

The Psychopathology of Hyperreflexivity

Thomas Fuchs

UNIVERSITÄT HEIDELBERG

The structure of human embodiment is fundamentally characterized by a polarity or ambiguity between *Leib* and *Körper*, the subjective body and the objectified body, or between being-body and having-a-body. This ambiguity, emphasized, above all, by Helmuth Plessner and Maurice Merleau-Ponty, is also of crucial significance for psychopathology. Insofar as mental illnesses disturb or interrupt the unhindered conduct of one's life, they also exacerbate the tension within embodiment that holds between being-body and having-a-body. In mental illnesses, there is a failure of tacit mediations upon which one's bodily being-toward-the-world is based. Instead of serving as a medium of relating to the world, the body makes itself noticeable as disturbing or resistant. What was taken for granted suddenly becomes unfamiliar or strange; what was implicit becomes explicit and enters the focus of attention. This explication of the implicit always means a certain estrangement from oneself and, as such, already results in increased self-observation. It is even intensified by processes of reflection that revolve around the lost sense of self-congruence and in which the patients try to bridge over or compensate the break incurred. In fact, they generally only achieve the very opposite. Self-centeredness and hyperreflection are thus, on the one hand, the result of the illness, but on the other hand, they often additionally contribute to it.

Thus, explication of the implicit, self-alienation, and hyperreflexivity are fundamental phenomena in psychopathology. In order to explore their connection in more detail, in what follows, I first explain the implicit or, as one can also say, the transparent structure of embodiment and its relation to reflexive consciousness. In the second part, I will describe the phenomena of explication and hyperreflection by means of psychopathological examples.

The Implicit Structure of the Body

The implicit structure of embodiment may be explained in the following way: The intentional arc of our perception or of our action is aimed at what is in the focus of our attention.¹ This arc is formed by the combination and integration of individual elements—for example, of the letters of which a read text is composed, the individual facial features from which a complete mimic impression results, or of the individual movements that altogether lead to the complete acts of cycling or dancing. It is this integration of single elements into *gestalten* of perception or movement that is realized in the medium of the body, without the need for an awareness of the individual elements. Thus the body forms the intentional arc of each perception and action in a tacit and implicit manner. In other words, it is transparent with regard to their intentional object.

Michael Polanyi (1967) has analyzed this structure of embodiment as “implicit” or “tacit knowledge.” It is based on processes of gestalt formation that enable us to understand wholes and meaningful complexes instead of individual elements. We understand the facial expression of another person directly without being able to say which features it amounts to. We hear and understand the sentences someone speaks but not the individual sounds; in other words, we hear the sounds *as* sentences. Similarly, we feel the structure of an object by perceiving our feeling fingertips *as* the surface we are feeling. A blind man feels Braille print as words; he reads with his feeling fingers. That is, in Polanyi’s terms, through the proximal, which remains in itself implicit or transparent, we are directed to the distal in the focus of our awareness.

Embodied consciousness, by means of a concept of Helmuth Plessner’s, can also be characterized as “mediated immediacy” (*vermittelte Unmittelbarkeit*). The body mediates between us and the world but

remains transparent itself, and thus, our relationship to the world becomes immediate. On the other hand, this mediation cannot be taken for granted; it is rather prone to various disorders. Mere clumsiness or inability in dealing with objects makes us conscious of the body as a cumbersome instrument. In illness, the body makes itself felt in an unpleasant way, as a burden or as an obstacle: The otherwise transparent medium becomes opaque. Sensory impairments or motor paralyzes, indeed even brain lesions of the most varied kinds, can reduce or remove certain means of access to the world that the body otherwise opens up. After all, serious mental illnesses can disturb the mediating function of the body and its overall transparency. In that case, the immediacy of the relationship to the world is lost, and a more or less profound alienation arises.²

Reflexive consciousness, that is, self-directed deliberation, serves basically to close the gap that has emerged in the implicit mediations by means of new connections—and to repair the breaks, so to speak, that have occurred in embodiment. Conscious awareness can establish and guide new ways of dealing with the world until they have taken on the character of habits and have “become second nature to us.” By means of exercise and accustoming oneself, the body incorporates new abilities. Characteristic of success is an experience of spontaneity or “on its own,” which allows one to dedicate oneself to bodily enaction, to surrender, so to speak, to one’s own embodiment. The dancer has learned a new figure and can dedicate herself to it completely. The pianist has practiced a new passage that he can now modulate freely, listening to himself, so to speak. Forgetting oneself is the mark of successful bodily enaction. The body has become transparent for a new ability, so that focal consciousness can withdraw from the action and can be directed toward the distal aim. “It is a general principle in psychology,” as William James writes, “that consciousness deserts all processes where it can no longer be of use” ([1890] 1950, 496).

Thus, under conscious guidance, new capabilities are acquired until one has finally forgotten how exactly one does what one does. On the other hand, reflexive consciousness, the turning back of attention to the process of life itself, can also exercise an analytical, decomposing effect, as it were, on the implicit couplings of embodiment. Then we can literally not see the forest for the trees—a phenomenon that I would describe as the *explication of the implicit*. Let us look at some examples.

If we pronounce a familiar word a few times and, at the same time, pay attention to the mouth movements or syllables, it suddenly seems strange

or meaningless. The implicit coupling between syllables and meaning has been transitorily dissolved. A perceived facial expression is lost or distorted if one pays attention to single emerging features. If one examines a text for printing errors, one can scarcely pay attention to the meaning of the text at the same time. Similarly, if we concentrate too much on it, a body part no longer functions as an element of implicit ability. A musician who pays attention to his individual fingers during a passage will easily make a mistake, just as one can stumble if one is overly concerned with the individual steps when walking downstairs. In general terms, the backward turn of attention from the distal to the proximal, from meaning to the carrier of meaning, frequently leads to a disintegration of habitual, natural enactions. The transparency of the bodily medium gets lost, and the familiarity of the things, the readiness to hand in the accustomed dealings, gives way to irritation and alienation.

Focused attention can be particularly detrimental if directed at bodily enactions that are not subject to conscious control and, as such, cannot be “made.” Examples are falling asleep, laughing and crying, sexual arousal, and even giving birth. They happen “by themselves,” that is, they arise from a source of embodied spontaneity.³ Volitionally one can, at best, bring about a situation in which such enactions come about. If they are directly intended, this usually leads to their inhibition or blockage. A further insight is to be gained here: reflexive consciousness is not capable of, so to speak, going back to the source of embodied enactions, either spatially or temporally.

Spatially the directions of the body start from a source that cannot be localized. My body always remains the zero or central point of orientation in space; I am unable to bring it before me. I never see myself as someone seeing. Moreover, I also never see myself as others see me. Kleist, in his writing “Über das Marionettentheater” (“On the Marionette Theater”), relates a story of how the glance of the other brings about a break in embodiment and cancels the naturalness of pre-reflexively being oneself.⁴ Similarly, Luigi Pirandello describes in his novel *One, No One and One Hundred Thousand* (1992) a grave psychic crisis into which the protagonist gets when he becomes aware one day of the fact that how his face is seen is completely up to others and that for himself he must always remain different from how he appears to others.

But also in temporal terms, conducting one’s life eschews direct personal observation and always antecedes any reflexive account. Particularly

in our bodily feelings of hunger, thirst, pain, freshness, or tiredness we experience that we are never completely in control of ourselves, that something essentially shapes us that we, however, cannot enact or produce ourselves. We experience in ourselves a source of becoming, an origin of spontaneity and movement that we cannot put our finger on. Life is something that has affected us before we are able to seize it, understand it, and answer to it. We always remain withdrawn from ourselves.

Because of this spatial and temporal withdrawal from oneself, the attempt to seize the conduct of one's life in a self-reflexive manner must basically fail. Once the spontaneity and transparency of the body are disturbed, the reflexive consciousness works itself off on the disorder and gets entangled in empty hyperreflection, fruitless brooding, or compulsive personal observation. This additionally promotes the explication of the implicit and frequently leads to vicious circles of self-observation and self-alienation.

I have, by this means, presented some basic structures of the relationship of embodiment and reflexive self-awareness. In what follows, I will, on this basis, consider various psychopathological manifestations of hyperreflexivity.

Psychopathologies of Hyperreflexivity

A. Sleep Disorder

Let us start with the everyday example of sleep disorder. An insomniac has lost confidence in the bodily self-activity of sleep. When it is time to go to bed, his dread of the next sleepless night seizes him; he becomes restless and, for that reason alone, cannot fall asleep. Then he begins to observe himself, and he pursues what is happening in himself in a stressed, overly attentive manner. At the same time, the fleeting time is foregrounded, the hands of the clock, the minutes, or the hours. The insomniac tries at all costs to induce sleep—thus preventing it more surely. We fall asleep, as the language says so beautifully, and whoever wants to seize it only manages to drive it away. It seems natural that therapy should aim at replacing the compulsive intention to sleep by an opposite intention, such as getting the patient to practice a relaxation technique in the evening without being allowed to fall asleep. In this way he can learn to forget falling asleep again, thus letting it happen of its own accord.

B. Compulsive Disorder

Viktor Frankl gives a good example of hyperreflection on the basis of a compulsive personality, and he has also developed the technique of “de-reflection” and “paradoxical intention” for the treatment of such disorders. A twenty-one-year-old, perfectionist patient, always top pupil and best in the class, began a career as a bookkeeper after his final exam. He soon noticed, however, that his writing was not always legible. When his boss made him aware of this, he tried to improve it and sacrificed all his time to learning to write well. He tried to copy letters from his friend’s handwriting but soon did not know which letters to use anymore or how he should write. Since he was now completely concentrated on his handwriting, he could no longer write in front of other people, developed worries about their observing him, and had to give up his job. It was possible to cure the disorder within three weeks with the guideline of the paradoxical intention: “I’ll scrawl something for that person, I am only writing to scrawl, only to get stuck 30 times” (Frankl 2007, 198).

We see here very clearly how the backward turn of attention to bodily enaction can lead to the dissolution of an implicit ability, reinforced by dread and shame in front of others. At first the outward form of the writing itself replaces the intended contents. That would in itself not do any damage since conscious practice could, of course, lead to an improvement in the writing. The compulsive neurotic, the perfectionist, however, as soon as he has given up taking his bodily enaction for granted, never gets back to it. He wants to do everything deliberately and can allow nothing just to happen for fear of losing control and letting himself go. The paradoxical therapeutic instruction allows him just this and picks up on his secret rebellious wishes: for once in his life to be able just to scrawl, indeed “to scrawl something for his boss.” By this means, the “crump of reflection” is dissolved, and the patient gets back his confidence in his implicit bodily abilities.

C. Hypochondria

The paradigm of pathological reflection on the body is hypochondria. The hypochondriac has also lost confidence in her natural bodily processes and seeks in vain, by means of more exact medical supervision, to secure the reliable performance of her body. However, by these very means, she cancels the inconspicuousness of her bodily enactions and disturbs their

spontaneous activity. By means of her suspicious self-observation, she herself reinforces or produces unusual bodily sensations that she then interprets as threatening symptoms.

That is how a patient of mine was frightened by a tumor that might cause him to lose his eyesight. He was constantly observing his ability to see and registered his ocular sensations in a tense manner, thus evoking only additional tensions, negative feelings, and tear secretions. Indeed, his attention was also typically directed back from the distal to the proximal, from the seen to seeing, to the eye itself.

However, already the loss of confidence in one's own body has to do with reflexively gained knowledge. Indeed, in the background of hypochondria is the consciousness that as a physical human being one is prone to illness and vulnerable to being mortal, with the result that every banal pain can basically indicate the possibility of a lethal illness. The more sensitive a hypochondriac is about the vulnerability of her physical existence, the more unbearable it is for her. That is why she tries to keep at bay the fear of sickness and death that she constantly experiences up close to her by worryingly observing all her physical processes. Her body increasingly becomes a quasi-erotic object that places the world in the shade instead of being transparent for it. One's own and, ultimately, any medical professional's care for the body now replaces what gets lost in social relations. Medicine and doctors are supposed to close the crack that has emerged in the person's existence—as if the basic fact of the vulnerability and mortality of the human body could be cancelled by the body being constantly observed, examined, and forced into diet rituals. The hypochondriac represents the natural scientific aspiration to absolute control of the body, but nevertheless she cannot deny the fact of sickness and death. Hypochondriac neurosis often becomes a lifelong battle against a basic condition of existence that is not recognized and is negated. De-reflection is also therapeutically necessary here, to turn one's attention away from the body to the outside, above all to others.

D. Body Dysmorphic Disorder

Another form of hyperreflexivity can be found in body dysmorphic disorder or dysmorphophobia ("fear of deformation"), the exaggerated or delusional idea that an objectively inconspicuous body part, above all the face, the nose, the mouth, or the skin, is deformed or ugly. In the patient's experience, the

body part in question protrudes as deformed or sticks out, as the constant object of one's attention and concern. Characteristic of this are feelings of shame, fear of being visually exposed, and the feeling that one is being observed, stared at, or secretly laughed at. This fearful shame makes spontaneous physical behavior impossible and can escalate to paranoid ideas of reference. Cosmetic operations that the patients often have carried out on themselves do not usually change anything in the serious underlying destruction of their sense of self-worth.

In contrast to hypochondria, body dysmorphic disorder is a question of showing oneself or being seen in one's own bodily form, of displaying one's body image (Fuchs 2002, 2010). The potential self-alienation that can be triggered by the other's gaze was famously analyzed in detail by Sartre (1956). The pre-reflexive body thus receives an outside; it becomes an unprotected, stared at, or bared body, a "body-for-others," the object of their evaluation or possible refusal. This is the origin of self/other-related emotions, especially of embarrassment and shame. A person struck by shame is placed into the center of attention and is painfully touched by centripetal directions of being looked or pointed at for which he would like to sink into the ground (Fuchs 2002). The flushing or burning of his face corresponds to the embarrassment of being seen: The person who is ashamed feels himself at the hot point of attention. His movements become clumsy, and his posture, unnatural. Connected with this is a self-alienation or dissociation at that moment. The person affected looks, so to speak, through the eyes of others at his own bodily self, which has been shamed and ridiculed. He is simultaneously the one who sees and is seen.

Shame is thus the central emotion of disorders of body image, particularly of body dysmorphic disorder. Characteristically, the disorder usually arises in adolescence when one's own body is changing and, as a result of sexual changes, develops a new external appearance. Insecurity, hurts, and lack of self-esteem trigger the disorder then. Spontaneous physical presence gets lost or cannot be developed at all. Instead of that, the body that one considers to be deformed comes into the limelight, that is, the proximal replaces the distal. The body appears reified as an object, around which the patient revolves in his hyperreflexive brooding. Quite frequently this leads to a manifest depersonalization in which one's own body feels strange, numb, or without feeling. Again a vicious circle of ashamed self-observation and alienation arises that the patient is no longer able to break through.

E. Schizophrenia

Probably the most far-reaching dissolution of taking oneself for granted bodily and of one's spontaneity is found in schizophrenia. Particularly in the basic and early stages of the illness, schizophrenic patients experience a loss of implicit ability and tacit knowledge, which can also be described by the concept of "common sense": It means our basic familiarity with the world and with other people, which is bound up with the medium of the body. In phenomenological psychopathology, schizophrenia is also described as a "disembodiment" (Fuchs 2005a; Fuchs and Schlimme 2009; Stanghellini 2004). It consists of a creeping disintegration of bodily habits and actions, which especially makes what we take as natural and everyday seem more questionable. This explication of the implicit seizes, as we will see, increasingly proximal areas of bodily actions until these are experienced as completely alien to the ego and, indeed, finally driven from the outside.

Let us look at some examples of early stages of this disorder:

- A schizophrenic patient of Minkowski's was no longer able to read because "he becomes attached to a word, a letter, and does not attend to the meaning of the sentence. He examines whether all the 'i's have dots over them, whether there are accents where needed, whether all the letters have the same form" (Minkowski and Targowla 2001, 273).
- "At times, I could do nothing without thinking about it. I could not perform any movement without having to think how I would do it. . . . Sometimes I would think about words and wonder why 'chair' now means 'chair,' for example, or such things" (remarks from a schizophrenic patient treated in the Psychiatric Department of Heidelberg University).
- "If I do something like going for a drink of water, I've to go over each detail—find cup, walk over, turn tap, fill cup, turn tap off, drink it" (Chapman 1966, 239).

Here the implicit couplings or sensorimotor syntheses of the body break down and must be replaced by conscious planning and execution. The patients no longer manage to carry out a unified arc of action or use their body naturally for this. This leads to a loss of spontaneity, to increasing self-observation, and to hyperreflection. Every action, however trifling, requires targeted attention and action of the will, as it were, a "Cartesian" impact of the Ego on the body. It is not for nothing that the patients often

speak of a break between themselves and their body, feel hollowed out or like lifeless robots. This is because the feeling of being alive consists in being an incarnated self, which can direct itself naturally through its body to the world: “I am like a robot which someone else can use, but not me. I know what has to be done but cannot do it” (Chapman 1966, 231).

The disorder of usual bodily dealings with the world can manifest itself in a subtle alienation of everydayness, as Blankenburg (1971) has impressively described it. It also affects the habitual intercorporeal contact with others. Precisely those things become a problem “which cannot rationally be unequivocally defined, which are a matter of tact”: which dress one wears, how one addresses someone, how one apologizes, and so on. The loss of innate naturalness “makes itself noticed, above all, . . . in the innumerable little happenings of everyday life, but, beyond that, seizes one’s whole life orientation” (Blankenburg 1971, 82). Whatever the healthy person has forgotten because he was used to it, before he could ask about it, imposes itself as an unavoidable problem on the patient: recognizing how it is possible to be in the world, to act—how it is possible to live. It is precisely what is forgotten, that is, what we are accustomed to through our implicit bodily memory, that is no longer at the disposal of the patient.

In contrast to what it is like in the case of neurotic disorders, which we looked at before, we must assume a deeper-reaching cause for these phenomena of schizophrenic alienation. Recent phenomenological psychopathology works from a disorder of basic bodily self-experience that underlies all life conduct and imbues it with mine-ness and self-coherence (Parnas 2000; Sass and Parnas 2003). It is, so to speak, most proximal, that is, at the core of all intentional acts. The disorder of this pre-reflexive self-awareness thus permeates all areas of experience and cannot be compensated reflexively: “I constantly have to ask myself who I actually am. 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.’ . . . I think about that so much that I cannot do anything else. It is not easy when you change from day to day. As if you were a totally different person all of a sudden” (de Haan and Fuchs 2010, 329).

A further example of compulsive self-observation is quoted by Parnas and Handest:

If a thought passed quickly through his brain . . . , he was forced to direct back his attention and scrutinize his mind in order to know

exactly what he had been thinking. In one word, he is preoccupied by the continuity of his thinking. He fears that he may stop thinking for a while, that there might have been “a time when my imagination had been arrested.” . . . He wakes up one night and asks himself: “Am I thinking? Since there is nothing that can prove that I am thinking, I cannot know whether I exist.” In this manner he annihilated the famous aphorism of Descartes. (2003)

In vain, the patient tries to banish his existential fear of losing himself by constantly reassuring himself. This explicit turn backward does not, however, reach the source of thinking, which should imbue it with a sense of “mine-ness” (or self-ownership). If the intentional act is no longer embedded in self-awareness, it remains unrealized and has to be repeated emptyly.

Let us take a look at a more detailed exemplary case. A thirty-two-year-old patient reports that at the age of sixteen, he had become more and more uncertain about whether his personal things really belonged to him or had somehow been exchanged by others. When buying books, he was not sure if the salesman had not secretly replaced the ones he had chosen; so he had to give them away and always buy new ones. When leaving things on his school desk inattentively, he later began to doubt whether they were still the same and had to throw them away. More and more he lost trust in his environment.

At the age of twenty-one, during his studies at the university, he could not trust his own notes anymore. Finally, he began to doubt whether it really was his own arms or somebody else’s that did the job that he was actually occupied with. He had to carefully observe his arms from the hands up to the body in order to make sure that they were his own, and he repeatedly looked behind himself in order to see if there was not somebody else who moved them. Now he could not trust his own hands anymore and was in doubt about the simplest actions. He took endless time to dress, since he had to touch the clothes several times and had to consciously repeat his movements again and again to make sure that they were his own. He did not know whether he held his trousers the right way and in which order to dress. Every movement was like an arithmetic problem that had to be pondered with extreme concentration. So he became stuck in his everyday performances and felt more and more desperate (Bürgy 2003).

The fundamental self-alienation of the patient, at first, manifests itself in his mistrust in the belonging of his property. The reliability of his personal belongings is of existential import for him, because the continuity of the external environment should compensate the felt fragility of self-coherence. But the familiarity of things cannot be reproduced, and the personal environment seems increasingly alienated. Ultimately the sense of agency is lost from his own actions, and habitual action units dissolve. In order to compensate this loss, the patient has to consciously prepare and execute every movement by using his body like an external instrument. But even so he cannot be sure that the movement was not executed by someone else. Natural embodied know-how is lost, and as such, the intentional arc of directed action breaks down. The only remaining options are powerless self-observation and hyperreflection.

As alienation and explication of embodied intentionality increase, finally the act of perception as such can become an object of awareness. In this case the patients become observers of their own perceptions:

I become aware of my eye watching an object. (Stanghellini 2004, 113)

I saw everything I did like a film camera. (Sass 1992, 132)

For me it was as if my eyes were cameras, and my brain was still 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. (de Haan and Fuchs 2010, 329–30)

The perceiving subject gets into a position external to the world; he becomes a homunculus who looks on his own perceptions like pictures. This extreme alienation, indeed contortion of the bodily medium, also changes the things perceived into mere appearances or phantom pictures. That is the core of the artificial, mysterious, and uncanny alienation from the environment in the early stages of acute psychosis, which Jaspers (1963) describes as “delusional mood.” Instead of constituting an objective, common world, schizophrenic perception is caught in a subjective,

monadic view: it is no longer transparent in relation to the world; rather, it is opaque (Fuchs 2005b).

A final stage is reached when the dissolution of the intentional arcs of perception, thinking, and action is so far advanced that the remaining fragments of perception, thought, or movement take on a strange, object-like character and finally appear to be imposed on the patient from the outside: "I could no longer think the way I wanted to. It was as if one could no longer think oneself, as if one were prevented from thinking oneself. As if the ideas came from outside. . . . I began to wonder am I still that person or am I an exchanged person" (Klosterkötter 1988, 111). It is not hard to see how typical ego disorders such as thought insertions or verbal hallucinations can develop from such forms of experience.

To sum up, in schizophrenia the transparency of the body is so reduced that it can no longer function as a medium of turning to the world. The disturbance of basic self-experience alienates the person from her bodily enaction, and the "mediated immediacy" of the relation to the world is corroded. This results in a "disembodiment," a pathological explication of the natural, implicit functions of the body. In vain, the patients try to compensate for this by means of compulsive self-observation, ritualized making-sure-of-themselves, and hyperreflexivity. In the end the intentional arc is disintegrated, and its pieces appear to the patient as strange, thinglike fragments of feeling, thought, and movement.

Therefore, instead of functioning as a transparent medium of being-in-the-world, the bodily organization of the schizophrenic increasingly distorts perceived reality and finally entangles him in a delusional view of himself. The body he lives becomes an alienated, outwardly body machine that, in the end, appears to no longer be moved by the patient himself but, rather, driven by anonymous and strange powers. We can nowhere recognize so clearly what it means to be an incarnate bodily being as in the case of schizophrenia, in which the self is, so to speak, no longer at home in its body.⁵

Conclusion

We have examined some of the ways the psychopathology of hyperreflexivity manifests itself. One could add further examples to these, for example, the

brooding directed back to the past and the tormenting personal reproaches of depressive patients. However, the forms here presented should suffice to draw some conclusions:

1. Mental illnesses represent disorders or holdups in conducting one's life directed at the world and into the future. As such, they are connected with increased self-observation and self-evaluation, with a narrowing of attention to one's own person, to the deficits or symptoms experienced, and finally, with the backward turn of thinking to what has already been done or has happened. These phenomena can be summed up in the concept of *hyperreflexivity*.
2. The disorder of enaction is manifested also in a dissolution of the habits, gestalt units, and implicit couplings on which the body's intentionality is based. Comprehensive intentional arcs of perception and action are dissolved, so that single elements appear disturbingly in the foreground. I have called these phenomena the *explication of the implicit* or *pathological explication*.
3. Hyperreflexivity and explication condition and reinforce one another reciprocally. What was taken for granted up to now becomes questionable, the familiar becomes alienated, but the brooding self-reflection triggered by this contributes additionally to this disorder. Vicious circles of self-observation and self-alienation arise from this.

The anthropological basis of these phenomena can be localized in the destabilization that the natural enaction of life undergoes through the self-relationship of the person: The "ex-centric position" (Plessner 1975) that a human being takes toward herself by seeing herself from the outside and with others' eyes always already implies a component of self-alienation. It also manifests itself in the ambiguous structure of embodiment, insofar as our bodily nature is not only something that we are but also something that we have. Similarly, mental illness means more than simple suffering from certain states or symptoms. It also always implies a self-alienation or self-separation of the person. Something in myself faces me, withdraws from my access, or dominates me, whereas I try in vain to get back my command of myself, whether it be a panic attack, a depressive mood, a compulsive impulse, or audible thoughts. Functions or impulses that were integrated up to now become independent or particularized and are derailed from my control. Being mentally ill touches the person centrally, in other words, in her self-relationship.

For this reason the relation of the patient to his self represents a constantly effective component of the course of the illness. Every psychopathological state is characterized by a certain relationship that the person affected assumes to it—he can suffer it passively, give in to it, act it out, brood about it, fight against it, and so on. These different ways of behaving oneself are in themselves significant features of an illness. The most radical manifestation of the relationship to self (and, as such, one possibility only given to the human being) is represented by suicide, to the extent that it means a patient's final statement of opinion on his situation.

Of course, we should not forget that major therapeutic means of treatment are based on the personal relation to oneself. Among these are reflection on one's own path in life and relations to others as well as directing attention toward new behavioral patterns or exercises in mindfulness. Especially mindful, nonevaluating, and nonintervening observation of one's own condition leads to a distancing from oneself that makes this state bearable and, at the same time, surreptitiously changes it. Under therapeutic guidance consciousness can ultimately become a tool for overcoming pathogenic relationships and patterns of behavior; for to be changed, they need to be made explicit in therapy. As such, the polarity of the explicit and the implicit that results from the personal relationship to oneself brings with it the potential for illness as well as healing.

NOTES

1. The phrase "intentional arc" was coined by Merleau-Ponty (1962, xvii, 137, 243) as a means of referring to the natural underlying intentionality of the body that is not subject to ego activity.

2. Of course, the body can become conspicuous in a plethora of pleasant or pleasurable experiences as well; see, e.g., Shusterman 2008, 15 ff.

3. In the last analysis, this holds for all embodied enactions. For if I intentionally lift my arm, the origin of its movement remains inaccessible to me: Volitionally I can only *release* the movement, just like one shoots an arrow by letting the bowstring loose.

4. In this story, a young man loses his extraordinary natural grace through an inconspicuous event: After taking a bath together with a friend, in the mirror, he notices himself performing a spontaneous gesture, which reminds them both of a classical sculpture. His attempts to reenact the gesture that has now become conscious turn into an empty pose and fail awkwardly: "From that day, from that very moment, an extraordinary change came over this boy. He began to spend whole days before the mirror. His attractions slipped away from him, one after the

other. An invisible and incomprehensible power seemed to settle like a steel net over the free play of his gestures. A year later nothing remained of the lovely grace which had given pleasure to all who looked at him" (Kleist 1961).

5. It is not possible to address in more detail therapeutic interventions. These consist mainly of methods from movement, dance, or art therapy that aim at furthering the experience of self-efficacy and the grounding in embodied enaction.

WORKS CITED

- Blankenburg, W. 1971. *Der Verlust der natürlichen Selbstverständlichkeit*. Stuttgart: Enke.
- Bürgy, M. 2003. "Zur Phaenomenologie der Verzweiflung bei der Schizophrenie." *Zeitschrift für klinische Psychologie, Psychiatrie und Psychotherapie* 51:1–16.
- Chapman, J. 1966. "The Early Symptoms of Schizophrenia." *British Journal of Psychiatry* 112:225–51.
- de Haan, S., and T. Fuchs. 2010. "The Ghost in the Machine: Disembodiment in Schizophrenia. Two Case Studies." *Psychopathology* 43:327–33.
- Frankl, V. 2007. *Theorie und Therapie der Neurosen. Einführung in die Logotherapie und Existenzanalyse*. Munich: Reinhardt.
- Fuchs, T. 2002. "The Phenomenology of Shame, Guilt, and the Body in Body Dysmorphic Disorder and Depression." *Journal of Phenomenological Psychology* 33:223–43.
- . 2005a. "Corporealized and Disembodied Minds. A Phenomenological View of the Body in Melancholia and Schizophrenia." *Philosophy, Psychiatry, and Psychology* 12:95–107.
- . 2005b. "Delusional Mood and Delusional Perception—A Phenomenological Analysis." *Psychopathology* 38:133–39.
- . 2010. "Phenomenology and Psychopathology." In *Handbook of Phenomenology and the Cognitive Sciences*, ed. S. Gallagher and D. Schmicking, 547–73. Dordrecht: Springer.
- Fuchs, T., and J. Schlimme. 2009. "Embodiment and Psychopathology: A Phenomenological Perspective." *Current Opinion in Psychiatry* 22:570–75.
- James, W. (1890) 1950. *The Principles of Psychology*, vol. 2. New York: Dover Publications.
- Jaspers, K. 1963. *General Psychopathology*. Trans. J. Hoenig and M. W. Hamilton. Chicago: University of Chicago Press.
- Kleist, H. v. 1961. "On the Marionette Theatre." Trans. Idris Parry. <http://www.southerncrossreview.org/9/kleist.htm>.
- Klosterkötter, J. 1988. *Basissymptome und Endphänomene der Schizophrenie*. Berlin: Springer.

- Merleau-Ponty, M. (1945) 1962. *Phénoménologie de la perception*. Paris: Gallimard. Reprint. *Phenomenology of Perception*. Trans. Colin Smith. London: Routledge and Kegan Paul.
- Minkowski, E., and R. Targowla. 2001. "A Contribution to the Study of Autism: The Interrogative Attitude." *Philosophy, Psychiatry, and Psychology* 8:271–78.
- Parnas, J. 2000. "The Self and Intentionality in the Pre-psychotic Stages of Schizophrenia." In *Exploring the Self: Philosophical and Psychopathological Perspectives on Self-Experience*, ed. D. Zahavi, 115–47. Amsterdam: John Benjamins.
- Parnas, J., and P. Handest. 2003. "Phenomenology of Anomalous Self-Experience in Early Schizophrenia." *Comprehensive Psychiatry* 44:121–34.
- Pirandello, L. 1992. *One, No One and One Hundred Thousand*. New York: Marsilio Publishers.
- Plessner, H. 1975. *Die Stufen des Organischen und der Mensch*. Berlin: De Gruyter.
- Polanyi, M. 1967. *The Tacit Dimension*. Garden City, N.Y.: Anchor Books.
- Sartre, J.-P. 1956. *Being and Nothingness*. New York: Philosophical Library.
- Sass, L. A. 1992. "Schizophrenia, Delusions, and Heidegger's 'Ontological Difference.'" In *Phenomenology, Language, and Schizophrenia*, ed. M. Spitzer, F. Uehlein, M. A. Schwartz, and C. Mundt, S. 126–43. Berlin: Springer.
- Sass, L. A., and J. Parnas. 2003. "Schizophrenia, Consciousness, and the Self." *Schizophrenia Bulletin* 29:427–44.
- Shusterman, R. 2008. *Body Consciousness. A Philosophy of Mindfulness and Somaesthetics*. New York: Cambridge University Press.
- Stanghellini, G. 2004. *Disembodied Spirits and Deanimated Bodies: The Psychopathology of Common Sense*. Oxford: Oxford University Press.

Copyright of Journal of Speculative Philosophy is the property of Pennsylvania State University Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.