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On incomprehensibility in schizophrenia

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Abstract This article examines the supposedly incomprehensibility of schizophrenic delusions. According to the contemporary classificatory systems (DSM-IV-TR and ICD-10), some delusions typically found in schizophrenia are considered bizarre and incomprehensible. The aim of this article is to discuss the notion of understanding that deems these delusions incomprehensible and to see if it is possible to comprehend these delusions if we apply another notion of understanding. First, I discuss the contemporary schizophrenia definitions and their inherent problems, and I argue that the notion of incomprehensibility in these definitions rests heavily on Jaspers' notions of understanding and empathy. Secondly, I discuss two Wittgensteinian attempts to comprehend bizarre delusions: (a) Campbell's proposal to conceive delusions as framework propositions and (b) Sass's suggestion to interpret delusions in the light of solipsism. Finally, I discuss the phenomenological conception of schizophrenia, which conceives delusion formation as resulting from alterations of the structure of experiencing and from underlying self-disorders. I argue that although a psychological understanding that seeks to grasp meaning in terms of motivations, desires, and other more straightforward psychological connections between mental states is impossible in schizophrenia, we can in fact have a philosophical understanding of the schizophrenic world and of the emergence of delusions typically found in schizophrenia.

Keywords Schizophrenia · Delusions · Self-disorders · Phenomenology · Understanding

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Traditionally, incomprehensibility is considered the hallmark of schizophrenia with regard to both delusions and expressive symptoms (e.g., autistic traits, impaired social skills, flat affects, and formal thought disorders). I will here mainly discuss the incomprehensibility of delusions in schizophrenia. Although present in all forms of psychoses, delusions are unspecific phenomena that are not easily defined and their etiopathogenesis remains unknown. During the history of psychiatry, many psychopathologists have tried to identify those characteristics of delusions which specifically could indicate the most severe form of psychosis: schizophrenia. Although no pathognomonic symptom for schizophrenia has been identified, bizarre delusions and other first-rank symptoms are essential components of the schizophrenia definition in both DSM-IV-TR and ICD-10. The presence of bizarre delusions is, according to these classificatory systems, a sufficient criterion to diagnose schizophrenia (if the duration criterion is fulfilled and the exclusion criteria are not). In DSM-IV-TR, delusions are deemed bizarre "if they are clearly implausible and not understandable and do not derive from ordinary life experiences" (APA 2007, 299), while delusions, in ICD-10, can be considered bizarre if they are "culturally inappropriate and completely impossible" (WHO 1992, 87). Both definitions draw extensively on Jaspers' distinction between delusions that are psychologically comprehensible and delusions that are completely incomprehensible (Jaspers 1997); schizophrenic delusions being the paradigmatic example of the latter. It has been argued that the contemporary schizophrenia criteria are inconsistent (Heinimaa 2002), inadequate, and, in some respects, downright misleading (Spitzer 1990; Parnas and Sass 2001). Despite being a crucial component of the schizophrenia criteria, the concept of incomprehensibility and the problems it encompasses are neglected in the recent psychopathology of schizophrenia (Heinimaa 2002). This article seeks to fill this void by inquiring into the incomprehensibility of schizophrenic delusions. Which criteria deem some schizophrenic delusions incomprehensible? If we adopt another notion of understanding with a different set of criteria, can we then begin to comprehend these delusions or do they remain beyond comprehensibility? What are the limits of interpersonal understanding? These are the questions I seek to answer. I will therefore see if it is possible to comprehend some of the schizophrenic delusions that traditionally are considered incomprehensible. Indeed, this is a balancing act between trying to comprehend mental phenomena that traditionally are considered incomprehensible and avoiding to make these phenomena too comprehensible, by which I would fail to recognize their specificity and strangeness.

This article is divided into three sections. In the first section, I discuss the DSM definitions of delusions and bizarre delusions, the theoretical premise underlying them, and their historical origin. More specifically, I criticize the defining properties of delusional beliefs and I dispute the "poor reality-testing" premise, which presupposes that the overall form of the schizophrenic world and the way patients experience it are essentially normal. Since the contemporary definitions echo Jaspers' distinction between delusions proper and delusion-like-ideas, I discuss this distinction and explore the criteria underlying his notion of understanding. I argue that these definitions and the "poor reality-testing" premise bar the way to an understanding of bizarre delusions. In the second section, I examine two Wittgensteinian attempts to extend the range of

understanding to bizarre delusions: (a) delusions as framework propositions (Eilan 2000; Campbell 2001) and (b) delusions interpreted in the light of solipsism (Sass 1994; 2003a). I argue that insights can be drawn from these studies that may elucidate parts of the experiential world of schizophrenia patients. In the third section, I try to integrate these insights with a phenomenological conception of schizophrenia, which conceives delusion formation as resulting from alterations of the structure of experiencing (Bovet and Parnas 1993). According to phenomenological psychopathology, schizophrenic symptomatology arises from self-disorders (i.e., anomalies of self-experience and self-awareness) which reflect a basic disturbance of consciousness (Parnas et al. 2005). I first discuss Conrad's account of delusion formation in schizophrenia, and thereafter, I explore the role of self-disorders in schizophrenia and discuss the empirical data supporting this approach (Gross et al. 1987; Klosterkötter 1988; Møller and Husby 2000; Parnas et al. 1998; Parnas and Handest 2003; Parnas et al. 2005; Raballo et al. 2009). I argue that if we consider how the structure of experiencing alters in schizophrenia patients from early pre-morbid, non-psychotic anomalous experiences to the onset of psychosis, then we can have some understanding of the schizophrenic world and the emergence of delusions typically found in schizophrenia. I argue that this form of philosophical understanding is different from an ordinary psychological understanding, and I briefly discuss the relation between philosophical understanding and empathy.

Contemporary definitions: inherent problems and historical origin

The notion of bizarreness in schizophrenia is today restricted to the domain of delusions. DSM-IV-TR defines delusions as "erroneous beliefs that usually involve a misinterpretation of perceptions or experiences" and these false beliefs must be strongly held by the person despite obvious contradictory evidence (APA 2007, 299). Bizarre delusions form a subcategory of delusions and they are defined as "clearly implausible and not understandable and do not derive from ordinary life experiences" (APA 2007, 299). Although ICD-10 does not use the term *bizarre delusions*, it does beside Schneiderian first-rank symptoms specify "persistent delusions of other kinds that are culturally inappropriate and completely impossible" (WHO 1992, 87), thereby closely following the DSM-III-R definition of bizarre delusions as "involving a phenomenon that the person's culture would regard as totally implausible" (APA 1987, p. 194). Recognizing that bizarreness can be culturally dependent, the DSM-III-R definition incorporated Jaspers' notion of incomprehensibility (Andreasen and Flaum 1991). This definition replaced the previous definition in DSM-III, where delusions were considered bizarre if the "content is patently absurd and has no possible basis in fact" (APA 1980, p. 188). This survey illustrates that *bizarreness* is an ambiguous concept; it can refer to beliefs whose content are considered implausible, incomprehensible, absurd, impossible, or culturally inappropriate.

Bizarre delusions form one of the heaviest-weighted diagnostic criteria of schizophrenia, but recent studies have found poor reliability for diagnosing bizarre delusions and questioned its status as a sufficient criterion to diagnose schizophrenia

(Bell et al. 2006; Cermolacce et al. 2010). In addition, Heinimaa has argued that the DSM-IV definition of bizarre delusions is contradictory. The three conjunctive criteria (clearly implausible, incomprehensible, and not derived from ordinary experiences), which all must be present to diagnose a bizarre delusion, cannot be present simultaneously; implausibility presupposes a sort of comprehensibility that excludes the incomprehensibility criterion (Heinimaa 2002). Furthermore, almost every element of the DSM-III-R and DSM-IV-TR definition of delusions has been criticized (Spitzer 1990; Sass 1994; Parnas and Sass 2001, Heinimaa 2002). For example, the properties that a belief must have in order to be judged as delusional are problematic. Spitzer has among others discussed the problems of defining delusions by means of the three properties or criteria: falsity, certainty, and incorrigibility (Spitzer 1990). Certainty and incorrigibility are not sufficient criteria to define delusions because they occur in normal conditions as well. Falsity, however, cannot be a defining criterion because it is not universally applicable. For example, delusions of morbid jealousy or persecutory delusions may be perfectly true and still be delusions. Rather than primarily examining the truth value of a specific belief and its degree of conviction, the clinician usually considers multiple factors when diagnosing a belief as delusional, e.g., the belief's empirical plausibility and cultural consensus, the coherence between beliefs held by the patient, the patient's ability to distance himself from this particular belief, the certainty by which the patient holds the belief, and the patient's overall appearance, behavior, life situation, etc. However, not all these clinically relevant factors are incorporated in the DSM-IV-TR definition of delusions.

Furthermore, I want to draw attention to a theoretical premise underlying the contemporary definitions of delusions. The definition of delusions as "erroneous" or "false" beliefs that involve "misinterpretation" of perception or experience implies that to be deluded is a matter of being unable to distinguish the imaginary from the real—to mistake the imaginary for the real so to say. I am here aiming at the defining criterion for diagnosing a psychotic condition, namely the so-called impairment or failure of "reality-testing"; the function by which we supposedly are able to distinguish "subjective" experiences from "objective" experiences of the external world. This criterion reflects a global tendency to conceptualize schizophrenia as a disorder of cognitive functioning; Frith's well-known hypothesis that delusions result from deficient meta-representational capacities is an example hereof (Frith 1987; 1992). However, what is presupposed in the "poor reality-testing" criterion is that, while the content of the delusional beliefs is false or erroneous, the overall form of the patient's world and the way he experiences it are essentially unchanged and normal (Sass 1994). In various ways, the following inquiries question the validity of this premise.

The inconsistencies and contradictions in the contemporary definitions reflect more generally the difficulties in defining delusions and bizarre delusions. Indeed, it is dubious if it is possible at all to formulate universally valid definitions of these complex mental phenomena. In contrast to the current definitions in DSM-IV-TR and ICD-10, phenomenological psychopathologists (e.g., Jaspers, Schneider, and Conrad) have tried to delimit delusions specific to schizophrenia by focusing on their experiential dimension rather than exclusively on their propositional content, i.e., by exploring the structural alterations of experiencing that

accompany and shape the delusional belief. From a phenomenological perspective, the propositional aspect of delusions stems partly from a non-propositional form of experiencing. Although focus is on the structure of experiencing, the delusional content is not neglected; in fact, the content and structure of delusional experiences are considered dialectically intertwined. Schneider's first-rank symptoms, which he considered strong indicators for schizophrenia thereby granting them the status of "first-rank" in the hierarchy of symptoms, are examples of psychotic symptoms that are diagnosed primarily by focusing on the structure of experiences rather than on their specific content (Schneider 1959). In the DSM-III and DSM-IV definitions of bizarre delusions, some first-rank symptoms represent prime examples of bizarre delusions, e.g., thought insertion, thought withdrawal, delusions of control (DSM-IV), and thought broadcasting (DSM-III). Several studies have examined this, not unproblematic, overlap between first-rank symptoms and bizarre delusions (Tanenberg-Karant et al. 1995; Nakaya et al. 2002; Nordgaard et al. 2008; Cermolacce et al. 2010). Since the contemporary definitions are strongly influenced by Jaspers, it is reasonable here to briefly recollect his conception of schizophrenic delusions. We can, for example, trace the three defining criteria of delusions (i.e., falsity, certainty, incorrigibility) back to his works, and, as noted above, see a similarity between the contemporary definitions of bizarre delusions and Jaspers' notion of delusions proper.

In *General Psychopathology*, Jaspers claims that a delusion is not simply "a mistaken idea which is firmly held by the patient and which cannot be corrected" (1997). Rather than being a false judgment or belief, a delusion "manifests itself in judgments." Having made this reservation, he claims that the term delusion *vaguely* is applied to all false beliefs that share three external characteristics: (1) they are held with subjective certainty, (2) they are incorrigible, and (3) their content is impossible (Jaspers 1997, 95f.). These characteristics were later incorporated in the DSM definitions of delusions as defining criteria (APA 1987; 2007) by which Jaspers' warning that "a delusion may be correct in content without ceasing to be a delusion" went unheeded (Jaspers 1997, 106). Consistent with the phenomenological approach he endorsed, he claimed that if "we want to get behind these mere external characteristics into the psychological nature of delusion, we must distinguish the original experience from the judgment based on it" (Jaspers 1997, 96). For Jaspers, a delusion is essentially an experience and not a belief. He divided delusions into two groups according to their origin and emergence: one group of delusions, which he termed delusion-like ideas, emerge in a psychological comprehensible way from preceding affects and experiences, while the other group, delusions proper (also called primary or true delusions), emerge from primary pathological experiences, and therefore, these delusions cannot be psychologically traced back (reduced) to other psychic events; they remain psychologically irreducible and thus empathically incomprehensible (Jaspers 1997, 96). According to Jaspers, delusions proper, which he considered characteristic for schizophrenia, involve "a transformation in our total awareness of reality" (Jaspers 1997, 95). A significant aspect of this transformation in the awareness of reality is that in delusional experiencing, the meaning of the experienced is immediately given without any reflective acts. No (further) interpretation is needed because the deluded patient already "knows" that this is so

and so; and we do not question what we think we already know. For example, one of Conrad's patients reported that he suddenly became fully convinced that his fellow soldiers' snoring was fake and that they only pretended to snore to provoke him (Conrad 2002, 88ff.). According to Jaspers, primary delusions often develop from a delusional mood (*Wahnstimmung*) in which the patient has a vivid sensation that something decisive is about to happen. Gradually, this mood can become self-referential such that the patient starts believing that whatever is about to happen has a special relation to him. Finally, the delusional mood can culminate in the formation of a primary delusion which brings the vagueness, restlessness, and anxiety of the delusional mood to an end.[1] Several delusion-like ideas may develop from this primary delusion. According to Jaspers, delusions proper are primary since they are not derived from other delusions and since they are inaccessible to normal emphatic comprehension. We cannot, he explicitly argues, understand them as originating in preceding affects and experiences.

The delusions characteristic for schizophrenia remain incomprehensible. But in what sense are they incomprehensible? To answer this question, we must explore his account of comprehensibility a bit further. According to Jaspers, the discipline of psychopathology is pervaded by an insurmountable epistemological divide. Jaspers, using Dilthey's well-known distinction between explanation (*Erklären*) and understanding (*Verstehen*), differentiates between two methodological incongruent approaches to psychopathology: (a) the biological approach that seeks to explain psychic phenomena by reducing them to neurological dysfunctions and (b) a psychological approach that tries to understand psychic phenomena as resulting from severe emotional distress. The former seeks to explain the cause of mental disorders through "causal connections" on a neurological level, while the latter tries to understand this cause through "meaningful connections" between mental states on a psychological level. Jaspers stressed the limits implicit in both methods and argued that the psychiatrist must endorse both methods to apprehend, as far as possible, the human being as a whole. Furthermore, he divided the understanding of subjective symptoms into two modes, namely static understanding and genetic understanding (Jaspers 1997, 27). Static understanding, which is nearly synonymous with phenomenology in his terminology, refers to a descriptive study of symptoms and signs of mental disorders based on a common sense view of how things seem to appear (Parnas and Sass 2008, 250). Genetic understanding (also called psychological explanation) refers to the attempts to meaningfully understand how mental states emerge from each other (Jaspers 1997, 27). Both static and genetic understanding are, according to Jaspers, forms of empathy, which he conceived as the ability to sink or to transfer oneself "into the other individual's psyche" (1968, 1313; Jaspers 1997, 301). Thus, for a subjective experience to be comprehensible either by static or genetic understanding, it must be accessible through empathy. In other words, Jaspers' criterion for the comprehensibility of mental phenomena is that they largely fall within the range

[1] For a detailed account of the transition from the delusional mood to overt psychosis in cases of paranoid schizophrenia, see Conrad's *Die beginnende Schizophrenie. Versuch einer Gestaltanalyse des Wahns* (2002).

of normal experiences. This is also a key point in Thornton's reading of Jaspers' text: "the detection or comprehension of subjective symptoms requires having and sharing a particular kind of mind" (Thornton 2008, 160). Since primary delusions are inaccessible through empathy, they can, according to Jaspers, only be explained causally or organically (Jaspers 1997, 27f.).

Given the crucial role Jaspers attributed to empathy in his account of comprehensibility, it seems only reasonable to say that he operated with a rather restricted or as Eilan puts it "somewhat minimal" notion of comprehensibility (Eilan 2000, 98). Is Jaspers' conception of empathy really a necessary condition for the comprehensibility of the mental states of others? Or to put it differently, if we apply another notion of understanding, can we then comprehend some of the delusions Jaspers considered incomprehensible. Can we move beyond empathy?

Wittgensteinian attempts to comprehend schizophrenic delusions

The question of the comprehensibility of schizophrenic delusions is an ongoing matter of debate in philosophy of psychiatry. For example, Maher (1988) sought to extend the range of comprehension by conceiving delusions as attempts to explain anomalous experiences—reformulating Wernicke's notion of explanatory delusions (*Erklärungswahn*; 1900, 86). Berrios has shown that the conceptualization of delusions as false beliefs stems from major changes in the 19th century philosophical psychology, and that the inherited concept of delusion entails the perspective that delusions are likely to be mere "empty speech acts" in the sense that, once crystallized, delusions carry no information about their brain inscription and their content is likely to be exclusively related to biographical data often expressed in a symbolic form (Berrios 1991, 8, 12). While recognizing weaknesses in Maher's hypothesis (Cf. Parnas and Sass 2001, 13f.; Thornton 2008, 162f.) and striving to prove the "empty speech act"-perspective wrong, several philosophically inspired attempts to comprehend bizarre delusions have been put forth. Among them are the two Wittgensteinian approaches I discuss in the following.

(a) Delusions as framework propositions

In an article discussing Cotard delusion (i.e., the belief than one is dead or somehow non-existent) and Capgras delusion (i.e., the belief that a family member or intimate has been replaced by an impostor), Campbell asks to what extent these patients can be said to believe what they claim to believe: "The key question is whether the deluded subject can really be said to be holding on to the ordinary meanings of the terms used" (2001, 95). To illustrate why this is a central question for the task of comprehending delusions, we can consider the following question: Why does a patient who believes to be dead still walk around in the ward, talk to doctors and nurses, and consume food? This normal behavior (walking, talking, and eating) certainly seems at odds with what we would expect from a person, who firmly believes to be dead. Jaspers also touched upon this issue when stating that "the attitude of the patient to the content of his delusion is peculiarly inconsequent at times" (Jaspers 1997, 105). In an attempt to make sense of Cotard and Capgras delusions, Campbell suggests that there is analogy

between the status deluded patients ascribe to their delusional beliefs and the status Wittgenstein claims attaches to what he calls hinges (*Angeln*; Wittgenstein 1972, §§341–344) or, as Campbell puts it, "framework propositions" (Campbell 2001, 96). This analogy is also discussed by Eilan (2000), who credits Campbell for the idea.

During the last part of his life, Wittgenstein worked on topics relating to Moore's project regarding a "defense of common sense" (Moore 1925). After Wittgenstein's death, parts of his material were published posthumously under the title *On certainty* (1972). Here, he examines the epistemological status of different sorts of beliefs and he claims that we must distinguish between ordinary beliefs about empirical matters (e.g., I believe they only serve Italian food in that restaurant) and beliefs expressed by a heterogeneous group of propositions such as "there are lot of objects in the world," "the world has existed for quite a long time," and "this is one hand and this is another." These latter "beliefs" are not typical beliefs that can be proven right or wrong. On the contrary, they form the background or framework within which all testing of hypotheses can take place (Wittgenstein 1972, §105), and they are immune to doubt (Wittgenstein 1972, §§341, 359, 494). Framework propositions make any kind of inquiry and justification possible; they are not justified by other beliefs nor do they require justification. Wittgenstein's account of framework propositions appears to be a type of epistemological foundationalism although it obviously does not fit into the conventional division between empirical foundationalism (that appeals to perceptual experiences to stop the infinite regress for empirical beliefs) and a priori foundationalism (that appeals to the idea of self-evidence as a regress-stopper for a priori beliefs; Everitt and Fisher 1995, 70–101). Brice describes Wittgenstein's "foundationalism" as a "new kind of foundationalism" in which the regress-stopping certainties are manifested in neither perception nor claims of self-evidence, but in our actions (Brice 2009, 17; Wittgenstein 1972, §204). Against Campbell, I argue that his term "framework propositions" is somewhat misleading, because these propositions (*Sätze*) are in fact not propositions in any ordinary sense. To avoid this natural misunderstanding, I would have preferred the term "framework assumptions" (*Annahme*) to describe the status of Wittgenstein's hinges: "We just can't investigate everything, and for that reason we are forced to rest content with assumption. If we want the door to turn, the hinges must stay put" (Wittgenstein 1972, §343). Following Brice's interpretation, the so-called framework propositions reflect a non-propositional certitude demonstrated in our actions. It must be accentuated that framework propositions should not be equated with actions, but rather with the assumptions or guidelines for acting and interacting that are manifested in our actions and behavior. In other words, acting reflects an implicit knowing, an assumption or a guideline for acting which is not propositional in nature. Since these assumptions or guidelines are culturally dependent and flexible to a limited extent, Wittgenstein's "foundationalism" is essentially dynamic in contrast to the static, conventional forms of "foundationalism" (1972, §§97, 99).

Given this interpretation of Wittgenstein's framework propositions, I agree with Thornton when he criticizes Eilan for not fully recognizing that framework propositions, which she calls framework beliefs (Eilan 2000, 108), are in fact not beliefs, but "certainties expressed by our actions" (Thornton 2008, 164). I argue that also Campbell falls foul to this criticism. Although he clearly recognizes that framework propositions are "not ordinary factual beliefs" (Campbell 2001, 96), he

still largely treats them as beliefs. Since he does not account for the relation between framework propositions and acting in *On certainty*, he fails, I think, to see that Wittgenstein in fact moves away from a propositional toward a non-propositional conception of certainty (Brice 2009, 6, 17 ff.), namely certainty as guidelines for acting. From the perspective of this form of non-propositional actional certitude, we do not form beliefs or hypotheses about every aspect of our experiential life. Rather, we have certain basic ways of dealing with ourselves, others, and the world, and these are not necessarily propositionally structured. Following this interpretation, which is neither Campbell's nor Eilan's, we can spot a similarity between Wittgenstein's framework propositions and what Searle calls "Background capacities" (1992, 175–196).[2] According to Searle, background capacities are not beliefs but ways of behaving which manifest that something is taken for granted (1992, 77, 186). For example, he claims that "I cannot, while sitting in this chair, leaning on this desk, and resting my feet on this floor, consistently deny that objects are solid, because my behavior presupposes the solidity of these objects. It is in that sense that my intentional behavior, a manifestation of my Background capacities, commits me to the proposition that objects are solid, even though I need have formed no belief regarding the solidity of objects" (1992, 185). Within the tradition of phenomenological psychiatry, Blankenburg's notions of "common sense" and "natural self-evidence" concern the same subject as Wittgenstein's framework propositions and Searle's background capacities.[3]

Having made these reservations against Campbell's interpretation of Wittgenstein's framework propositions, I return to Campbell's proposal which basically is that bizarre delusions of patients with Cotard's or Capgras' syndrome may be functioning as framework propositions (Campbell 2001, 97). In other words, he suggests that the epistemological status patients assign to the belief expressing their delusion is similar to the status Wittgenstein ascribes to framework propositions. By construing delusions as framework propositions, Campbell elegantly puts forth the thesis that delusions are not beliefs without drawing the conclusion that delusions are "empty speech acts" masquerading as beliefs (Campbell 2001, 91). Campbell's proposal is promising for at least two reasons. First, by conceiving delusional beliefs as framework propositions, we can begin to understand what Jaspers claimed "in its

[2] Among the few philosophers who, according to Searle, have examined the subject he calls "Background capacities," is, besides Nietzsche and Bourdieu, Wittgenstein (1992, 177). In a note, Searle even claims that *On certainty* "is one of the best books on the subject" (1992, 253), thereby indicating a similarity, most likely, between his notion of Background capacities and Wittgenstein's notion of hinges.

[3] Blankenburg argued that schizophrenia consists in a global crisis of common sense or in a lack of natural self-evidence (1971; 2001). In other words, schizophrenia involves, according to him, an impairment of the ordinary pre-reflective, automatic immersion into the intersubjective world, which constitutes our normal dynamic sense of what is contextually relevant and socially appropriate. One of his patients, a 20-year-old female, described the basic lack she experienced in the following way: "What is it that I am missing? It is something so small, but strange, it is something so important. It is impossible to live without it. I find that I no longer have footing in the world. I have lost a hold in regard to the simplest, everyday things. It seems that I lack a natural understanding for what is matter of course and obvious to others. [...] Every person knows how to behave, to take a direction, or to think something specific. The person's taking action, humanity, ability to socialize...all these involve rules that the person follows. I am not able to recognize what these rules are. I am missing the basics. [...] I don't know what to call this....It is not knowledge....Every child knows these things! It is the kind of thing you just get naturally" (Blankenburg 2001, 307f.).

essence cannot be understood—i.e. the specific schizophrenic incorrigibility" (Jaspers 1997, 105). These patients cannot correct their delusional beliefs because the beliefs are immune to doubt due to their framing role and epistemological status. Secondly, insofar as they function as foundational certainties for the whole framework, we may better comprehend how they can influence other beliefs and potentially distort the whole belief system. Campbell argues that a change in framework propositions can destabilize the original framework and bring with it "a change in the meanings of the terms used" (2001, 98); thereby reaching an answer to his key question. However, we can push the argument a bit further: a change in framework propositions can transform the entire framework significantly and not only the meanings of the terms used. In other words, Campbell's proposal seems compatible with a core motif in phenomenological psychopathology, namely that the overall form of schizophrenia patients' world is profoundly altered. His proposal can, in that respect, also be seen as disputing the "poor reality-testing" criterion for diagnosing a psychotic condition.

In an article discussing the limits of empathic comprehension and in particular Campbell's proposal, Thornton questions the feasibility of Campbell's attempt to interpret delusions as framework propositions: "for the proposal to work—for it to enable us to have some understanding of delusions as a whole by thinking of them as abnormal framework propositions—we need to be able to understand the idea of a genuinely different framework proposition. It is not clear that we can" (Thornton 2008, 170).[4] It is a reasonable objection and Campbell partly anticipates it when he claims that "there is no translation from one framework into another" (2001, 98). But if no "translation" between frameworks is possible, how can we then comprehend a framework different from our own? Leaving aside many details in Thornton's argument, he does state that "the ability to articulate others' framework propositions presupposes shared understanding" (Thornton 2008, 167) and that the possibility of fully comprehending a profoundly different framework would "require successfully undermining familiar Davidsonian and McDowellian arguments against the very idea of factoring a worldview out into a neutral world and a linguistic structure" (Thornton 2008, 170). Finally, Thornton concludes that framework propositions cannot contribute to the understanding of delusions and furthermore that they are "better deployed (...) as part of an explanation of why they [delusions] are not

[4] Thornton has proposed another Wittgensteinian interpretative tool, namely to conceive delusions as expressions of, what Wittgenstein called, secondary sense (Wittgenstein 1997, 216), i.e., a specific way we use words that is neither the primary use nor a metaphorical use, but "one which we find natural given the primary use, but which is discontinuous with, and could not be used to teach, the primary use" (Thornton 2004, 222). As an example, he says (referring to Wittgenstein) that in the utterance "Wednesday is a fat day," the adjective "fat" is used in a secondary sense. I appreciate Thornton's proposal because it stresses that the meaning of the patients' verbal expressions is not univocal and that we always must remain open to several interpretations when considering these expressions. It is, nonetheless, difficult to see how this proposal can aid us in the task of trying to comprehend delusions. Thornton himself explicitly states that the notion of secondary sense perhaps can provide structural descriptions of the delusional expression, but that it does not bring us any further toward an empathic understanding of these phenomena (ibid.).

understandable" (2008, 173).[5] Although his criticism appears to be devastating to Campbell's proposal, I claim that the criticism depends on a debatable and rather narrow view of the limits of understanding. Thornton's argument seems to presuppose both a notion of empathy similar to that of Jaspers', i.e., empathy as the ability to sink into another person's mental states (*zusammenschmelzen*), and a Davidsonian model of understanding insofar as empathy requires "having and sharing the same kind of mind and thus finding particular kinds of thought-transitions natural" (2008, 160). Light will be shed on these issues by looking at the second Wittgensteinian approach: Sass's.

(b) Delusions interpreted in the light of solipsism

In *The Paradoxes of Delusion: Wittgenstein, Schreber, and the Schizophrenic Mind* (Sass 1994), Sass strives to comprehend some of the most bizarre schizophrenic delusions experienced by Schreber and recollected in his autobiographical book, *Memoirs of my nervous illness* (Schreber 1988). Sass's inquiries take place within a phenomenological framework, but his main idea is to use Wittgenstein's account of philosophical solipsism to shed light on the apparently contradictory and incoherent delusional world of schizophrenia patients. Among the contradictions Sass seeks to illuminate is the clinically well-known phenomenon Bleuler called double bookkeeping (Bleuler 1950), i.e., the puzzling fact that although schizophrenia patients retain their delusional beliefs with strong conviction and unshakable certainty (despite obvious counterevidence), they frequently do not act upon them. For example, Sass writes, a "patient who claims that the doctors and nurses are trying to torture and poison her may nevertheless happily consume the food they give her; a patient who asserts that the people around him are phantoms or

[5] Such an interpretation has been put forth by Klee (2004). Contrary to Campbell's proposal, Klee does not propose a parallel between delusions and framework propositions but claims that bizarre or, what he calls, stark delusions necessarily are inexplicable because they involve content that negate our framework propositions and because they cannot be explained by their relations to other beliefs (2004, 31). More specifically, he argues from a Wittgensteinian perspective that by denying the certainties from which the framework emerges, the "framework that makes any kind of psychological explanation possible is missing" (Klee 2004, 32). Although he rejects Davidson's idea that rationality is constitutive for the attribution of mental content (2004, 31), Klee's account is strongly influenced by Davidson's theory and in particular his so-called principle of charity, which requires that the interpreter maximizes the rationality and the self-consistency of the person he seeks to understand (Klee 2004, 31; Davidson 1967, 313). From a Davidsonian perspective, Klee argues that the rationality and the consistency of the patient's belief system are violated in bizarre delusions, and consequently, that they are inexplicable. However, we can, as Sass has done, question Klee's notion of psychological explanation; we also frequently find inconsistencies in the belief systems of normal subjects (Sass 2004, 74–76). Sass argues that Klee's account does not allow us to comprehend "a delusion as anything other than a mistake, or of understanding it in the light of an at least partially comprehensible, although significantly altered, experiential framework" (Sass 2004, 76). I also find Klee's argument that stark delusions are stark partly because "no one could possibly have predicted the thematic content of their [the individuals'] delusions" (Klee 2004, 33) problematic. This is not entirely correct because although the specific content of a delusion is impossible to predict, Kepinski has, among others, shown that the themes of schizophrenic delusions are metaphysically tainted (ontological, eschatological, or charismatic) in contrast to delusions found in other mental disorders (Kepinski 1974; cf. Bovet and Parnas 1993, 591f.).

automatons still interacts with them as if they were real" (Sass 1994, 21). Bleuler, whom Sass also quotes, famously wrote that "Kings and Emperors, Popes, and Redeemers engage, for the most part, in quite banal work, provided they still have any energy at all for activity. This is true not only of patients in institutions, but also of those who are completely free. None of our generals has ever attempted to act in accordance with his imaginary rank and station" (Bleuler 1950, 129). From a common sense perspective, this inconsequential attitude strikes us as irrational. It simply does not make sense. But according to Sass, double bookkeeping is neither meaningless nor incomprehensible. On the contrary, it reveals something about the paradoxical quality of certain kinds of delusions typically found in schizophrenia; something, he suggests, Wittgenstein's account of solipsism may help us see.

Solipsism (from Latin *solus*, alone, *ipse*, self) is a philosophical concept that refers either to the idea that only oneself and one's own mind exists (metaphysical solipsism) or to the idea that only oneself and one's mind can be fully known (epistemological solipsism). Both types of solipsism rest on the skeptical assumption that all possible knowledge is grounded in experiences that are immediate and private. This implies that we only can know our own mental states and that everything "outside" our own mind (e.g., other minds, entities, and the world) remain unjustified and doubtful. In the following, I will discuss Sass's attempt to understand aspects of schizophrenia through Wittgenstein's analysis of solipsism.

Sass describes solipsism as "a vision of reality as a dream, but with awareness of the fact that one is dreaming" (1994, 34), and he claims that Wittgenstein diagnoses solipsism as a philosophical disease arising from abstraction and passivity (Sass 1994, 8f., 35). According to Sass, the circumstances of Schreber's delusions, i.e., obsessive scrutiny and extreme inactivity, correspond exactly to those conceived by Wittgenstein as the sources of solipsism (1994, 37). For example, Schreber claims that the so-called "wasp miracles" (i.e., his hallucinatory experiences of insects suddenly appearing before him and him "knowing" that they only exist when he experiences them) only happened when he was in a state of passivity (Sass 1994, 33, 37f.). He also describes various forms of obsessively reflecting on his experiences and thoughts. Sass also argues that Schreber's delusional experiences of being transformed into a woman only occurred when he combined intense concentration with passivity, e.g., when staring at himself in a mirror for a longer period of time (1994, 39). Sass terms this attitude of passivity and hyper-concentration *quasi-solipsism* and he claims that this attitude involves a subjectivization of reality (1994, 39f.). Thus, quasi-solipsism denotes a specific form of experiencing and not a philosophical position. Sass now suggests that some bizarre and apparently contradictory experiences in schizophrenia can be understood in the light of quasi-solipsism, e.g., the paradoxical phenomenon of double bookkeeping and the incorrigibility of some delusional beliefs. Acting in a solipsistic world may, as he puts it, "feel either unnecessary or impossible" (1994, 42); not only does it not make sense to act in an absolutely mental world, but real acting might even disrupt this world insofar as it depends on inactivity (1994, 42). And with regard to the "specific schizophrenic incorrigibility," it seems only logical from a quasi-solipsistic perspective that delusional beliefs formed within a solipsistic world cannot be proven wrong or false in a public domain; in fact, it seems irrelevant to try to do so.

Both incorrigibility and inconsequentiality can then be seen as "normal and natural qualities of a solipsistic, dereified universe" (1994, 42).

Furthermore, Sass argues that quasi-solipsism is fraught with inner contradictions stemming from the self-contradictory nature of solipsism itself and that these contradictions inevitably compromise the very foundation of solipsism.[6] As Sass illustrates, Schreber experiences himself in multiple ways and some of these experiences seem strikingly at odds with each other. For example, he experiences himself both as an omnipotent being who has received divine revelation and as a being so small and weak that he almost does not exist (Sass 1994, 65). Similarly strange is his polarized relation to his own experiences. On the one side, he is aware that some of his experiences must seem odd to others, and sometimes he seems to restrict their validity to his private reality. On the other side, however, he also claims that he is pursuing the interests of science and that he seeks to expand the knowledge of truth in religion, thereby ascribing objective validity to his experiences and assertions (1994, 53f.). Hence, quasi-solipsistic experiencing involves an ongoing paradoxical oscillation between polarized and, in some cases, coexisting attitudes, e.g., between contradictory feelings such as immense power and powerlessness, between experiencing oneself as a deity and as an automaton, and between experiencing the world and experiencing oneself experience the world. This instability harbored within quasi-solipsism itself threatens not only to destroy the solipsistic world, but also, and more disturbingly, to dissolve the basis of the experiencing subject.[7] The oscillation between contradictory experiences reflects "a loss or diminishment of self," which Sass here conceives as "an intrinsic and even predictable outgrowth of the peculiar inner logic of solipsism itself" (Sass 1994, 66f.).

[6] For example, communicating (Cf. Wittgenstein's rejection of the possibility of a private language) and acting seem to undermine the solipsist's apparent self-sufficiency (Sass 1994, 58). Due to the subjectivization of reality, the solipsist is unable to be in the world because he is the center of the world. In order to act and communicate adequately, the solipsist would have to rely on other subjects and this would undercut his solipsistic stance.

[7] Elyn Saks, a professor and a lifetime sufferer from schizophrenia, describes in a passage from her memoir an experience of dissolving: "And then something odd happens. My awareness (of myself, of him, of the room, of the physical reality around and beyond us) instantly grows fuzzy. Or wobbly. I think I am dissolving. I feel—my mind feels—like a sand castle with all the sand sliding away in the receding surf. *What's happening to me? This is scary, please let it be over!* I think maybe if I stand very still and quiet, it will stop. This experience is much harder, and weirder, to describe than extreme fear or terror. Most people know what it is like to be seriously afraid. If they haven't felt it themselves, they've at least seen a movie, or read a book, or talked to a frightened friend—they can at least imagine it. But explaining what I've come to call 'disorganization' is a different challenge altogether. Consciousness gradually loses its coherence. One's center gives away. 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. There is no longer a sturdy vantage point from which to look out, take things in, assess what's happening. No core holds things together, providing the lens through which to see the world, to make judgments and comprehend risks" (Saks 2007, 12f.). I quote this long passage not only because it provides a concrete example of a patient's experience of dissolving, but also because it elucidates why some schizophrenic experiences cannot be understood as mere exaggerations or variations of normal experiences. It seems only logical that such unusual experiences are difficult to grasp as well as to convey to others in usual everyday terms as Saks claims. Schreber is also well aware of these difficulties and he explicitly warns readers not to try to understand his experiences in the light of their own normal experiences because, as he puts it, "matters are dealt with that lack all analogies in human experiences" (Schreber 1988, 117, quoted in Sass 1994, 28).

Sass's solipsistic interpretation of Schreber's delusional world provides clues for unraveling the paradoxical combination of incorrigibility and inconsequentiality in schizophrenia. If we accept his proposal, i.e., that a "consciousness that is hyperacute, hyper-self-conscious, and highly detached" underlie the constitution of the quasi-solipsistic experiential world (1994, 40), then we can begin to comprehend some aspects of schizophrenic delusions that Jaspers deemed beyond any possible understanding. Although Sass in some passages seems to consider hyper-consciousness rather than diminishment of self as primus motor in the formation of the delusional, quasi-solipsistic world, he argues elsewhere that hyperreflexivity and diminished self-affection are mutually implicative facets of the self-disorder schizophrenia is taken to be (Sass 2003b; Sass and Parnas 2003). He thereby anticipates the pressing question about whether or not Schreber's attitude of inactivity already involves a sort of diminishment of self in terms of a diminished sense of existing as a living and acting agent. In a somewhat critical response to Sass's book, Read claims that Sass, in a "worrying" manner, is "interpreting" rather than "describing" Schreber's experiences (Read 2001, 461), and that Sass furthermore fails to see that solipsism, according to Wittgenstein (as Read reads him), is nothing but nonsense—from which it supposedly follows that the proposed analogy between schizophrenic experiences and solipsism must necessarily be empty, given that nonsense by definition has no meaningful content (Read 2001, 459). It is, however, by no means clear that Sass actually falls foul to either of these objections. With regard to Read's first objection, I argue that hermeneutic philosophy has corrected the initial phenomenological methodological ideal of describing without presuppositions recognizing that whenever we describe something, our description is always pervaded by interpretation (Cf. Heidegger 2007, Gadamer 1999). Briefly put, it is naive to assume that we can describe without interpreting. Thornton, who is also not fully convinced by Read's criticism, has argued that Sass's proposal fails because he uses Wittgenstein's description of solipsism to construe a coherent and meaningful account of Schreber's experiences while ignoring that solipsism is incoherent and nonsensical according to Wittgenstein (Thornton 2004, 220f.). This is a rather odd argument for Thornton to make, given that Sass himself repeatedly emphasizes (1994, 51–85; 2003a, 128) Wittgenstein's point about the incoherence of solipsism, and uses this point to clarify the, in his view, parallel incoherencies of Schreber's delusional experiences and lived world. It is true that the solipsistic interpretation, according to Sass, reveals a "powerful coherence" underlying Schreber's contradicting experiences (1994, 15) and that Sass uses Wittgenstein's perspective on solipsism to make sense of some aspects of Schreber's delusional experiences. However, as the title of Sass's book indicates, he is not on a mission to deny or dissolve the paradoxical nature of Schreber's experiences but to show that they can have a common ground in his altered structure of experiencing. Sass's argument is basically that if we take the alterations of experiencing into account, then we can make some sense of Schreber's strange and contradictory experiences. At first sight, it may seem as if Thornton's objection primarily is motivated by philosophical reasons (e.g., the proper understanding and use of Wittgenstein's works), but he is also on a more general level skeptic about the attempts to extend the limits of understanding in psychopathology. As he puts it in an article discussing Campbell's analogy

between delusions and framework propositions: “Interpreting or understanding but still finding utter strangeness are incompatible goals” (Thornton 2008, 173).

I have already indicated that Thornton operates with a rather different notion of understanding than Sass or Campbell and that the problems Thornton encounters not necessarily are pertinent to Sass or Campbell. Let me elaborate a bit: if we assume with Jaspers that both static and genetic understanding are forms of empathy and that empathy is all there is to understanding mental states of others, or if we assume as Thornton seems to do that understanding is tied to a Davidsonian project of rational interpretation and the principle of charity, then neither of the two Wittgensteinian approaches would work. They simply could not enable us to understand something so strange as bizarre delusions in schizophrenia. However, I suggest that we are not obliged to accept these restricted notions of understanding. Sass is, for example, obviously neither committed to Jaspers’ notion of empathy nor to Thornton’s notion of understanding. Instead of investigating whether or not it is possible for us to believe what Schreber or Saks claims to believe, Sass strives to imagine what it might be like to experience the world as they do and the potential consequences of this altered “world-view” for reasoning skills, actions, affects, and language use. And in the service of this imagining, he has looked to various sources, including Wittgenstein’s philosophy, Heidegger’s philosophy (1990, 1992a), and many aspects of modernist and postmodernist art, literature, and thought (1992b). Of course, as Thornton following Read argues, Sass runs the risk of reading significance into Schreber’s experiences (and schizophrenic experiences more generally) which they might not actually have (Thornton 2008, 219). In his own reply to Read, Sass fully acknowledges the presence of this risk (2003a, 128). I am, however, inclined to agree with Sass when he states that this is a risk that is well worth taking. After all, do we not risk far more if we just assume that we cannot understand schizophrenia patients? What role is psychotherapy for schizophrenia likely to play if we deem these patients far beyond any possible understanding? I believe that Sass takes the favorable risk in his attempt to understand aspects of schizophrenia through solipsism. The clinician should try to understand the patient’s assertions within the context of his altered experiential world and always respect that some assertions may reflect experiences so strange and bizarre that they cannot be grasped by reducing them to experiences in normal conditions.

Schizophrenia as disorders of the self

Both Campbell and Sass endorse more or less Jaspers’ view that schizophrenic delusions involve a “transformation in our total awareness of reality,” i.e., a transformation in the belief system or framework in Campbell’s terminology. Furthermore, both authors shed light on “the specific schizophrenic incorrigibility,” which Jaspers considered incomprehensible. Campbell argued that the incorrigibility of schizophrenic delusions reflects the epistemological status attached to them, whereas Sass argued that the incorrigibility stems from an altered form of experiencing, which he describes as quasi-solipsism. In contrast to Campbell, Sass also provided some resources for understanding delusion formation (i.e., the combination of passivity and hyper-consciousness and the associated withdrawal

from social interactions) and the paradoxical relation between incorrigibility and inconsequentiality in schizophrenia. Some schizophrenia patients' failure to act upon their delusions can, as Sass suggests, indicate that they do not always take their own delusional beliefs literally (2004, 78f.). His analysis of the peculiar combination of incorrigibility and inconsequentiality raises indirectly the question concerning the feasibility of defining delusions as propositional beliefs. Are delusional experiences reducible to propositional beliefs? The same question emerges from Campbell's proposal. If we accept the idea that delusions function as framework propositions, then the conceptualization of delusions as propositional beliefs becomes problematic because framework propositions are precisely not beliefs but certainties manifested in our actions. Obviously, the relation between beliefs and delusions is complex (Cf. Sass 2004, 75–79). Both authors suggest that delusional beliefs significantly differ from ordinarily held beliefs. For example, when a patient with Cotard's syndrome reports "being dead," this "belief" is of a different nature than the patient's belief that "The Eiffel Tower is located in Paris." The problems in accounting for the different types of beliefs arise partly because delusions are defined as isolated propositional beliefs. From a phenomenological perspective, the definition of delusions as beliefs with specific properties is to some extent misleading because it reduces the multifaceted delusional experience to a decontextualized proposition disregarding both the fact that a proposition always refers to a web of other propositions and that an experience always is embedded in a multidimensional context from which it receives its meaning. What is lost in this reduction is the quality and richness of delusional experiences that may not only enable us to more plausibly demarcate delusional from non-delusional experiences, but also aid us in the task of understanding delusions in schizophrenia. If we accept this idea, then one path worth exploring is that of phenomenological psychopathology, i.e., the systematic study of altered forms of experiencing in pathological conditions. Hoping to be able to say more about the genesis of delusions in schizophrenia and thereby further challenge their status as incomprehensible, I will now discuss a cornerstone in phenomenological psychiatry, namely the idea that schizophrenia reflects a basic disturbance of the self.

Already from the introduction of the concept of schizophrenia, self-disorders were recognized as intrinsic aspects of the clinical picture of schizophrenia. Although these mental phenomena were not explicitly addressed as self-disorders or with a specific reference to the self, they were, at least implicitly, discussed under different headings and within various theoretical traditions. From the beginning of the twentieth century, detailed descriptions of anomalies of self-experiences in patients who today, most likely, would receive a diagnosis within the schizophrenia spectrum began to appear in the French psychiatric literature (e.g., Janet 1903; Hesnard 1909). In 1904, Pick published an important article on the pathology of the self-consciousness (Pick 1996), which was strongly influenced by Störring's account of self-consciousness (*Ichbewusstsein*) from 1900. Berrios and Marková claim that Pick's analysis of the disturbance of self-consciousness gave rise to the concept of *Ichstörungen* (self-disorders) which at that time encompassed what in modern terminology is called passivity phenomena (such as Schneider's first-rank symptoms), disturbance of body schema, and depersonalization (Berrios and Marková 2003, 17f.). Self-disorders (*Ichstörungen*) should thus not be mistaken for

personality disorders (*Persönlichkeitsstörungen*; Spitzer 1988); self-disorders are disorders of the structure of experiencing, i.e., they are disturbances on a basic experiential and pre-reflective level in contrast to personality disorders, which rather express a disturbance on a narrative or autobiographical level. Among the various psychiatric conditions, schizophrenia is considered the most severe self-disorder. In 1913, Kraepelin (1913) argued that schizophrenia (dementia praecox) involved a specific breakdown of the self, which he identified as "the loss of inner unity of understanding, mood, and will," and he famously described this disunity using the metaphor of an "orchestra without a conductor." Similarly, Bleuler described pathologies of the self in schizophrenia in his monumental *Dementia Praecox or the Group of Schizophrenias* from 1911. He conceived schizophrenia as a basic self-disorder in which the "ego may undergo the most manifold alterations" including loss of feelings of activity (sense of agency) and loss of ability to direct one's thoughts (Bleuler 1950, 143). Bereft of these essential components, Bleuler argued that the self may split or disintegrate leaving the person with an unstable and confused sense of identity and reality (1950, 143–147). Berze, who was influenced by Brentano's work on the intentionality of consciousness, focused in his analysis on the structural aspects of mental acts. Berze proposed that a "primary insufficiency of mental activity" causing profound alterations of consciousness and gradually leading to its disintegration was at the core of schizophrenia (1914). More recently, Sass and Parnas have argued that schizophrenia is an ipseity disturbance (from Latin *ipse*, self) involving two complementary distortions of consciousness and self-experience: diminished self-affection (declined sense of existing as a living subject of awareness and action) and hyperreflexivity (exaggerated and alienating forms of self-consciousness; Sass and Parnas 2003; 2007; Sass 2003b). In phenomenological psychiatry, schizophrenia is conceptualized as a self-disorder, and anomalies and abnormalities of experience, self-awareness, and self-consciousness are among its major expressions. From this perspective, the "transformation in our total awareness of reality" is caused by underlying self-disorders.

In this attempt to comprehend schizophrenic delusions, I will use the idea of self-disorders to further challenge Jaspers' view that schizophrenic delusions emerge in an incomprehensible way. I argue that if we examine the schizophrenic world and the structure of experiencing preceding the development of delusions, then we can reach some understanding of how these strange mental phenomena emerge. I will first discuss Conrad's account of the transformation of experiencing at the onset of paranoid schizophrenia. Although this is a considerable contribution to the task of understanding the emergence of delusions in schizophrenia, I argue that a closer look at early pre-morbid and non-psychotic anomalies of self-experience can help us further detect a self-constellation vulnerable to schizophrenia.

By combining phenomenology and Gestalt psychology in a study of 117 cases of paranoid schizophrenia, Conrad was able to identify alterations of the structure of experiencing at the transition to psychosis. He claimed that in the prodromal phase, which he called *trema* (adopting the term from the world of theater where it denotes the tension experienced by actors before getting on stage), patients are subjugated to an unspecific pressure; they may, for example, believe that something extraordinary is expected from them, that they are about to be tested, or that something decisive is about to happen (Conrad 2002). According to Conrad, patients have no specific

knowledge but only vague ideas about the nature of the impending. Gradually, the pressure increases creating barriers that limit the patient's mind. The patient can, so to say, no longer maneuver freely but is being pushed toward something inevitable. The pressure increases and barriers continue to rise until culminating with the onset of psychosis. The transition to a psychotic condition involves, according to Conrad, a twofold alteration of the structure of experiencing. First, patients experience the meaning of the perceived directly, i.e., they do not, as in normal conditions, consider what the perceived might mean, because they already "know" this (although they would be unable to justify this "knowledge"). In other words, patients do not question their delusional beliefs because they experience them as self-evident, and consequently, they often have difficulties in understanding why others can question the validity of their beliefs. Conrad terms this form of experiencing *apophany* (referring to the Greek *apophainein*, meaning *appearing*), which conveys the quality of a revelatory experience. Second, every meaning is experienced as somehow related to the experiencing subject, i.e., the patient's experiences are centered around him in a peculiar and unusual manner; Gruhle called this aspect "self-reference without cause" (*Beziehungssetzung ohne Anlass*). Conrad terms this form of experiencing *anastrophe* (literally meaning *a turning back*). Apophany and anastrophe are dimensions of the same, altered form of experiencing, and they constitute, according to Conrad, the core of schizophrenic experiencing (2002, 269).[8] This form of experiencing involves a fragmentation of the perceptual Gestalt, i.e., familiar objects that normally are perceived as parts of a meaning–giving context may become strangely isolated and appear strikingly unfamiliar. Devoid of their ordinary, specifiable meaning, objects or events are often experienced as having extraordinary meanings; everything that happens seems somehow related and there appears to be no coincidences. Conrad's description of apophantic–anastrophic experiencing and the inherent loss of the ability to transcend the self-centered position (*Überstiegsverlust*) in psychosis is consistent with Sass's account of the subjectivization of reality in schizophrenia. Another structural trait of schizophrenic experiencing consistent with Conrad's account is found in Müller-Suur's analysis of delusional conviction (1950). He argues that schizophrenia patients become overwhelmed by a sense of absolute, apodictic certainty (*Gewissheitsbewusstsein*) already from the very onset of the delusional experience, whereas the delusional conviction in patients with non-schizophrenic delusional disorders reflects a more progressively and inferentially solidified belief. Although schizophrenia patients in prodromal phases are uncertain about the nature of the impending, they know without a doubt that something is about to happen. Where the non-schizophrenic paranoid delusion begins with suspiciousness ("I wonder if that means something?"), the formation of a schizophrenic delusion is, according to Müller-Suur, permeated by experiential certainty ("that means something!") (1950, 45f.).

Thus, we have seen that according to phenomenological psychopathology, bizarre delusions in schizophrenia (or primary delusions in Jaspers' terminology) are formed upon a non-propositional, overwhelming sense of absolute, experiential certainty

[8] Conrad's *Die beginnende Schizophrenie. Versuch einer Gestaltanalyse des Wahns* (2002), originally published in 1959, has not yet been translated into English. For a summary of his account, see Bovet and Parnas (1993) or Mishara (2010).

that stem from profound alterations of the structure of experiencing. Hence, the certainty associated with schizophrenic delusions is not a certainty concerning a specific propositional content, but rather an experiential certitude, i.e., a certainty not of belief, but of believing. In an attempt to show what these alterations of the structure of experiencing more specifically amount to in early, pre-psychotic conditions of the illness, and thus to see how this experiential certainty can arise, I will in the following discuss the role of self-disorders (i.e., non-psychotic anomalies of self-experience and self-awareness) in schizophrenia.

Recent studies have found self-disorders in schizophrenia that precede the transformations of experiencing in the late-prodromal, pre-psychotic phase. Although these self-disorders may vary in intensity, they have a tendency to persist and some of them may have been present since childhood or early adolescence. These self-disorders are not to be conceived as independent symptoms, but rather as interdependent aspects of the same psychopathological *Gestalt*, which has been proposed to underlie and influence the schizophrenic symptomatology (Sass and Parnas 2003, 2007; Parnas and Sass 2008). I will not provide an exhaustive account of self-disorders in schizophrenia, but only present some of the self-disorders frequently found in schizophrenia when interviewing patients. The self-disorders presented below are retrieved from the phenomenological and clinical descriptions of self-disorders found in the manual *EASE: Examination of Anomalous Self-Experience* (Parnas et al. 2005). Further detailed descriptions of self-disorders in the schizophrenia spectrum are found in Parnas and Handest (2003).

Often, schizophrenia patients' complaints seem nonspecific or vague (e.g., they complain about being depressed, lacking energy, insomnia, and concentration difficulties) and usually, it requires in-depth interviews with a skilled clinician familiar with the psychopathology of schizophrenia to recognize these complaints as potential expressions of underlying self-disorders. Some of the most basic self-disorders reflect an instability in the very basic and normally implicit sense of being present. Patients often report that they feel an inner void or that their innermost identity has vanished. They also report that they feel different from others or not feel fully present when interacting with others or when engaging in everyday activities. These forms of self-estrangement and self-detachment involve a tendency to monitor or observe one's own thoughts, feelings, and behavior, thereby further enhancing the distance between the experiencing subject and the experienced world. One patient described that when he listens to music, he is not really attentive to the melody, but rather to how he experiences it. The intrinsic combination of a diminished sense of self and a hyperreflexive consciousness has various manifestations in the domain of cognition, for example, in terms of interfering thoughts (i.e., thoughts that are disconnected from and disrupts the main line of thinking), ruminations (e.g., tendencies to obsessively reproduce unproblematic conversations and events—apparently for no reason), loss of thought ipseity (i.e., some thoughts, often interfering thoughts, may seem so strange "as if" they were not generated by the patient), thought pressure (i.e., the experience of multiple, unrelated thoughts occurring simultaneously and chaotically), and thoughts aloud (i.e., thoughts acquire an acoustic or auditory quality so that the patient hears his thoughts internally). Also the domain of self-awareness is disturbingly affected. The self-awareness which in normal conditions is an implicit and pre-reflective part of our experiential life is in

initial schizophrenia distorted causing profound qualitative alterations of the structure of experiencing. For example, patients often experience a diminished presence (i.e., an unwillingly decreased ability to become affected by others, objects, or events), depersonalization (i.e., feelings of being alienated from oneself, one's own thoughts, feelings, and actions), derealization (i.e., experiences of the milieu or world as somehow changed or unreal), hyperreflectivity (i.e., excessive tendencies to reflect upon one's own thoughts, feelings, and actions; this reflective stance is associated with an inability to live spontaneously), loss of common sense (i.e., a lack of the usual automatic and pre-reflective sense of what is contextually relevant and socially appropriate), and various forms of anxiety (e.g., social anxiety, panic attacks, and ontological anxiety; the latter refers to a pervasive sense of insecurity, i.e., others and the world are not experienced as safe, but rather as unreliable and threatening). Furthermore, several self-disorders are found in other domains, for example, in terms of transitivism or loss of ego-boundaries (i.e., persistent feelings of being painfully exposed and at the mercy of the cruel world), experiences of self-reference (i.e., the patient senses a link between him and external events or others, and this link cannot be explained by preceding psychological states), feelings of centrality (i.e., fleeting feelings "as if" being the center of the world), and feelings of solipsistic grandiosity (i.e., feelings of superiority over others). From this survey, it is clear that the described self-disorders overlap, co-occur, and are mutually implicative. Patients usually experience self-disorders as highly disturbing or terrifying, and for the most part, they do not dare to reveal their anomalous experiences to anyone. Inevitably, this reinforces their feelings of being different from others and the associated feelings of isolation, alienation, loneliness, guilt, anxiety, and despair.

Several empirical studies have found correlations between schizophrenia spectrum diagnoses and high levels of self-disorders. Huber, Klosterkötter, and their colleagues in Germany found many non-psychotic "basic symptoms" specific to schizophrenia, e.g., disturbances of consciousness, action, and bodily expression, and forms of depersonalization (Huber et al. 1979; Huber 1983; Klosterkötter 1988; Klosterkötter et al. 1997; 2001). In a Norwegian study of 19 first-episode schizophrenia patients, Møller and Husby found high levels of self-disorders and they argue that a "disturbance of perception of self" characterized by a group of pervasive experiences of losing oneself is a core feature of the initial prodrome of schizophrenia, e.g., painful emotional indifference and distance to oneself, feelings of being unreal and experiences of unreality, feelings of being changed or detached from one's previous identity, lack of feelings, and feelings of turning inhumane (Møller and Husby 2000). Similar prodromal profiles were discovered in a Danish study of 19 first-onset schizophrenia cases (Parnas et al. 1998). Another Danish study—the so-called Copenhagen Prodromal Study—of 155 first-admission cases (57 patients were diagnosed with schizophrenia, 43 patients with schizotypal disorder, and 55 were patients diagnosed outside the schizophrenia spectrum; all patients were diagnosed according to ICD-10) found that self-disorders were specific to the schizophrenia spectrum (Handest 2002). Recently, Raballo and collaborates compared 305 subjects from different diagnostic groups (29 patients were diagnosed with schizophrenia, 61 patients with schizotypal personality disorders, 112 patient with a non-schizophrenia spectrum mental illness, and 103 subjects had no mental

illness; all patients were diagnosed according to DSM-III-R) and found that the diagnoses of schizophrenia and schizotypal personality disorder predict higher levels of self-disorders, and that the score of self-disorders were significant between schizophrenia spectrum and non-spectrum individuals (Raballo et al. 2009). These empirical studies seem to support the hypothesis that self-disorders are specific or at least highly correlated to schizophrenia spectrum conditions and that self-disorders might have pathogenetic significance for the schizophrenia spectrum.

From the phenomenological descriptions of early, non-psychotic anomalies of self-experiences (self-disorders) in the schizophrenic prodrome and from the phenomenological accounts of delusion formation in schizophrenia (e.g., Conrad, Sass), we can begin to understand aspects of the schizophrenic world, e.g., how a patient experiences his altered world, the impact the altered structures of experiencing have on his existence, and how he may react to these subtle, but disturbing and anxiety-provoking changes (e.g., by social withdrawal and isolation, alienation, eccentricity, diminished initiative and vitality, and preoccupation with metaphysical themes). It is, however, also clear that these phenomenological analyses operate with a rather different notion of understanding than, for example, Jaspers or Thornton, and that we therefore carefully must distinguish between these two forms of understanding. The one form, which I here term psychological understanding, encompasses Jaspers' notions of static and genetic understanding. Psychological understanding tries to grasp meaning in terms of motivations, desires, and other more straightforward psychological connections between mental states. Such an understanding is, as Jaspers pointed out, not possible in schizophrenia. Thornton, whom I have argued also endorses this form of understanding (combined with a Davidsonian model of understanding), is therefore right to stress that "understanding but still finding utter strangeness are incompatible goals." However, if we try to understand experiences in schizophrenia on a more deep, ontological level, then we can find both meaningful coherences and understanding without suspending or denying the strangeness and paradoxical qualities. Hence, I do not dispute Rümke's description of the "praecox feeling," i.e., the sense of radical strangeness a skilled clinician may experience when encountering a schizophrenia patient, and that this feeling or intuition can serve as a strong diagnostic indicator of schizophrenia (Rümke 1990). While some schizophrenic experiences are so strange and unfamiliar that they cannot be understood as mere exaggerations of normal experiences, we may nonetheless still have some understanding of their genesis and the altered world in which they are embedded. In fact, both Sass's account of the subjectivization of reality and the phenomenological accounts of schizophrenia as self-disorders provide such an understanding. This form of understanding, which I here term philosophical understanding, seeks to grasp and conceptualize the schizophrenic world in which patients experience themselves as ontologically displaced, i.e., they are deprived the ontological security that grounds our normal existence and thus bereft what Blankenburg called "common sense." In a vulnerable state of instability, schizophrenia patients frequently experience and express paradoxical combinations of various forms. Schizophrenia patients are thrown into a world where everything seems unfamiliar, uncanny, unreal, or strange; a world permeated by existential feelings not unlike Heidegger's anxiety (Heidegger 2007, 233; Henriksen et al. 2010). Despite the strangeness and the inherent paradoxes of

the schizophrenic world, we can by means of philosophical analysis begin to unravel and understand the subjectivization of reality in schizophrenia and in some cases even patients' reactions to this subjectivization. This is, however, an understanding that is quite different from the described psychological understanding.

From this perspective, the philosophical understanding which I have given examples of in this article is crucial in any attempt to understand schizophrenia. We must recognize that the schizophrenic world significantly differs from the world experienced in normal conditions. Using Campbell's terminology, we can say that the normal framework has changed and without this framework, the psychological understanding that applies to normal conditions is impossible. The task is thus to reconstruct the altered framework in schizophrenia and to imagine the impact this may have for, for example, acting, affects, and language use. I further suggest that the philosophical understanding enables a form of empathy in the sense of allowing the psychiatrist or therapist to understand something of what it might be like to experience the world as schizophrenia patients sometimes do. This form of empathy is quite different from and goes beyond Jaspers' commonsensical notion of empathy, and I think that this form of empathy is crucial also for the psychotherapy of schizophrenia. In their feelings of profound separateness, uniqueness, and loneliness, patients may appreciate normal empathic concerns but nonetheless experience this empathy as somewhat shallow if it is not grounded in an understanding of their condition. In other words, although warm empathic concerns are at the outmost importance in treatment, the therapist must know what she is empathic with, i.e., she must convey an understanding of the altered forms of subjectivity and the inherent vulnerability in schizophrenia. In that sense, an empathy founded on a philosophical understanding of the underlying pathology is to some extent a prerequisite for the positive impact of empathy. Additionally, I suggest that what I here have called "philosophical understanding" draws the apparently clear-cut distinction between understanding and explanation into question. Insofar as the philosophical understanding is able to explain patients' actions or inaction and to some extent their anomalous and abnormal subjective experiences, the philosophical understanding can also be seen as a genuine form of scientific explanation, i.e., explanation (*Erklären*) not in terms of causal relations, but in terms of rational reconstruction and elucidation (*klar werden lassen*).

Obviously, there is a difference between understanding the emergence of, for example, a reactive depression resulting from the loss of a beloved one, and understanding the genesis of anomalous or abnormal experiences often reported in schizophrenia, e.g., "I am not fully present," "I am becoming a monster," "I am dead," "I am Messiah," "I am dissolving," etc. What is difficult and sometimes nearly impossible to imagine is what it may be like to have these strange and disturbing self-experiences. For this reason, the philosophical understanding and its aid in the reconstruction of the schizophrenic world is pertinent. I do not deny that schizophrenia is a complex and unpredictable mental disorder that balances on the threshold of comprehensibility, but in contrast to Jaspers' claim that schizophrenia is incomprehensible—a claim that seems to have lost none of it potency in modern psychiatry, I argue that we can in fact understand schizophrenia to a considerable

extent. As I have tried to show, this requires that instead of focusing exclusively on the content of the delusional beliefs, we must explore the schizophrenic world and the altered structures of experiencing that underlie and form the specific delusional content.

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