them:

L.N.: 'I feel as if I am sitting on some distant planet and there is somehow a camera in my head and those images are sent there. As if I am completely far away from here, where I am sitting right now.'

S.N.: 'For me it was as if my eyes were cameras, and my brain would still be in my body, but somehow as if my head were enormous, the size of a universe, and I was in the far back and the

cameras were at the very front. So extremely far away from the cameras. And I walk, and I look around ... and I'm dizzy, and all is like a machine ... I just didn't have much control over myself. Or, at least, that's how I felt. And, also, everything was hard. Suddenly, I felt an inhibition. I was scared to do things. For instance, when I was walking at the central station, there is a group of people and there is a bench, I have this robot-like feeling in my head, to be looking through cameras, and you observe your whole body, and the steps you take towards the bench. The gazes of the others almost physically affect you. You can feel the gazes.'

Whereas normally the subject and his experience coincide, here we see that there is no direct perception of and no direct contact with the world. On the contrary, instead of directly seeing something, they looked at images transmitted to them by a camera (note: not even by their own eyes), and they themselves were far away from the world where these images originated. This distance between the subject and his experiences conveys the classical picture of a homunculus sitting 'at the back of the head'. The 'almost physical' impact of the others' gazes again refers to the feelings of vulnerability and thin skin.

Hyperreflectivity and Hyperautomaticity as Coping Strategies

Confronted with these deficiencies, patients resort mainly to two basic coping strategies. First of all, patients may try to volitionally steer the otherwise tacit processes. Sass [16, 17] termed this hyperreflectivity. Everything the patient does, he does deliberately. Schizophrenic patients describe how even the most everyday actions require conscious attention. S.N. states:

S.N.: 'There were periods in which I felt extremely badly coordinated, when I just made a movement with the arm and the arm had moved further than I wanted it to move. But I also found myself to be extremely clumsy, somehow, when walking. I therefore constantly observed my walking and my movements ... Climbing the stairs was also very extreme, when you need a bit of concentration and a feeling of balance. I really thought each step after the other, as it were, each movement ...'

His movements and actions lacked smoothness and fluidity, and he tried to compensate this by hyperreflectivity, by volitionally steering the normally tacit practice.

Not only movements but also social interactions were subjected to constant observation and deliberation:

S.N.: 'When I said two sentences, they blatantly overlapped because with every word I said, I simultaneously had to think about it so that, in the end, I just clammed up.'

S.N.: 'No matter where, the observing was with everything I did. Even when playing games on the computer, even when I am walking through a virtual world. And the hand-eye coordination, you observe it all. Simply everything you do, everything you say.'

L.N.: 'I just observe everything I do and everything that is happening around me very closely. I probably cannot help doing that ... When I talk to other people, I always try to consider everything twice, to do it right ... When I want to make a joke, I reconsider it ... It is as if I am an outsider.'

L.N. even went on to analyze his own hyperreflectivity or his 'need to reconsider', as he himself called it, and suspected that it stood in the way of being present in the here and now and prevented him from a spontaneous grasp of the world:

L.N.: 'I even considered that, perhaps, this feeling of not being present follows from this constant reconsidering. Perhaps I think

so much that my brain can no longer manage to automatically understand the environment.'

The second way of coping is the opposite: the patient retreats into automatism. If he succeeds not to think about what he is doing, he can surrender to the bodily memory that is still available. In analogy to hyperreflectivity, we may call this *hyperautomaticity*. This is not necessarily an unpleasant sensation. Especially for patients suffering from hyperreflectivity, such a complete shutting off of observing and thinking may be quite a relief. Patient S.N. even compared it to a 'runner's high':

S.N.: 'At work, I had to put tires on a workbench all day long ... When I felt like shit after 4 hours of work, it was like runners with their 'runners-high': sometimes I really got into it, and I completely switched off, my mind was totally away from my body, and I just worked. Sometimes it did me really good, to be away from it all. And I thought, when I can still achieve that, that it all goes automatically, then there has got to be a way for me to feel better again.'

Schizophrenic patients also use this strategy to prevent psychotic breakdowns: when they sense they are becoming unstable, they try to literally distract themselves by handing themselves over to manual automatic jobs like cleaning the house, for instance. In such cases, the body can be experienced as a robot or a machine.

L.N. described how he resorted to either hyperreflectivity or hyperautomaticity but precisely lacked the in-between:

L.N.: 'Everything I do, I do with logic and reconsideration. Almost nothing works naturally, of its own accord ... However, I can also do things without even noticing. I get up, I brush my teeth, I get back, and I cannot even remember what I have done in between. That also happens. It is a combination of both: either complete automatism, or complete control.'

Hence, there is no modulation, no flexible switching between controlled and uncontrolled action. The observation that 'almost nothing works naturally' applies to both hyperreflectivity as well as to hyperautomaticity.

Discussion

The central theme that emerges out of these case studies is a fundamental multilayered disconnectedness. Both internal coherence and external relatedness are disturbed. *Internally*, first of all, patients report that their self is fragmented into parts; it is no longer experienced as a whole. Moreover, there is a split from the body: the body is not sensed, it feels alien, or not even alive, and acquires a mechanic quality. Thirdly, there is a distance between the experiences and the experiencer: S.N. and L.N. do not coincide with their perceptions, but were observing the perceptual process from a distance. Feelings, thoughts and movements may also appear as split off from the self, as if coming from nowhere. *Externally*, schizophrenic patients report difficulties in relating to other persons; they feel they are profoundly different, or experience themselves as an outsider. The problem can be

the experience of either being too vulnerable and open, with the danger of dissolving (e.g. transitivity), or being too closed, as if there were a wall around them that prevented any real contact. Moreover, the external relatedness to the world is often marked by alienation, different forms of derealization, or even hallucinations.

We could analyze both characteristics of schizophrenic self-disorder as proposed by Sass and Parnas [5] ultimately as problems of connection. Self-affection refers to a fundamental familiarity with oneself, or one could say a *coinciding* with oneself as a body-subject. This normally self-evident *coinciding* is disrupted, disconnected. Whereas every reflection already entails a certain split because one takes a stance toward something, this distancing still takes place within, or is grounded on, the continuity of self-affection. In case of hyperreflectivity, the reflection has turned rigid, detached from experience in the here and now.

Disembodiment

In schizophrenia, the self-evident 'knowledge' of who you are and what you want, of the world and your place in it, is no longer at disposal. Blankenburg [18] has described this as a 'loss of common sense', which is at the core of schizophrenia. Common sense can be characterized as a self-evident embeddedness in the world, in other words, as a fundamental *connectedness*.

The point we want to stress is that the 'knowledge' of common sense is neither a cognitive knowledge nor does it primarily rest on cognitive or metacognitive abilities: it is rather *embodied*. As Fuchs [19] has argued, common sense has a bodily basis. For a better understanding of schizophrenia, we therefore need to take the bodily dimension into account.

The role of the body is easily overlooked because of its tacit nature. It even needs to be overlooked in order to function the way it does. When we perceive the world and act in it, we rely on our body without having to attend to it. The German philosopher Plessner [20] refers to this specific role of the body as 'mediated immediacy': the body can best (i.e. most immediately) mediate the world when the mediating process itself keeps out of our awareness. We see the other person in front of us; we do not see our seeing.

There are two cases in which the bodily dimension *does* show itself. First of all, in the case of learning: the transparency of the body is not given from the outset but needs to be mastered. Any new skill that we want to adopt requires (conscious) effort and habituation to get the information out of the head and into the body. Learning

how to drive is a famous example of how we increasingly rely on our motor-sensory reactions. It shows that learning is the twofold process of incorporation of the learned into bodily abilities, paralleled by the retreat of the attention of the mind. The acquired skill becomes part of our body memory, and the mind can, for example, focus on learning Spanish while driving. As William James [21] put it: 'It is a general principle in psychology that consciousness deserts all processes where it can no longer be of use'. We could add that it is precisely because of its embodied nature that consciousness can do so and leave it to the body, so to speak.

Whereas learning processes demonstrate the role of the body in habituation and the *enlargement* of the sphere of familiarity, the role of the body also comes to the fore when this familiarity *breaks down* – as in the case of schizophrenia. As our case studies show, the tacit mediating role of the body has become explicit and felt, thereby changing the whole nature of experiencing. For S.N. and L.N., for instance, *seeing* has turned into looking at images through a camera. They perceive the perceiving. Since experiences are no longer lived from the inside, they can be observed as reified objects or data [16]. We could call this a mechanization of experiencing. It is, therefore, no coincidence that schizophrenic patients often refer to technical devices to try to describe their way of experiencing, or that they even develop delusions of alien technical control [22].

In schizophrenia, the learned, tacit, mediating body (*Leib*) turns into the body as an object (*Körper*). It does not provide a natural access to the world any longer and becomes the more or less steerable 'appendix of the mind'. Patient S.N. described how he experienced his body as a machine, both when he was hyperreflectively steering his body, and when he switched his mind off to leave it to the body's automatic functioning. The image of the Rylean ghost in the machine captures the subtle, but at the same time dramatic, changes that result from the split between mind and body [23]. The disconnection between body and mind fundamentally alters both of them: the mind becomes a hyperreflective observer, the body a hyperautomatic machine. Both are 'deanimated', as Stanghellini [24] termed it.

Lack of Modulation

When the normally self-evident bodily orientation slackens, hyperreflectivity and hyperautomaticity present themselves as ways of coping. It is striking that both conducts are extremely one-sided: either the mind controls and steers everything or it is 'completely switched

off' and 'totally far away from my body'. Or, like L.N. described it: 'It is a combination of both: either complete automatism, or complete control'. A middle way is lacking, a flexible switching from doing to deliberating and vice versa. They have lost the possibility of *modulation*. Normally, when we are immersed in some action or thought, we do not need to completely steer it, but neither are we like sleepwalkers who cannot consciously interfere at all. Even when immersed, we are still able to *adjust* to whatever slight changes present themselves. We naturally modulate our focus of attention.

Hyperreflectivity is therefore not the same as deliberate action, and hyperautomaticity is not the same as the 'doing without thinking' of our habits. The lack of modulation fundamentally alters the phenomenology of the respective experiences. When we do something 'automatically', like cleaning the house, for instance, we do not have to think about what we are doing, and in the meanwhile, we can be lost in thought. We do not, however, stand opposite to our movements, as minds observing the automatic workings of the body as a machine. The word 'automatism' with its mechanistic connotation in fact much better reflects the schizophrenic experience than our own. Our so-called automatisms are rather *habits* that function in virtue of our lived bodily attunement to the world, while schizophrenic automatisms on the contrary attest to a disembodiment or mechanization of the body. That is why we can make flexible adjustments without even noticing it because we are still present in what we are doing. There is precisely no split between a monitoring mind and a functioning body.

Likewise, hyperreflectivity is not the same as our attentive action. When we pay attention to what we are doing because we are still learning, or because we want to make sure that we do not make a mistake, our concentration is still mostly outwardly directed. Take dancing lessons as an example. We may switch back and forth between observing and correcting our movements as if from the outside ('am I standing upright?') and doing what we intend to do ('now I will turn my dance partner around'). We deliberate how to do it, try to imitate the teachers or even formulate sentences to remember the right order of arm and torso movements. Although we take an observing stance, our intentionality is not aimed at any inner process as such: we are directed at what we want to learn. In schizophrenic experiences of hyperreflectivity, however, the intentionality is itself directed inward. One young schizophrenic patient described his preoccupations as an inward journey in order to analyze himself and the way in which he experienced things, un-

like his classmates, who went out into the world and traveled abroad.

Moreover, the inward directedness of the intentionality is itself understandable as the result of an altered embodiment. If the bodily foundation for engaging in the world and interacting with other people shakes, the mind is left with nothing but theories and thinking to make sense of it all. The normally participatory sense making [25] is cut off by a lack of intercorporeal communication, and a monadic schizophrenic mental world ensues. Hyperreflectivity thus serves as a compensatory sense-making strategy¹, perhaps even as a quest for new certainties. For if only I could understand and analyze how my experiences function, I would at least have a secondary form of control. The rituals and thought systems of schizophrenic patients might serve as self-constructed compasses, replacements of common sense. Naudin et al. [29] describe how some patients formulate explicit theories to compensate for their lack of common sense. They also point to the 'inflexible attachment' of schizophrenic patients to these theories. However, whereas they judge this loss to be a metacognitive deficit, we think it is rather a bodily one, namely a lack of intercorporeal attunement.

Our natural common sense is not itself a metacognitive operation; it only turns into theorizing when the self-evident bodily dealing with the world does not function properly. Theorizing is precisely the constructed substitute of a direct bodily know-how. Hyperreflectivity tends to make things worse by enlarging the gap between a dis-

¹ The fundamental role of an *embodied* tacit familiarity with oneself, other people and one's surroundings also calls into question whether any form of *reflectivity* can be regarded as a *constitutive* part of the schizophrenic disorder of the basic self. As Sass [17] remarks: 'to distinguish with certainty between the core of an illness and its immediate sequelae (which may be compensatory or consequential) is an impossible task' (pp. 169–170). Still, whereas Sass and Parnas [5] argue that diminished self-affection and hyperreflectivity are equiprimordial, we encounter hyperreflectivity as a compensatory strategy ensuing from the disturbances at the basic, embodied level. In fact, Sass [16, 17] discerns both 'reflective' and 'operative' forms of hyperreflectivity. 'Reflective' hyperreflectivity relies on Blankenburg's [18] description of a compensatory recourse to deliberating that schizophrenic patients often seek due to a loss of the more implicit natural understanding of common sense. 'Operative' hyperreflectivity (also termed 'hyperreflexivity' [26, 27]), on the other hand, is neither a consequential nor a compensatory phenomenon, but denotes the breakdown of what Husserl [28] calls the 'passive synthesis' of experience: the normally tacit becomes focal and explicit. We agree that such an 'explication of the implicit' [19] is fundamental. However, it is not the result of deliberately directing one's thinking back towards the just-passed experience, but an automatic process over which the patient has little or no control. Therefore, we would describe it as a forced shift into the direction of attention rather than as a reflective or even hyperreflective process [14]. Thanks to one of the anonymous reviewers for drawing attention to this point.

embodied mind and a deanimated body, which speaks *against* the idea of common sense as a metacognitive ability. It shows that bodily habituation cannot be compensated by mere thinking, and that it never has been a matter of theorizing in the first place. A disconnected mind will not retrieve the natural fluidity of being at home in the world. Therefore, current approaches to schizophrenia as a deficit in the ‘theory of mind’ are at least problematic from a phenomenological point of view.

Conclusions

A phenomenological investigation of the changes that schizophrenic patients describe in the structure of their experiences reveals the dominance of a multilayered disconnectedness. Both hyperreflectivity and hyperautomaticity are used in an attempt to regain the grip on themselves and the world. The aim of this article has been to show how these main disturbances in schizophrenia are all characterized by their bodily nature. A focus on the bodily anchorage of concepts such as the loss of self and

common sense, self-affection, hyperreflectivity and *hyperautomaticity* literally gives more flesh to these notions and makes it possible to see their coherence. The patients here quoted show how a fundamental disconnectedness permeates all their experiences, to such an extent that they resemble the Rylean image of a ghost in a machine, or a disembodied mind in a deanimated body [24].

The primary role of the body should warn us against an overly cognitivist reading of the impairments that are at stake in schizophrenia. Moreover, taking the role of the body seriously not only allows for theoretical clarification, but could have practical implications as well. An important subject for further research would be whether and how body- and movement-oriented therapies might strengthen the embodiment of schizophrenic patients.

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