THE SELF AND SCHIZOPHRENIA:

LEARNING ABOUT THE SELF THROUGH SELF-DISTURBANCES

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Abstract: In this thesis I argue that schizophrenia should be understood as a disorder affecting the self and that the characteristic changes this disturbance causes can inform us about the nature of the self. In the first chapter, I present a brief overview of how schizophrenia as a diagnostic concept developed, highlighting how schizophrenia became classified as a psychotic disorder. In the second chapter, I present and defend the ipseity disturbance model, which presents schizophrenia as primarily a disturbance of the minimal-self. I present the concept of the minimal-self, show how the ipseity disturbance model understands schizophrenia as a disorder, and discuss key motivations which I believe motivate the model. After defending the model against objections, I close the second chapter with a brief discussion of how one's interactions with other people may influence the minimal-self and affect one's risk of developing schizophrenia. In the third and final chapter, I present three implications my discussion has for our understanding of the self. The self has multiple parts, is vulnerable to disruption, and controls automatic functions which are essential to our everyday lives. I briefly discuss how philosophers discussed or ignored these implications prior to the twentieth century and present two opposing views of the self to show how the implications of my discussion might be interpreted in different ways.

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CHAPTER I

INTRODUCTION

Schizophrenia is a mental illness which can have a profound impact on how a person sees themselves and the world. As a psychotic disorder, schizophrenia is characterized by symptoms like delusions and hallucinations which "add" to a person's experiences (Tandon et al 5-6). Someone with delusions that malevolent actors are inserting thoughts into their head (Carpenter 333-334) will have a different relationship to their thoughts than other people, viewing them as foreign and potentially threatening. Other symptoms of schizophrenia – like avolition – which "subtract" from a person's experiences (Marder & Galderisi 19) also alter their experiences. Such symptoms change the motivational structure which causes us to act 'normally' (Sass & Parnas 431), thereby changing how a person behaves and their reasons for (not) acting. These changes in one's experiences have been of interest to philosophers studying the nature of mental illnesses and of our mental states. For instance, some philosophers have argued that delusions should be understood not as beliefs, but as "hinges" which ground our beliefs about the world which we cannot meaningfully question (Ratcliffe 154-160). That is, delusions radically alter how one's beliefs are justified, which in turn alters how one understands the world and oneself. By investigating delusions, we learn that beliefs depend upon unquestioned suppositions about the nature of the world. Similarly, philosophers have argued that verbal hallucinations involve a failure to recognize our own inner speech, indicating that we possess a system in our mind which

normally recognizes speech as our own (Sass & Parnas 432). Philosophical inquiry into the symptoms of schizophrenia has been used to draw conclusions about our mental states and how the mind is constituted.

By looking at the disturbances caused by schizophrenia, we can learn about the nature of the non-disordered self. As Karl Jaspers noted, we need to operate with an understanding of normal subjectivity in order to understand mental illnesses (Stephensen & Parnas 2). In this thesis I aim to show that the converse can offer us insight as well; we can learn about the "normal" self by looking at mental illness. Schizophrenia appears to alter how people perceive the world as well as how they regard themselves as subjects. Aside from hallucinations, patients' experiences of the world are altered through changes to how they relate to other people and once-familiar objects (Sass & Parnas). Patients also seem to adopt different systems of values as schizophrenia develops, feeling existentially threatened by and alienated from other people while coming to regard the world as a kind of mechanical problem they must solve (Sanghellini & Ballerini 136-138). Coupled with feelings of losing their selves or that they have become fundamentally different (Sass & Parnas 437-438), this suggests that patients with schizophrenia undergo profound and disorienting changes to the self. The normal self appears to be altered in schizophrenia, causing feelings of unease as well as changes in one's values and relationship to the world. If this is true, we can look at the changes wrought by schizophrenia to learn about the nature of the non-disordered self as well as which parts of the self can change. Additionally, we can learn how the self is vulnerable and the processes that the self enables which can be altered.

In this thesis, I will argue that schizophrenia should be understood as a disturbance of the minimal-self and that the characteristic changes to the self this disturbance entails can inform us about the nature of the self. Specifically, I will claim that these changes show us that the self is composed of multiple parts, that these parts are vulnerable to disruption, and that these disruptions largely affect automatic processes we normally take for granted. My thesis will be

divided into three chapters. In the first chapter, I will present a brief historical overview of how the diagnosis of schizophrenia developed. I will introduce several historical understandings of the disorder which I will draw upon in later chapters and present the contemporary diagnostic parameters of schizophrenia in the DSM-5 in order to situate my discussion within the history of discussions about schizophrenia. In the second chapter, I will discuss the ipseity disturbance model, which I will use to understand schizophrenia as a disturbance of the self and its impact upon the self. The ipseity disturbance model describes schizophrenia as a disruption of the minimal-self, the part of the self which makes my experiences *mine*. I will describe the minimal-self, explain how the ipseity disturbance model understands schizophrenia and its symptoms, and defend the model against some possible objections. In the third and final chapter, I will present the implications this discussion has for our understanding of the self; the self is composed of multiple parts, is vulnerable, and underlies automatic processes we take for granted. I will also discuss how two different kinds of views of the self can accommodate these implications to show different ways in which these implications can be understood.

CHAPTER II

A BRIEF HISTORY OF SCHIZOPHRENIA

In this chapter, I will present a brief history of how the contemporary diagnosis of schizophrenia developed to highlight central features of the diagnosis as well as important concepts and historical threads I will draw on in chapters two and three. I will begin by presenting the main precursor to the contemporary concept of schizophrenia, Emil Kraepelin's dementia praecox. I will argue that his assumptions about the course, prognosis, and symptoms of dementia praecox inform continue to shape our contemporary understanding of schizophrenia. I will then show how Eugen Bleuler attempts to expand on the theoretical dimension of schizophrenia as a mental disorder and argue that his work begins a shift towards understanding schizophrenia as primarily a psychotic disorder. Then, I will discuss the contributions made by Karl Jaspers and Kurt Schneider, focusing on the former's application of phenomenology to psychiatry and the latter's contribution of a diagnostic scheme for identifying schizophrenia. I will conclude by presenting the contemporary, mainstream diagnostic concept of schizophrenia as presented in the DSM-5.

While descriptions of mental illnesses which can be retroactively labeled as 'schizophrenia' are found in the early 1800's (Carpenter), schizophrenia was not seen as a distinct psychiatric diagnosis until 1893, when Emil Kraepelin formulated the diagnosis of dementia

praecox (Hoenig 547).[1] Dementia praecox described a presumed somatic pathology which resulted in a particular kind of mental deterioration, harming a patient's higher cognitive functions while leaving simple skills relatively intact (548). While no single symptom unique to the illness was identified, Kraepelin claimed that the overall picture was the same between cases (Hoenig 548): the course, outcome, psychological manifestations, and cerebral pathology were the same, so Kraepelin argued that dementia praecox was a genuine disease-entity (Jaspers 566-567). That is, the symptoms were present in other mental illnesses, but the contours and presentation of the disease were unique. Dementia praecox, as well as all other mental illnesses, was viewed as a somatic disease with psychological consequences according to Kraepelin, and appeals to psychological explanations served as a stopgap until neurological observations of the underlying disease were made (Jaspers 852-853).

This initial formulation of dementia praecox as an essentially somatic disease with a recognizable symptom profile and a poor prognosis resulted in a demarcation between mental illnesses which still stands today; the Kraepelinian Dichotomy. In 1899, Kraepelin divided the psychoses of the time into "manic-depressive psychosis" – which would become bipolar disorder and other mood disorders (Pearlson & Ford 1) – and dementia praecox (Jaspers 567). One motivation for this division was a belief that these groupings had different courses; the course of manic-depressive psychosis tended towards recovery, whereas dementia praecox promised inexorable mental decline (567). The extent and speed of this decline may vary (Hoenig 549), but the endpoint was the same. This historical division has several important consequences. Most obviously, schizophrenia and bipolar disorder are distinct diagnoses, even though their symptoms overlap and we lack strong evidence that they have different genetic bases (Pearlson & Ford 1-2). In addition, evidence that schizophrenia can be distinguished from (psychotic) bipolar disorder is

[1] Dementia praecox was given its name because it was seen as a form of early-onset dementia (Berrios 117).

highlighted in theories aiming to describe the nature of schizophrenia (See for instance Sass & Parnas, 437, Sass 2014, 6). Attempts to describe schizophrenia and validate it as a distinct mental disorder can do so by reaffirming the Kraepelinian Dichotomy, since doing so maintains its distinctiveness from other psychotic disorders.[2]

In addition to introducing schizophrenia as a distinct diagnosis, Kraepelin's dementia praecox contributed in several enduring ways to the contemporary diagnosis. First, schizophrenia is assumed to have a somatic component and to be heritable to some extent. While the exact physiological causes of schizophrenia are still unknown, differences in the brains of schizophrenics and non-schizophrenics have been observed (APA 101-102) and certain genes have been linked to a greater risk of developing schizophrenia (103). In addition, there is no single symptom unique to schizophrenia or whose presence necessarily indicates schizophrenia (Tandon et al 4-5). Different patients can have schizophrenia without necessarily having the same symptoms (4-5), but the overall picture of the diagnosis is the same; one or more psychotic symptoms in conjunction with observable functional declines (5). Finally, while the course of schizophrenia varies significantly between cases (Tandon et al 7), the prognosis is generally a diminished ability to live without permanent care (APA 102). Thus, Kraepelin's general view of dementia praecox as a degenerative somatic disease with a variable prognosis has been retained, even though particular aspects of his view have been discarded.

Dementia praecox was rechristened schizophrenia by Eugen Bleuler to emphasize his view that "the tearing apart or splitting of psychic functions is a prominent symptom" of the

[2] While some authors suggest that Kraepelin rejected this dichotomy later in life (Berrios 113, Hoenig 549, Pearlson & Ford 1), it is not clear to me that he does so. He wrote that "the phenomena of illness which we have hitherto used are not sufficient to enable us to distinguish reliably between manic-depressive illness and schizophrenia in all cases" (Quoted in Decker 341). This could indicate that he doubted the distinction between the two, but might also indicate a belief that they are distinct even though the tools and medical knowledge to easily distinguish them does not exist. Regardless, my reason for discussing the dichotomy is to highlight how it affected research into schizophrenia and its existence as a distinct diagnosis, not to adjudicate whether Kraepelin continued believing in it.

disorder (Bleuler 59) and that it is neither a form of dementia nor a disorder with an early onset (59). Bleuler's schizophrenia is superficially similar to Kraepelin's dementia praecox; the prognosis in most cases is cognitive decline, though the course varies between cases (Bleuler 60-61); the disorder is caused by an underlying disease process (Hoenig 550); and the disease is diagnosed using an overall picture, since characteristic symptoms need not appear in all cases (Hoenig 550). However, though Bleuler claimed that his and Kraepelin's concepts were identical (Hoenig 549, Bleuler 59), Bleuler made several additions which profoundly affected the diagnosis. Most importantly, he introduced a distinction between primary and secondary symptoms (Bleuler 65). Primary symptoms are caused by the disease process itself, while secondary symptoms arise from the interaction of primary symptoms with the environment (65). Bleuler uses osteoporosis as an example to illustrate this distinction; the primary symptom is how brittle the patient's bones are, and the secondary symptom is how easily physical trauma breaks those bones (65). The disease itself causes the bones to become brittle, while an interaction between the primary symptom (i.e., brittleness) and the environment (i.e., physical trauma) is needed to break them. Similarly, Bleuler claims that many symptoms of schizophrenia depend on a core psychic disturbance caused by the disease process itself (66-68). There seem to be two reasons for classifying symptoms as secondary; the symptom remits in some cases while the disease or other symptoms remain (67), and the symptom's content depends on environmental factors (67-68). Consequently, seemingly characteristic symptoms like delusions, hallucinations, and cognitive deficits are secondary symptoms (66-67). The contents of delusions and hallucinations depends on a patient's environment and circumstances (66), while cognitive deficits can improve dramatically with a change in environment even in seemingly advanced cases of schizophrenia (67). By contrast, then, primary symptoms remain so long as the disease-process is still present and are not affected by a patient's environment.

If none of the symptoms we typically associate with schizophrenia are primary symptoms, what could they be?[3] For Bleuler, certain bodily symptoms and a "change in associations" are the primary symptoms of schizophrenia (Bleuler 67-68). This change in associations is the core psychic disturbance which allows delusions,[4] hallucinations, and other psychological symptoms to manifest (Hoenig 550). This view comes out of association psychology, which held that psychic activity is held together by a force – associations – and that these activities cease if associations are impeded (Moskowitz & Heim 474). That is, associations were seen as the glue holding all mental activities together, making everything from acting to thinking and perceiving possible (474-475). For Bleuler, schizophrenia alters the psychic pathways which are essential for mental activity, causing associations to form through random environmental stimuli rather than the controlled channels necessary for normal thought (Bleuler 68). This is supposed to explain how hallucinations, delusions, and other psychological symptoms appear; environmental stimuli take on a greater significance and affect patients in new ways, profoundly altering their perceptions, thoughts, and actions. In acute stages of schizophrenia, these associational pathways are eroded entirely, making action and coherent thought impossible because of the volume of contradictory inputs (68). Bleuler conceptualized schizophrenia as a disease affecting the possibility of cognitive activity, altering cognition such that normally unremarkable stimuli take on an increased significance.

The splitting of psychic functions – the symptom schizophrenia is named after – for Bleuler meant that a patient's psychic unity is disrupted, such that one group of psychic complexes dominates the patient's personality while others are "split off" and limited in their

[3] This presents a possible concern: Bleuler and Kraepelin's views on schizophrenia are too distinct for them to be the same concept. One possibility is that Bleuler and Kraepelin are pointing to the same clinical picture of schizophrenia, within which Bleuler identifies symptoms which are seemingly directly caused by the disorder. If this is the case, Bleuler is refining Kraepelin's concept rather than creating something distinct.

[4] While the traditional view is that Bleuler's focus on the psyche reflects the influence of Freud (Hoenig 449-550), Moscowitz & Heim argue that Freud's influence on Bleuler's thought was limited (475-477).

influence (Moskowitz & Heim 473). This happens in the course of the disease and when the disease remits; delusional ideas can split off from the patient's personality, leading to improvement even though the delusions are still present in a dormant state (Bleuler 70). This is related to Bleuler's view that schizophrenia is incurable (61-62). While a patient's symptoms can abate with a change of environment or the passage of time, their delusional ideas can return and affect their behavior if patients are reminded of them (62). In this sense, delusional ideas do not normally affect a patient's behavior, but they are still present. Moskowitz & Heim interpret this splitting as similar to dissociation; splitting occurs without the patient willing it and involves the psyche losing the ability to interface with part of itself (474).

Bleuler's view of schizophrenia contributed in several ways to the contemporary diagnosis, though many of his theoretical views have been discarded. Thematically, his focus on schizophrenia as a disorder of the psyche has been carried forward. Schizophrenia is conceptualized primarily as a psychotic disorder and emphasizes psychological symptoms like delusions and hallucinations (Tandon et al 4), as opposed to Kraepelin's view that the disorder is primarily a dementing process. The focus on splitting as a central feature of the diagnosis has also been carried forward, but has been deemphasized in more recent conceptualizations of the disorder (4). However, Bleuler's distinction between primary and secondary symptoms has been discarded. While similar lines of reasoning are arguably used in some non-mainstream views of schizophrenia,[5] there is no claim that one or more symptoms underlie the others (Tandon et al 4). While Bleuler's views shaped the tenor of the schizophrenia diagnosis, many of his theoretical claims have been disregarded.

The final historical figures I will briefly discuss in this chapter are Karl Jaspers and Kurt Schneider. Jaspers's primary contribution to psychiatry and research into schizophrenia is the

[5] For instance, one way of characterizing the Ipseity Disturbance model, which I will present in chapter 2, is that a disturbance of the minimal-self underlies the symptoms of schizophrenia.

application of phenomenological methods to psychiatry to gather descriptions of patients' experiences. For Jaspers, phenomenology allows psychiatrists to gather descriptions of a patient's experiences of their present mental states without imposing psychological theories onto those descriptions or drawing connections between them (Jaspers 55-56). The aim is to represent the actual psychic experiences of the patient, how they are affected and feel about those experiences, and to carry the investigation as far as possible while avoiding generalizations which elide specific details (56). In this way, phenomenology serves as a tool for collecting data as well as a method for collecting experiences which allows the psychiatrist to empathize with and thereby understand the patient's mental state. In addition, Jaspers distinguishes between the form and content of psychic events. The form of a mental state is the mode – such as "Perceptions, ideas, judgments, feelings, drives, self-awareness (58) – through which they are experienced, while the content is what the mental states are about (58-59). For example, a belief and a delusion that I will pass a class both have the same content – "I will pass this class" – while the way we experience that content differs. Jaspers is only concerned with the form which mental states take: that some event is a hallucination, thought, perception, etc. is important, whereas the contents of that event are less so (58-59). This is because the content of a psychic event is accidental, since the same content can be presented through multiple forms, while the form gives a clearer insight into what is happening in the patient's psyche (59).[6] In the context of psychiatry, then, phenomenology aims to provide a rich description of a patient's psychic experiences in order to develop a full psychological portrait and uncover abnormalities in the forms of their experiences.

Schneider used the methods developed by Jaspers but is best known in mainstream psychiatry for developing pragmatic standards for diagnosing schizophrenia. Schneider

[6] *Form* for Jaspers seems to mean something like "the way in which objects/content is presented to me." For instance, when I perceive a sound as much more intense than normal (Jaspers 61), the form of that experience is "perceived *x* as more intense than normal." So, the content of the experience is the object the experience is about (the sound), and the form encompasses the mode and "modifiers" or alterations through which the object is experienced (perceived + as louder than usual).

introduced a distinction between first- and second-rank symptoms of schizophrenia; the clear presence of a first-rank symptom is supposed to indicate that a patient has schizophrenia, while second-rank symptoms also appear in other disorders (Cutting 131, Moscarelli 2). First-rank symptoms include certain kinds of "abnormal 'modes of experience'" (Moscarelli 2), including specific kinds of audio-verbal hallucinations, experiencing one's actions, thoughts, and feeling as if one is under the control or influence of an outside agent or force, and thought disturbances (2). Importantly, only certain kinds of hallucinations and delusions serve as first-rank symptoms, since other kinds appear in other disorders as well (3). With this list of symptoms, Schneider does not attempt to offer a shared phenomenological basis for them (Cutting 132). First-rank symptoms were distinguished to serve as a diagnostic tool rather than serving to highlight a common feature of schizophrenic symptoms. In addition, schizophrenia can be diagnosed in the absence of these symptoms if second-rate symptoms are present in the right configuration (Moscarelli 2). First-rank symptoms are sufficient for a schizophrenia diagnosis but not necessary. Finally, unlike Bleuler's distinction between primary and secondary symptoms, Schneider's first- and second-rank symptoms are supposed to be atheoretical (Cutting 131-132, Moscarelli 2). Whereas Bleuler's distinction aims to clarify the nature of schizophrenia as a disease, first-rank symptoms only aim to have diagnostic – rather than theoretical or prognostic – value (Moscarelli 2). Schneider described symptoms which are supposedly unique to schizophrenia, and which can be used as a basis for diagnosis.

Whereas the direct influence of Jaspers is limited to phenomenological approaches to psychiatry which are not mainstream, Schneider's first-rank symptoms helped shape the mainstream view of what schizophrenia looks like. Schneider's first-rank symptoms were incorporated into DSM-III and DSM-IV as sufficient evidence that a patient satisfied criterion A for a schizophrenia diagnosis, but this special treatment was removed in DSM-5 (Tandon et al 4-5). Arguably, however, Schneider continues to influence how schizophrenia is viewed by

psychiatrists and by the culture at large. His focus on particular kinds of delusions and hallucinations fits into an overall move from viewing schizophrenia as principally a dementing disorder to a primarily psychotic disorder. Kraepelin described dementia praecox as a disorder whose central feature is cognitive decline and whose symptoms were supposed to spring from damage to the body (Hoenig 548). Bleuler argued that schizophrenia has somatic as well as psychological primary symptoms (67-68), changing the diagnosis from a presumed somatic problem to a somatic and psychological one. Schneider's first-rank symptoms refer strictly to psychological symptoms (Moscarelli 2), representing a shift in the diagnosis towards the psyche which remains relevant today. In the DSM-5, at least one symptom of schizophrenia must be a psychotic symptom – hallucinations, delusions, or disorganized speech (Tandon et al 5-6) – symptoms which correspond closely to Schneider's first-rank symptoms. For most people, first-rank symptoms are the stereotypical symptoms of schizophrenia, especially delusions of self-reference and audio-verbal hallucinations of voices commenting on one's actions or arguing with each other. Though Schneider's first-rank symptoms have not remained a basis for diagnosing schizophrenia, they still linger in the popular and psychiatric imagination. By contrast, Jaspers's contribution to psychiatry is largely confined to psychiatrists and research with an explicit commitment to phenomenological psychiatry.[7]

The contemporary diagnosis of schizophrenia is heterogenous, such that two people can be diagnosed with schizophrenia while having significantly different symptoms (APA 99, Tandon et al 5). While functional impairment in one or more areas of life – like socialization, work, and self-care – and a duration of at least six months are required for a diagnosis (APA 99), the functional area which is impaired, as well as the other symptoms which present themselves, can vary. As a psychotic disorder, a diagnosis of schizophrenia also requires that a patient

[7] I will have more to say about Jaspers's contribution and ideas in chapter 2 of my thesis, where I will be engaging directly with ideas from phenomenological psychiatry.

experienced a psychotic episode for a significant amount of time and exhibited two of five specified symptoms during that episode (APA 99). Thus, the contemporary diagnosis of schizophrenia is defined by two phases; an acute phase during which psychotic symptoms like hallucinations and delusions are readily apparent, and a residual phase characterized by functional impairments.

To conclude, the purpose of this historical analysis has been to present the diagnosis of schizophrenia as it is understood in contemporary psychiatry while contextualizing its development and presenting concepts and threads I will make use of in chapters 2 and 3 of my thesis. Throughout its history, schizophrenia has been increasingly understood as a psychotic disorder that affects a person's psyche and brings about functional decline. It is still presumed to have a somatic cause of some sort, though a widely accepted account of that cause is still forthcoming. Our conception of schizophrenia is heavily influenced by Kraepelin, Bleuler, and Schneider, each of whom serve as major foundations for the concept as well as how the diagnosis is formulated, even though many of their particular views have been set aside (Tandon et al 4). Kraepelin's distinction between what would become schizophrenia and bipolar disorder will present itself in chapter 2 as a main motivation levied by proponents of the ipseity disturbance model, who claim that self-disturbances can be used to distinguish schizophrenia from bipolar disorder and other psychiatric conditions (see for instance Sass 2014, 6). Likewise, I will return to Bleuler's conception of schizophrenia in order to clarify aspects of the ipseity disturbance model. Finally, I will return to Jaspers's views on phenomenological psychiatry when looking at how the ipseity disturbance model is used and to help judge whether it makes use of phenomenology well.

CHAPTER III

THE IPSEITY DISTURBANCE MODEL

In this chapter, I will describe and defend the ipseity disturbance model for understanding schizophrenia and argue that it can inform us about the nature of schizophrenia and the self. I will begin by presenting Dan Zahavi's concept of the minimal-self, which the ipseity disturbance model argues is disturbed in schizophrenia. I will then give an overview of the model and the evidence supporting it. I will structure my discussion around three motivations which I believe are central to the model: a desire to give a single cause for every symptom of schizophrenia, to distinguish schizophrenia from other mental disorders with overlapping symptoms, and to detect and treat schizophrenia as early as possible. I will then present and respond to two objections to the model; that the minimal-self is not a kind of self which can be disturbed, and that schizophrenia is better understood as a disturbance of a non-minimal self. I will conclude with a brief discussion of a possible addendum to the model, that the minimal-self can be disturbed by radical changes to our relationships with other people.

The Minimal-Self

To understand the ipseity disturbance model, we first need to understand the concept of the minimal-self articulated by Dan Zahavi. The minimal-self is a thin concept referring to the first-person character of our experiences (Zahavi 2014, 18). It refers to the "myness" of my experiences, the fact that my experiences occur for me in the first person (2008, 125). Whatever

the type of experience I am having – a perception, thought, intention, or hallucination, for instance – they are all *my* experiences (2014, 18-19). In other words, these experiences are all like something *for me* and happen *to me* (19). In this way, the minimal-self is a structural component of our experiences (Ratcliffe 14) rather than the object of those experiences. It is a condition making my existence as an experiencing subject with a point of view possible; it is the mode through which I can experience, referring to the *how* of my experiences rather than the *what* (Zahavi 2014, 21-22). The minimal-self is the first-person perspective which makes my experiences mine, not a quale shared by all my experiences (22). They are my experiences because of how they are presented to me, rather than any single felt quality they all share.[8]

As a feature of all our experiences, the minimal-self depends on a pre-reflective self-awareness of myself. Since the minimal-self is not, properly speaking, a thing which we can isolate from any conscious experience (Ratcliffe 238), it cannot be something we must reflect upon or which stands above our experiences (Zahavi 2008, 125). Zahavi presents Sartre's arguments that self-consciousness is an intrinsic part of our experiences rather than something arising from reflection to make this point (Zahavi 2008, 20-25). That is, all our conscious mental states share a property – their "myness" – which makes them conscious experiences *for us* (20). While I am usually conscious only of the *content* of my experiences rather than their belonging to me, I am aware of that content – and can reflect upon the form of my experiences – because it is *mine*. Reflection is taking a conscious experience as an intentional object, creating a different kind of experience in which I concentrate on an aspect of another experience and take it as an object (20-21). Accepting reflection as the basis of self-consciousness either generates an infinite regress of mental states taking other mental states as objects or requires non-conscious mental states to ground conscious mental states (20-21). If first-order mental states are conscious because

[8] While we usually have first-person experiences and view those experiences as our own, these aspects of experience can come apart. For example, a person who hears verbal hallucinations experiences those hallucinations in the first-person even if they do not feel like the experience is *theirs*.

they are taken as objects by second-order mental states, these second-order states must be the object of third-order mental states, and so on (24). We get an infinite regress of mental states reflecting upon other mental states. This is absurd, so self-consciousness cannot arise from reflection.

This first argument assumes that all reflective mental states are conscious, since this problem only arises because we need to explain how second-order mental states are reflective states. However, attempting to drop this requirement also seems to fail; it is utterly unclear how a non-conscious mental state could make us conscious of a different, previously unconscious mental state (Zahavi 2008, 25).[9] While unconscious mental states may give rise to new conscious mental states, this cannot explain how unconscious mental states can take conscious mental states as objects. For example, a subconscious association between an object and some tragedy in my life may produce a conscious fear of a place, but this is different from those subconscious states taking my conscious mental state as an object. If mental states become conscious when taken as objects by other mental states, it seems vacuous – and unfalsifiable – to claim that a second unconscious mental state exists which serves to transform the first state. Since reflection cannot adequately explain self-consciousness, conscious mental states must be states we are pre-reflectively aware of.

While this negative argument shows that reflective self-awareness cannot be the basis for consciousness, we still need a positive case for how we are pre-reflectively aware of ourselves through our conscious mental states. According to Sartre, pre-reflective self-awareness is not structured like a reflection; it does not take an intentional object and does not form a subject-object relation (Zahavi 2008, 21). That is, pre-reflective self-awareness does not enter into a

[9] Furthermore, this would undermine the concept of reflection. Normally, reflective mental states are conscious and take another (previously) conscious mental state as an object. For instance, I can reflect upon a perception which seemed odd or which was called into doubt. Allowing nonconscious mental states to reflect upon conscious mental states overextends the definition of a reflection.

relation with itself as both subject and object as would happen in the case of reflection. Rather, the self immediately grasps itself when we have conscious experiences (21); we are always already self-aware through our experiences. By virtue of their being experiences or mental states, they are experiences and mental states *for me*, and are hence part of my conscious experience. Consequently, reflection cannot render us conscious of the experience we reflect upon. Rather, we are aware of reflecting because we are pre-reflectively aware of our mental states; pre-reflective self-awareness is constitutive of the self-awareness we gain through reflection (22). This pre-reflective self-awareness is our direct access to our thoughts in the first person, which makes us tacitly aware that they are our thoughts (Sass & Parnas 430). My first-person experiences contain "a built-in self-reference" *because* I experience them in the first person, thereby making me aware – in a minimal sense – of my subjectivity (430). Pre-reflective self-awareness is a basic self-awareness of myself as a subject through the fact that I have first-person experiences.

Finally, our pre-reflective self-awareness of our actions gives us access to our experiences in the first-person (Zahavi 2008, 122). I am self-aware of my actions because they are *mine*, because they present themselves to me in the first-person. My experiences contain both the objects I am experiencing and the subject doing the experiencing (123); there is a built-in self-referentiality to my experiences, mental states, etc. (122). When I write, I experience the passage I am writing while also becoming aware that I am the one who is writing. My experiences refer to me without needing to be reflected upon, they *just are* mine through their structure as experiences. Pre-reflective self-awareness is not a relation between subject and object. It is a constitutive feature of our experiences which makes them accessible to us as conscious subjects.

Before moving on to discuss the ipseity disturbance model, it is useful to highlight that the minimal-self is significantly different from other conceptions of (the) self. The minimal-self is a structural aspect of our experiences which makes a conscious, first-person perspective possible,

whereas other conceptions of the self view it as an independent entity unifying our experiences under a single heading. For example, a narrative view of the self argues that I produce a coherent narrative about myself, my motivations and history, unifying my actions and experiences as stemming from a singular, diachronic agent (Zahavi 2008, 106-109). By contrast, the minimal-self is a part of the experiences which other concepts of the self attempt to unify and is the basis which makes other concepts of the self possible. All other notions of self build from one's experiences to say something about oneself; the minimal-self provides the first-person material which more robust notions of self utilize. The minimal-self is more fundamental than other selves, serving as an important aspect of our experiences which makes them conscious for us as first-person experiences.

The Self in Schizophrenia – The Ipseity Disturbance Model

The ipseity disturbance model describes schizophrenia as a disturbance of the minimal-self, which gives rise to characteristic alterations in consciousness (Sass 2014, 5) and underlies all the symptoms of schizophrenia (Sass & Parnas 437, 431). According to the model, the symptoms of schizophrenia all arise from the same disturbance at the core of the disorder (Sass & Parnas 428, 431). While Bleuler argued that symptoms of schizophrenia stem from a change in associations, the ipseity disturbance model argues that they are caused by a vicious loop involving two closely related changes to one's self-perceptions: hyperreflexivity and diminished self-affection (428). Hyperreflexivity is a form of exaggerated self-consciousness where a subject experiences a part of themselves as an object, as something external to them which they no longer inhabit (428). This is not a process of explicit reflection through which the subject purposefully takes part of themself as an object and consequently loses the sense that they inhabit that part (Sass 2014, 7). Rather, it affects the way a person pre-reflectively experiences themself as themself, as well as what does or does not "pop-out" for us to attend to (7). Normally, certain percepts or thoughts "pop-out" to us as significant and worth attending to depending on our

mental states. For instance, if I am hungry, any food I see appears more important to me than it usually does; the food automatically presents itself as significant and I explicitly attend to it. In schizophrenia, what automatically appears significant is altered, causing patients to consciously attend to parts of themselves – like random bodily sensations (Sass & Parnas 434-435) – which normally do not register as important. The sensations and parts of ourselves which we take for granted or which require conscious attention are altered, causing us to attend to things which we previously implicitly inhabited. That is, the relevant sense of hyperreflexivity is *operative* hyperreflexivity rather than something which is performed consciously (7).

Diminished self-affection refers to a diminished sense that one inhabits a unique first-person perspective (Sass & Parnas 428). It is a reduction of one's pre-reflective awareness of oneself, a loss of one's ability to take aspects of one's subjectivity for granted (Sass 2014, 6). It is tightly bound with hyperreflexivity; being less able to take a part of myself for granted leads to taking that part as an object, further alienating me from it and diminishing my sense that I inhabit that part of myself (6). For example, having the sense that a thought is not my own drives me (automatically) to interrogate that thought, furthering my sense that it is alien and reducing my ability to pre-reflectively inhabit my thoughts. The thought is not experienced as mine, making part of the minimal-self seem external. In this way, hyperreflexivity and diminished self-affection drive a cycle which disrupts a patient's pre-reflective sense that they inhabit a single first-person perspective.

This vicious cycle gives rise to a third component of the ipseity disturbance model; a disruption of the patient's field of awareness, on their "grip" on the world (Sass 2014, 6). The disturbance of one's sense of oneself as a subject in turn affects how one makes sense of the world around oneself as well as the "sharpness or stability" of the objects and symbols presented to oneself (Sass & Parnas 428). The ways in which a patient structures the world and its objects in space and time are altered, and distinctions between different kinds of experiences – like

remembering vs. perceiving something – are attenuated or lost altogether (Sass 2014, 6). The perceptual and actional field we typically take for granted is upended, such that the world and the things within it cease making sense in their usual way. There is a "loss of common sense" (6), a loss of access to symbols, things, and the meanings we unreflectively assign to them. In a way, the patient loses their pre-reflective understanding of the cultural world by losing their place within it. As humans, we always already find ourselves immersed in a world suffused by artifacts, symbols, and cultural meanings which other people have attached to physical objects (Merleau-Ponty 363). I perceive the things around me through a cultural lens (363); I *see* hammers as having typical uses and oak trees as symbols of fortitude. Through this encounter with cultural meanings and tools (363-364), and through my existence as an embodied perspective within the world (366-368), I am aware of the existence of other people who also possess first-person perspectives different from my own. My pre-reflective immersion as an embodied subject into a world full of meanings shows me that others exist and provides me with a lexicon for communicating with them.

With this overview of the ipseity disturbance model, I will now discuss the three motivations I see as central to the model. First, the model aims to give a unified account of schizophrenic symptoms, arguing that they ultimately stem from a disturbance of the minimal-self (Sass & Parnas 427-428). It attempts to explain the "positive" and "negative" symptoms of schizophrenia – which "add" and "subtract" from a patient's experiences, respectively – in terms of a disturbance of the minimal-self (431).[10] Concerning positive symptoms, the model is most concerned with explaining how Schneider's first-rank symptoms, specifically verbal hallucinations and delusions, can be explained by a minimal-self disturbance (431). The same description applies to both symptoms; one's ability to effortlessly inhabit part of oneself is

[10] Sass and Parnas argue that we should not draw a sharp distinction between positive and negative symptoms (431). Positive symptoms – like hallucinations – fill in the space left by something now absent and negative symptoms – like asociality – give rise to new behaviors (431).

impaired, leading one to direct concerted attention to that part, thereby further alienating one from oneself (432-433).

In the case of verbal hallucinations, one's thoughts are regarded as objects rather than a part of one's subjectivity, making them seem external and allowing one to "hear" them (432-433). These hallucinations often have the structure and content of inner speech or an inner monologue, suggesting that thoughts one normally takes for granted are taken as objects (432-433). That is, the content of these mental states is the same while the form in which they are experienced is altered. This explanation is supposed to describe the first-rank symptoms of voices arguing and voices commenting on one's behavior (Mocarelli 2, Sass & Parnas 433). These kinds of verbal hallucinations involve an alienation from one's thoughts as well as excessive self-awareness of the process generating those thoughts, making them seem external while drawing one's attention to them (Sass & Parnas 433).[11] Similarly, delusions that one's body is subject to external forces involve a disruption of one's ability to pre-reflectively inhabit parts of one's body (432). Just as I can make aspects of myself seem strange or troubling by directing inordinate attention towards them, delusions in schizophrenia are supposed to arise through an alteration in one's attention such that normal processes seem alien or hostile (432). By focusing attention on our mental and physical states, our sense that they are ours is vitiated, which in schizophrenia develops into the sensation that these states are imposed upon us by external forces.

While the model explicitly articulates reasons for believing that first-rank symptoms can be explained by a self-disturbance, it must be able to explain other positive symptoms as well. For instance, visual hallucinations occur in around a quarter of patients with schizophrenia (Waters et

[11] This explanation of verbal hallucinations aims to describe how normal thoughts become experienced as external voices in patients with schizophrenia; it aims to describe how the form of the experience changes. This by itself, however, does not explain stereotypical instances where the voices a patient hears are hostile and belittling. One possible explanation is that changes in the content of a patient's thoughts stem from excessive attention paid to normally transient thoughts. If we experience fleeting negative thoughts which can dominate our minds when we focus on them, then a patient explicitly attending to all their thoughts may experience more negative thoughts, causing the voices they hear to be disproportionately negative.

al S234), typically manifest differently in schizophrenia than in other disorders (S237-S238) and are acknowledged as possible symptoms of schizophrenia by the ipseity disturbance model (EAWE 12-13, 17). The discussion of other positive symptoms should allow us to understand less dramatic kinds of visual hallucinations like changes in the intensity of perceived objects (EAWE 16) or the fragmentation of things into their parts (17-18). In both cases, changes to what parts of our experiences "pop-out" for us as significant could explain why objects and their qualities seem different as well as why parts of ourselves are experienced as alien. However, it is less obvious how the model can explain more profound visual hallucinations where something appears added to a patient's visual field (17). To highlight this distinction, Jaspers distinguishes between illusions in which real perceptions are distorted (64-65) and hallucinations proper in which a new, false object appear alongside objects in one's visual field (66). Whereas illusions might plausibly be explained by changes in one's attention, it is unclear how hallucinations proper could be explained in this way. While I do not know how the ipseity disturbance model can explain more complex hallucinations, this is a problem faced by all models attempting to describe schizophrenia. Visual hallucinations were traditionally thought of as rare in schizophrenia, especially compared to auditory hallucinations (Waters et al S233), which Schneider regarded as first-rank symptoms. I do not know how the ipseity disturbance model would adequately describe all the positive symptoms of schizophrenia, but this seems like a difficulty all models of schizophrenia face.

According to the model, negative symptoms outwardly seem like deficit states, but reveal a qualitative change in a patient's experiences (Sass & Parnas 433).[12] Patients with negative symptoms typically do not report a straightforward decline in energy or ability to think, reporting

[12] The current conception of negative symptoms includes blunted affect, alogia, anhedonia, asociality, and avolition (Marder & Galderisi). The older conception which Sass and Parnas use is broader and includes deficit states in general (433) which are now viewed as components of one of the five negative symptoms (Marder & Galderisi 20).

instead feelings of alienation, self-consciousness, and disruptions of automatic cognitive processes (433). These alterations may cause performance deficits, but they are not themselves directly deficits. Sass and Parnas argue that negative symptoms manifest as a consequence of the patient's loosened grip on the world and the attendant loss of easy access to shared meanings (434). The patient's pre-reflective connection to the world is weakened because of hyperreflexivity and diminished self-affection, forcing them into an analytic mode of engaging with the world while reducing their ability to understand that world (434). Patients lose their place in the cultural world, making them less able to perceive the social meanings attached to objects and to other people's behaviors. This loss of place also causes a deterioration of habits which allow people to navigate the world automatically, forcing patients to consciously reflect on their actions to compensate (434). One's way of interacting with the world is qualitatively altered, giving rise to seemingly odd behaviors which yield worse results than a non-schizophrenic mode of engagement. Since patients still need to interact with a world they have difficulty understanding, they maladapt an analytic, overly reflective mode of engaging with the world, producing behavioral deficits. Hyperreflexive awareness of oneself makes acting and engaging with the world more difficult (434), producing negative symptoms which originate in a disturbed minimal-self.

Though the psychiatric concept of negative symptoms has changed since the ipseity disturbance model was proposed, the model can still provide an adequate account of them. Blunted affect and alogia refer to decreased expressions of emotion and quantity of speech, respectively (Marder & Galderisi 15-16) and are amenable to explanation under the ipseity disturbance model. Both of these negative symptoms can be understood as consequences of self-monitoring done in an attempt to act appropriately in a world which seems "off" or alien. Put another way, hyperreflexivity makes a patient less able to inhabit themselves and "live through" emotional expression and social encounters, making them less able to say what they want, emote,

and engage with an interlocutor. Anhedonia might be explained similarly; patients with schizophrenia react similarly to healthy controls to emotionally charged stimuli in laboratory conditions (17), but experience less pleasant emotions in normal circumstances due to expending more effort to understand their surroundings.[13] Finally, asociality and avolition are explicable as consequences of positive symptoms (18-19) and as a loss of natural self-evidence. A patient's desire to interact with other people and initiate goal-directed activities can be subdued by paranoid beliefs about other people or by threatening hallucinations, for instance (18-19). They might also arise from a deterioration of one's pre-reflective understanding of other people and the world. A qualitative change in one's experience such that interacting with others and pursuing goals now seems more difficult can lessen one's desire to pursue them, leading to asociality and avolition. Adopting a more analytic mode of engagement with the world could make engaging with others and accomplishing goals more difficult, causing one to desire those things less. That is, needing to think through how to go for a walk or strike up a conversation would make these tasks seem more daunting, making one less likely to do them. Thus, the current conception of negative symptoms seems amenable to explanation by the ipseity disturbance model.

With the ipseity disturbance model and the symptoms of schizophrenia in view, I will now present experimental evidence that self-disorders cluster in schizophrenia. I will argue that this evidence supports the claim that schizophrenia is a self-disturbance as well as the second motivation for the model which I posited; to give us a way to reliably distinguish schizophrenia from other disorders. The studies I cite in this discussion are concerned with distinguishing schizophrenia spectrum disorders from disorders outside of the schizophrenia spectrum. This spectrum includes schizophrenia and other psychotic disorders like schizophreniform and schizoaffective disorder, as well as non-psychotic disorders like schizotypal personality disorder

[13] It is also possible that patients with schizophrenia have an impaired ability to remember and anticipate pleasant experiences (Marder & Galderisi 17), but research into this question is still ongoing.

(APA 89). I will present the results of these studies in terms of the schizophrenia spectrum, since doing so allows me to better show that self-disorders appear in schizophrenia *because it is schizophrenia* rather than because of a symptom like psychosis.

In their presentation of the ipseity disturbance model, Sass and Parnas cite studies which found that anomalies in self-experience distinguish between patients with schizophrenia spectrum disorders and those with other disorders, and that higher scores for self-disorder distinguish patients with schizophrenia from those with psychotic bipolar disorder (437). These self-disorders attempt to describe trait-like changes to a patient's subjectivity which antecede the positive and negative symptoms of schizophrenia (Raballo et al 1008). Examples include a pervasive sense of lacking an identity or of being completely different from others (EASE 244), feeling as if one's body or its parts has changed (252), and feeling unable to act because something terrible is always about to happen (254), and are operationalized as high scores on scales like the Examination of Anomalous Self-Experience and the Bonn Scale for the Assessment of Basic Symptoms (Raballo et al 1010). In addition, patients with schizophrenia seem to exhibit more severe signs of self-disorder than patients with depersonalization disorder and other psychotic disorders (Sass 2014, 7-8). This indicates that self-disorders are a feature of schizophrenia and that the severity and frequency of self-disorders sets schizophrenia apart from other disorders. To the first point, a meta-analysis by Raballo et al of 32 studies comparing self-disorders in different mental illnesses found that self-disorder scores for patients on the schizophrenia spectrum were significantly higher than in any other disorder (1010-1012). Patients with schizophrenia and schizotypal personality disorder in the studies analyzed had comparable levels of self-disorders while patients with other disorders had significantly lower levels (1010-1012). Since self-disorders seem to cluster in the schizophrenia spectrum, they can be used to help distinguish schizophrenia from other disorders.

To the second point, since schizophrenia and schizotypal personality disorder have similar levels of self-disorders, since schizotypal is not a psychotic disorder, and since other psychotic disorders exhibit less severe self-disorders than schizophrenia spectrum disorders (Sass & Parnas 437, Raballo et al 1011-1012), self-disorders appear to be features of schizophrenia itself rather than of psychosis (Raballo et al 1013). The frequency of self-disorders does not just track the severity of psychotic symptoms, indicating that self-disorders in schizophrenia are caused by something else about the disorder. This supports the claim by the ipseity disorder that schizophrenia is primarily a minimal-self disturbance, since it does not appear that self-disorders are a secondary outcome of psychosis.

Further evidence for the claim that self-disorders are characteristic of schizophrenia itself comes from a follow-up study by Parnas et al. They found that patients were significantly more likely to be re-diagnosed with a schizophrenia spectrum disorder in the follow-up if they scored high for self-disorders (203). That is, patients with a non-spectrum diagnosis were much more likely to be given a schizophrenia or schizotypal diagnosis if they exhibited significant amounts of self-disorders than if they exhibited a low amount (203). Taken together with the evidence that self-disorders do not track the severity of psychotic symptoms in a disorder, this suggests that self-disorders are a characteristic of schizophrenia.

The third motivation behind the ipseity disturbance model is to provide a way to detect and treat schizophrenia as early as possible. This involves detecting schizophrenia during the prodrome, a period in which no outward behavioral differences can be observed but where changes to a patient's experiences begin to manifest (Sass & Parnas 428) which later lead to a psychotic episode. That is, the prodrome occurs before the onset of schizophrenia proper and features psychological changes which can develop into schizophrenia. Early intervention in the prodrome seems to correlate with improvements in the long-term course of schizophrenia (Møller & Husby 217). If detecting possible precursors to schizophrenia and treating them is possible, the

hope is that schizophrenia will not entrench itself and become a problem which can at best be managed (Tekin 256).[14] Detecting schizophrenia in the prodrome is difficult, however, since the behaviors of those in the prodrome fall within the range of normal behavior (Sass & Parnas 428) and changes in a patient's behavior occur too gradually for friends and family to become concerned and seek help (Møller & Husby 218). According to the ipseity disturbance model, patients should undergo changes in how they experience themselves and the world, attending explicitly to parts of themselves while losing their sense of agency and easy access to cultural meaning (Sass & Parnas 437-438). The hyperreflexivity-diminished self-affection loop should predate the onset of psychotic symptoms. If so, this provides a way to detect schizophrenia in the prodrome by inquiring after changes to the person's experiences.

The ipseity disturbance model gives us a way to detect insipient self-disorders which could develop into schizophrenia proper. Patients in the prodrome evince numerous characteristic complaints, reporting a difficult to articulate sense that they have changed or that their sense of self-cohesion was damaged (Sass & Parnas 437-438). Complaints like "I don't feel myself," "I am losing contact with myself," or "I have no consciousness" indicate that a normal sense of self has been lost (437-438). This affects the background of their experiences, causing them to act without the pre-reflective sense that they are present. The central themes in these prodromal disturbances seem to be a disturbed perception of the self and a preoccupation with one's thoughts (Møller & Husby 222-223). "Pervasive and enduring" changes to the patient's identity occur, altering their sense of themself as a subject (222-223). These changes line up with the

[14] Tekin argues that this proposition raises ethical questions: Should we treat people before they develop a psychiatric illness? If so, is it ethical to place them on antipsychotic medications with many side-effects? How would we address possible false positives any attempt at diagnosing would produce? (256). The authors proposing these interventions seem to treat prodromal schizophrenia as a disorder in its own right; prodromal schizophrenia is properly understood *as pre-psychotic schizophrenia*. Sass and Parnas distinguish between prodromal and premorbid phases of schizophrenia, for instance (428). On this understanding, Tekin's concerns apply to attempts to treat premorbid "schizophrenia," but prodromal schizophrenia is already a disorder which needs treatment. However, if we understand the prodrome as merely a warning sign that schizophrenia *might* develop, then the prodrome and premorbidity should be treated (or not treated) in the same way.

predictions of the ipseity disturbance model. The patient's sense of themself as an agent and as their old self is diminished while they become preoccupied with thoughts and topics that previously had not interested them as intensely. The "myness" of their experiences is lost, distances them from their actions and perceptions, requiring explicit attention to regain lost functionality (Sass & Parnas 438). The changes in a patient's experience in the prodrome are thus similar to those in schizophrenia proper. The minimal-self is disturbed, affecting the patient's experiences by vitiating their sense of agency and requiring explicit attention to perform normally implicitly lived tasks.

Objections and Replies

An objection to the account of schizophrenia I am defending is that the minimal-self cannot be disrupted in the way the ipseity disturbance model suggests. The minimal-self is the structure which allows us to have first-person experiences, and which supports any more sophisticated kinds of selves we build up. While my ability to consciously identify experiences as my own depends on the minimal-self, it is more fundamentally the thing which makes those experiences mine in the first place. Disruptions to the minimal-self would vitiate the mine-ness of my experiences in a fundamental way, damaging or destroying my ability to inhabit a unique perspective on the world. Not only would experiences not feel like they are mine, but it also seems that a disruption of the minimal-self would make it so that I cannot have first-person experiences at all. If this is the case and if we maintain that people with severe mental illnesses still have first-person perspectives, then the minimal-self cannot be disrupted in patients with schizophrenia. While higher-order selves like the narrative self can be disrupted in mental illness and sudden changes in one's life, the minimal-self as the thing undergirding my selves and ability to exist in the first person is not the kind of thing which can be disrupted.

If this threat to first-person experience is as serious as this objection alleges, one possible response is to accept that the minimal-self cannot be disrupted while maintaining that the ipseity disturbance model offers a basically correct account of schizophrenia. This involves dropping the claim that hyperreflexivity and diminished self-affection arise from a minimal-self disturbance while maintaining that they occur and cause the symptoms of schizophrenia. A possible way of arguing this position is to distinguish a disturbed sense of agency from a minimal-self disturbance. A disturbed sense that one is an agent who controls their own actions and experiences is different from the fact of having first-person experiences and could drive hyperreflexive attention towards oneself. Losing the sense that one is an agent could lead to conscious effort to regain this sense, leading to a further diminishment of self-affection and heightened hyperreflexivity. If this loop can be reexplained in these terms without losing the explanatory power a disturbed minimal-self gives it, one could retain the ipseity disturbance model while yielding to the objection that the minimal-self cannot be disturbed. This response would save the model and preserve the idea that the self has multiple parts *if* appealing to a minimal-self disturbance is not theoretically necessary.

Another response is that a minimal-self disturbance should not be understood as an elimination of the minimal-self or of one's first-person experience. That is, a disturbance of the minimal-self is a change in the structure of one's experiences, not an elimination of or damage to that structure. Drawing an analogy between the minimal- and narrative selves, disturbances to one's narrative do not eliminate that narrative or make narrativizing impossible. My narrative might need to be amended – perhaps substantially – and the way I shape my narrative of myself may change, but I retain an ongoing narrative self despite the disruption. Similarly, a disruption to the minimal-self would have wide-ranging implications for one's experiences and oneself, but this does not eliminate the possibility of experiencing. Worries that a minimal-self disturbance will render us unable to have a first-person perspective are therefore too hasty. As Zahavi puts it,

a disruption of the minimal-self causes the automatic saturation of our experiences with a sense of self to cease (2008, 135) without making experiencing itself impossible. A disruption to the minimal-self does not imply that first-person experiences will cease. A person's sense that their experiences are uniquely theirs is disrupted, not the experiences themselves.

A second objection argues that schizophrenia really does represent a kind of self-disturbance while claiming that the ipseity disturbance model characterizes this disturbance incorrectly. According to the ipseity disturbance model, the self-disturbance in schizophrenia changes how a patient automatically relates and attends to their body and mental states, alienating the patient from themselves and their world in the process. An opposing view put forward by Aaron Mishara – the subcomponents model – argues that the self-disturbance in schizophrenia is a disruption of the automatic processes which make me myself (Mishara 715). This disruption involves "dysfunctional pre-attentive binding between subcomponents of self" (such as "I", "me", "mine") prior to my awareness of myself as a unitary self (715). Normally my experiences, memories, volitions, character traits, etc. are bound to me and unified as a single subject – "I" – in a way that makes all these components seem unproblematically unified. The subcomponents model argues that these components of the self are separable and are unified by pre-attentive processes which can be disrupted. Schizophrenia disrupts these processes, causing these components of the self to become disunified, thereby causing the characteristic symptoms of the disorder.

The subcomponents model seems to argue that there is a short distance between my "I" and my perceptions, memories, thoughts, actions, etc. which is usually pre-reflectively bridged, but that this bridging process is disrupted. There is a tension between myself and my mental and physical states; I am normally myself *and* my various states, but I can dissociate myself from these parts of myself (Mishara et al 7). There is thus a space between these parts of myself which must be bridged to give me a unified self (7). Schizophrenia disrupts this bridging process,

resulting in passivity symptoms (7) by disconnecting me from myself, separating the "I" from parts of myself. This disruption would impact my ability to move between different frames of reference concerning myself (7). For example, conscious awareness that "I move myself" requires bridging the gap between "I" and my body, requiring me to understand that "I" and "my" are both parts of myself despite the distance between them (7). Similarly, our perceptions would be disrupted by a failure to bridge the gap between "I" and "my," resulting objects losing we perceive losing their context for us (Uhlhaas & Mishara 145-146). The resulting change in context and salience causes delusions as we try to make sense of the changed meanings we perceive (147). According to the subcomponents view, I am composed of multiple interlocking yet separate components, and this unity is disrupted in schizophrenia, affecting my ability to understand how the parts of myself fit together.

An important consequence of this model should be that a person's ability to represent themselves and others in narratives will be disrupted in particular ways, showing a decentering of oneself from the narrative and difficulties integrating different modalities of thought into a coherent while (Mishara et al 7). Patients with schizophrenia should be less able to weave together the mental activities and worldly context of themselves and others into a coherent narrative (7). If schizophrenia causes the bridge between "I" and "my" thoughts and context to collapse, patients should have difficulties providing rich descriptions of the thoughts and context behind their behaviors and circumstances. Mishara et al cite studies showing that patients with schizophrenia produce impoverished narratives of themselves compared to their family members and patients with long-term non-psychiatric conditions which demonstrate difficulties identifying aspects of themselves (9). In addition, there is evidence that lower levels of metacognition are linked to higher levels of negative symptoms (9), that is, worse presentations of schizophrenia. Finally, lower levels of metacognition seem to correlate with worse recovery outcomes for patients and a poorer sense by patients that they will recover (9). Taken together, this is supposed

to show that schizophrenia is primarily a disruption of processes binding the parts of myself into a single subject. Disruptions to these processes would have a profound impact on how we experience and understand ourselves and the world around us. This should manifest in difficulties producing narratives which coherently take all the mental states and circumstances a person is into account, which Mishara et al argue the evidence indicates.

One possible response is that the ipseity disturbance and subcomponents views are ultimately offering the same explanation for schizophrenia. The ipseity disturbance model claims that disturbances of the minimal-self affect the first-person givenness of my experiences, changing how they feel to me. This loss of first-person givenness causes me to attend to my experiences explicitly, driving a process which further diminishes my sense that I am a subject with my own perspective. The subcomponents view arguably claims something similar; the process or processes bridging the gap between "I" and my various states is disrupted, disconnecting me from my experiences. I lose pre-reflective access to the "myness" of my experiences and to various parts of myself, which gives rise to schizophrenic symptoms. Both views involve a disruption of the givenness of my experiences and consequent changes to how I relate to others, myself, and the world. If we describe disturbances of the minimal-self in terms of a distancing of the self from my sense that my experiences are my own, both views might be making the same claim. In that case, both views would describe schizophrenia as a collapse of the bridges which normally connect different components of our experiences. My experiences are no longer pre-reflectively given to the "I" as mine since the process underlying this – the minimal-self – has been disrupted. If this redescription accurately portrays both the ipseity disturbance and subcomponents views, then they may ultimately be offering the same account in different terms.

If this redescription is inaccurate and the views are distinct, we should prefer the ipseity disturbance model because it seems to offer a better explanation for the studies on schizophrenia I have presented. First, the narrative studies presented by Mishara et al can be explained in terms of

the ipseity disturbance model. If the "myness" of a person's experiences is disturbed and their grip on the world is loosened, we would expect any narratives they produce to reflect difficulties distinguishing self from other and difficulties remembering their experiences. Indeed, these problems appear in patient narratives (Mishara et al 9). We should take this to indicate that these studies should not conclusively support either model; both models highlight parts of patient narratives as significant.

In addition, it is unclear how the subcomponents view would explain changes in patient's experiences which happen in the prodrome. Patients in the prodrome often experience enduring changes to their personality and experiences, becoming engrossed in esoteric and existential concepts which were previously of little interest (Møller & Husby 223). In many patients, this change develops in schizophrenia proper into enduring concerns about the nature of reality and an active adoption of eccentric understandings of the world (Stanghellini & Ballerini 136-138). Patients with schizophrenia often undergo a personality change and become invested in understanding their new experiences, developing an opposition to conventional norms in the process. These changes offer support for the ipseity disturbance view, since they show patients hyperreflexively attending to ideas previously taken for granted, becoming engrossed in those ideas and losing their sense of themselves as selves in the process (Sass & Parnas 438). It is unclear how this personality change could result from a disruption of the process binding the parts of myself together. The subcomponents model may try explaining these changes as stemming from difficulties with metacognition (Mishara et al 9); patients experience difficulties thinking about their experiences, so they are forced to think about the world unconventionally. However, this seems implausible given that these new attitudes towards the world seem metacognitively intensive. In addition, the patient's thoughts are split off from their "I" according to the subcomponents model, which should make it difficult for patients to think about their thoughts. Since the "I," "my" and "mine" are dissociated according to this view, it seems that

patients should be passive towards any esoteric ideas they think, rather than becoming engrossed in them to the point of changing their personality. Since the subcomponents model seems unable to provide an explanation for these personality changes in schizophrenia while the ipseity disturbance model can, we should prefer the ipseity disturbance model.

Closing Considerations – Self-disturbances and Other People

I will conclude this chapter by discussing another way of understanding disorders to the minimal-self which Matthew Ratcliffe discusses. According to Ratcliffe, the minimal-self – or something like it (16)[15] – is developed and sustained by interactions with other people, and disruptions to those relations can also disrupt the minimal-self (17-18). A concern he expresses is that minimal-self disturbance models like the ipseity disturbance model discuss the disturbance central to schizophrenia as a fundamentally individual phenomenon (16-17). The hyperreflexivity-diminished self-affection loop within myself drives changes in my experience, and these changes disrupt my relationships with other people; a change within myself is the fundamental cause of all schizophrenic symptoms. Ratcliffe argues that how we relate to others is an important part of how we experience the world, that our trust in others shapes the modal structure of our experiences (176-177). Under normal circumstances, our interactions with others are governed by a shared pre-reflective trust in other people, a trust that others are reliable and not inherently dangerous (148). This trust affects the way we experience the world in fundamental ways. For instance, knowledge is something we verify with other people (148), we act in a world where others do not foreclose the possibility of achieving our goals (149), and we interact with others within a structure of pre-reflectively understood norms (146-147). The way we know, as well as how we distinguish between knowing and believing, normally involves references to the

[15] Ratcliffe is agnostic to the claim that schizophrenia is caused by a disruption to the minimal-self (16, 181). For him, we have something like what Zahavi calls the "minimal-self" and schizophrenia diagnoses are sometimes associated with changes to aspects of experience connected to that minimal-self (16-17). The view Ratcliffe articulates is supposed to be compatible with a minimal-self disturbance model (181), so I will be talking in terms of the minimal-self in this section.

epistemic states of others; something we *know* is something which is intersubjectively true. Thus, others are part of the modal structure of knowing.

A disruption of our pre-reflective trust in others also disrupts the modes of experience which rely on our relations with others. Losing one's pre-reflective trust in others leads to a collapse of these modes of experiencing; not trusting others as knowers changes the way in which one knows or accepts propositions (148). If I do not trust others as competent knowers or think they are trying to deceive me, I will no longer make reference to or seek the perspectives of other people when thinking that I know something. Similarly, if my trust in others collapses and the world seems threatening, my sense of agency will be diminished and the distinction between activity and passivity will be vitiated (149). In a world where others appear hostile to my goals and seem to thwart my actions, my sense that a robust distinction between activity and passivity exists will be attenuated, since I lose the sense that I can achieve my goals (149). In this way, changes to how I relate to others profoundly affects my experiences.

This pre-reflective trust in others can be lost after a person experiences trauma. Ratcliffe shows that rates of part trauma are high in people diagnosed with schizophrenia and that the vast majority of people who experience psychosis have experienced at least one traumatic event in their life (171). While he acknowledges that a causal connection between schizophrenia and trauma has not been established, this indicates that a loss of trust in others could explain disturbances to the minimal-self (172). Losing one's disposition to trust others leads to hypervigilance in an attempt to prevent harm from others (173). This causes a disconnection between self and world; there are no safe ways of interacting with others, so modes of engaging with the world which involve others must change (or be eliminated) to protect the person (173-174). The interpersonal aspects of knowing, believing, judging, learning, etc. are vitiated, preventing one from engaging with the world in the same way (173-174). Without trusting that others are not actively hostile, verifying one's perspective against those of others becomes a

dangerous proposition, so those activities fall away. This is also supposed to explain the patient's loss of their pre-reflective grip on the world (175). Trauma makes them lose a disposition of trust towards others, disrupting their ability to pre-reflectively understand and connect with others (175); colloquially, we might say they are placed "on a different wavelength." Changes in how one relates to others are supposed to change how we relate to the world and the structure of our experiences.

Whether the ipseity disturbance model should be modified to accommodate Ratcliffe's criticisms will depend on whether a loss of pre-reflective trust can explain the experiences and development of schizophrenia in patients. One consideration in favor of Ratcliffe's view is that patients with schizophrenia often feel detached from other people and may actively refuse to connect with others (Stanghellini & Ballerini 137). Corresponding behavioral changes occur in the prodrome, with patients withdrawing from – and in some cases avoiding entirely – social interaction (Møller & Husby 223-224). These changes could be due to a disruption of their pre-reflective trust in other people, making others seem threatening or unpredictable (Ratcliffe 147-148) and motivating social withdraw. If the population Ratcliffe discusses who have psychosis and experienced trauma (171) were traumatized before developing psychosis, that would also provide evidence for his view. Evidence that schizophrenia is heritable to some extent (APA 102) neither supports nor detracts from Ratcliffe's view; patients with a genetic predisposition to schizophrenia could develop the disorder without interpersonal stress being a contributing factor, or trauma could push someone genetically vulnerable over the edge. So, there are possible reasons why interpersonal considerations might be given a larger role in the ipseity disturbance model. Since this question is not central to my thesis, I will not attempt to adjudicate this question.

In conclusion, we should understand schizophrenia as a disturbance of the minimal-self which gives rise to characteristic symptoms. The minimal-self makes our experiences ours – gives them

their first-person character – and disruptions to it weaken our sense of ourselves as agents. This weakened sense of agency leads the sufferer to attempt to consciously compensate for the loss of functionality, explicitly attending to normally lived phenomena, thereby further vitiating their sense of self. This vicious loop is the core of schizophrenia according to the ipseity disturbance model, resulting in symptoms stemming from the abnormal experiences of the patient. These experiences serve as diagnostic markers for schizophrenia and its prodrome, allowing us to distinguish schizophrenia from other mental illnesses clearly.

CHAPTER IV

IMPLICATIONS FOR THE SELF

In this final chapter, I will present three implications my discussion of schizophrenia has for our understanding of the normal self. I will begin by briefly justifying the idea that we can learn about the normal self by looking at non-normal selves. I will then present three aspects of the self which schizophrenia highlights: the self is composed of multiple parts, these parts are vulnerable to disruption, and these disruptions largely affect automatic processes – like our attention or memories – and are therefore difficult to notice. While discussing these aspects, I will briefly present how they were discussed in the history of philosophy. I will also show how two opposing views of the self – a Deleuzian and a Freudian view – succeed or fail to accommodate these aspects of the self in order to demonstrate how different views can or cannot accommodate these aspects.

Initially, one might argue that we cannot draw any conclusions about the self from an investigation of schizophrenia, since mental illness is defined by being different than the normal self. In the introduction to this thesis, I stated that we need an understanding of normal subjectivity in order to understand mental illnesses (Stephensen & Parnas 2). That is, our understanding of mental illness depends on our already understanding the normal self. Schizophrenia disrupts the minimal-self and produces symptoms which differ from our normal experiences, but we understand these abnormal experiences *as disruptions* because we already

understand the normal self. For example, delusions are defined as unusually resistant to interrogation because we understand what beliefs are, just as hallucinations are percepts which are not really there because we understand normal perception. We understand these symptoms as divergences from normal subjectivity because we already possess an understanding of the normal states which they deviate from. In the same way, we can understand schizophrenia as a disruption of the minimal-self which results in symptoms *because* we understand the normal self which is disrupted. If our understanding of schizophrenia comes from its being defined as a lack of normal subjectivity, we might be unable to learn about the normal self by looking at schizophrenia.

Even if we accept that normal subjectivity is used to define and demarcate mental illness, we can learn about normal subjectivity by looking at the functions which mental illness disturbs. We can see this by drawing an analogy between mental and physical health. We understand diseases like the flu and damage to the body like a broken leg as diseases or damage because they take away our health. Symptoms of diseases and the consequences of injuries are understood against a background understanding of physical health; they are defined as an absence of health. However, we can look at diseases and physical damage to improve our understanding of physical health by highlighting how bodily systems are supposed to work and how they respond to disruptions. For instance, looking at the flu or other diseases can show us how the immune system responds to threats and how parts of the body react to illnesses. Damage to Broca's Area in the brain causes specific deficits in speech production, giving us insight into how functions are mapped onto the brain. In these examples, a lack or loss of physical health gives us greater insight into what constitutes physical health, showing how the body responds to damage or threats as well as showing us the normal function of body parts by negation. Similarly, looking at mental illness can clarify what normal subjectivity consists in as well as the mental functions which normally make it possible. In the case of schizophrenia, I have argued in chapter 2 that schizophrenia should be understood as a disruption of how the minimal-self normally operates.

Through this disturbance, schizophrenia highlights features of the self which would otherwise be difficult to notice.

First Implication – The Self is Composed of Multiple Parts

The first implication my discussion of schizophrenia has for our understanding of the self is that the self is composed of multiple parts. As I have discussed, schizophrenia disrupts the minimal-self, which affects our pre-reflective sense that our experiences are ours, which in turn has wider consequences for the self. Crucially, the minimal-self performs certain functions, like making my experiences feel like my own and giving me experiences in the first-person, which are important functions of the self as a whole. However, the self also performs functions which the minimal-self plays no part in, like possessing a personality and memories that are continuous over time. These other features can be also be affected in schizophrenia, but they are not necessarily affected and are secondary to the minimal-self disturbance. Since the self performs other functions which the minimal-self does not account for, we should conclude that the self is composed of multiple parts. To be more than a being with first-person experiences, the self must be composed of multiple parts which perform those functions. Without committing to a particular number of parts which the self has, in this chapter I will assume that the minimal-, autobiographical, and narrative selves are parts of the self which capture important dimensions of our subjectivity. The narrative self refers to a continuous "story" of one's life which is told in collaboration with other people, capturing one's personality and relationships with others over time (Zahavi 2008, 107-109). The autobiographical self (Sass 2014, 7) refers more narrowly to one's memories and personality and their continuity over time. These parts of the self capture the personal and interpersonal aspects of our lives, allowing us to remain the same person to ourselves and others.

This way of describing the self differs from descriptions offered prior to the 19th century. The claim that the self is multifaceted seems obviously different from the view attributed to Descartes, for instance.[16] According to Descartes, my self is metaphysically simple; I am a thinking thing (Tekin 2020, 2). Since I am aware that I exist through mental activity, and since the only thing about myself I cannot doubt is that I am thinking, I must fundamentally be a thinking thing (Descartes 17-18). Since I am fundamentally a thinking thing and no other kind of substance can think, the self must be metaphysically simple even if one takes the mind-body union as the basis of the self. By contrast, I am claiming that the self is a composite whose parts perform functions necessary for us to be selves in a robust sense. These parts of the self allow me to experience my experiences in the first-person, have an individual personality and continuous memories, maintain social relationships with others, and perform any other functions central to my self. Without an autobiographical self, for instance, I would remain myself in the sense that I am the one who has my experiences, but I would lack my memories or personality. Together, these parts of the self make selfhood possible, whereas a single, unified substance performs all these functions according to the view typically ascribed to Descartes.

How can the insights into the nature of the self be understood in terms of contemporary views of the self? While I cannot exhaustively discuss every view of the self which exists and show how they can or cannot accommodate my claims, I will present two views which can serve as poles around which other views of the self can distribute themselves. That is, these two views will accommodate – or fail to accommodate – the implications for the self I present in a way that can show us how other views of the self could respond as well.

[16] According to John Cottingham, many of Descartes' positions make more sense if we view him as a trialist rather than a dualist (224-225). That is, adding a third substance – mind-body Unity – to Descartes' account of human nature makes sense as an interpretation of his works (224-227) and solves common criticisms that his view faces (218-219). However, since my discussion of Descartes' views is focused on briefly presenting past views of the self which influence the discursive landscape, I will not attempt to reconstruct a trialist view of the self.

One way of understanding the self is as a process rather than a discrete entity. One such view is put forward by Gilles Deleuze and Félix Guattari, who argue that the self is a multiplicity which cannot be understood as a single, unchanging thing (Wolves 29). Against the Freudian view that multiple psychic currents converge and create a single self (27-28, 31), they claim that we are populated by psychic phenomena which influence one another, and which form a continuum with our environment (30-31). For instance, they begin *A Thousand Plateaus* by saying: "The two of us wrote *Anti-Oedipus* together. Since each of us was several, there was already quite a crowd" (Rhizome 3). That is, there was no single Gilles Deleuze that made his entire contribution to *A Thousand Plateaus*, but a succession of selves which emerged throughout the writing process. "The Self" as an independent, hermetically sealed entity does not exist. Rather, we are an ever-changing multiplicity of selves susceptible to influences from the world and other people.

Understanding Deleuze and Guattari's view of the self requires understanding core concepts of their philosophy; rhizomes and bodies without organs (31). Rhizomes refer to a kind of unity through multiplicity (Rhizome 6), a structure without a pre-defined starting point in which each part is connected to every other part (6-7). Multiplicities are different than groups of multiple things or multipart, unified objects (8). A multiplicity is like a swarm, having no principle which organizes or regiments its parts relative to one another, and is something which changes in nature whenever its parts change in relation to one another or the world (8). They need to be understood as genuinely independent entities, rather than as many entities grouped and acting together. A crowd of people at a concert is an example of a multiplicity. The crowd has its own behaviors and psychology over and above that of its members, responding to changes in the concert as well as changes within the crowd. A stellar performance can electrify the crowd and individuals trying to push onto the stage can get the crowd moving towards it. The crowd is thus an entity in its own right with behaviors and motivations which do not reduce to those of its

members. Rhizomes are composed of lines in motion (Rhizome 21) which organize the multiplicity and allows it to recontextualize itself and its environment (9-10). They are eternally becoming, being defined by a constant change of states as new connections are made and as the environment they are connected to changes (21). They are processes connected to other processes.

The body without organs is a rhizomatic way of understanding of the body; the body and its parts are a multiplicity, rather than a collection of connected yet separate entities (Wolves 30). Since all our organs and actions affect one another and would function differently – or not function at all – if each part did not contribute to every other parts' functioning, speaking of discrete organs obfuscates the essential interconnectedness of the organs (Schizophrenia & Society 20). For instance, a functioning heart is necessary for us to breath, digest, think, move, etc. and the heart depends on the functioning of our lungs, stomach, brain, etc. to function. Every part of the body is connected to every other part through our nerves and circulatory system. In this sense, the heart contains the functions of all other organs within itself (20). The body should thus be understood as a rhizome, as a constantly changing process which create connections between the body and environment.

For Deleuze and Guattari, the self is a rhizome, a multiplicity which is constantly changing by drawing new connections with others, the world, and within ourselves (Wolves 30-31). The self must be understood through the connections it forms and severs with its environment (29). For Deleuze and Guattari, the self is analogous to a wolf; it must be understood with reference to its pack, and a single wolf completely disconnected from others would not survive for lonf (29). Similarly, the self is composed of lines in motion which enter and exit the rhizome, causing it to constantly change with respect to oneself and the world (30-31). We connect ourselves to the world around us, changing ourselves and the world in the process. Furthermore, parts of the psyche move in relation to one another and form new associations,

changing the nature of the rhizome, thereby creating a new self. As lines within the self move in relation to one another or objects in the world, how I relate to myself and the world changes, causing the self to change in the process. The self is thus a process in motion, in which movements of parts of the self change how I perceive the world and my thoughts, changing who I am in the process.

Accepting this view would provide a way of understanding the self as composed of multiple parts in a sense. A single self seems to exist at a time, but that self changes quickly as new connections are drawn or broken. While one self presents itself at a time, each is replaced as time progresses. In addition, the self as a multiplicity is a moving process with many connections between itself and the world as well as within itself. As we connect ideas together, perceive things in the world, and think about our actions, new connections are formed to facilitate these processes. In this way, we have something analogous to the multiple parts of the self I presented in the beginning of this section. The roles of the autobiographical and narrative selves can be performed by these connections; the memories I have and my interactions with others are parts of myself which make me myself in a significant way. However, their view would reject the claim that there is a minimal-self as understood by the ipseity disturbance model. For Deleuze and Guattari, the self has multiple parts in the sense that connections between parts of the psyche and the environment are constantly being made and broken. However, this makes this makes describing a part of the self which is responsible for making my experiences *mine* impossible. The minimal-self is a stable part of the self which endures psychological and environmental changes, but seemingly cuts against Deleuze and Guattari's view of the self.

Another kind of view of the self we could use is one where there is a single self which is composed of or differentiated into multiple parts. One proponent of such a view is Sigmund Freud, who argued that the self is a whole which is differentiated into parts (Freud 19, 35-36). According to him, the self begins as the id, which houses our instincts (19) as well as unconscious

mental states repressed by the ego (17).[17] The ego forms as a differentiated part of the id which contains our conscious thoughts, and which is concerned with the external world (17-19). It is a "bodily ego," deriving its existence primarily from external stimuli affecting the body (20) and allows us to move ourselves and interact with the world (19). As the id's "representative of the external world," any animal which must respond to environmental stimuli also has an ego (35). In humans, the ego in young children begins to identify with objects to manage the id (24-25), leading to the creation of the superego (26). The superego develops out of the ego's identification with the father to repress the Oedipal Complex (30). It issues in ought and ought not commands (30) and has conscious and unconscious components, allowing us to morally judge ourselves unconsciously (21). The self for Freud thus consists in a self which is differentiated into different components, each of which performs different roles.

A large part of the self for Freud is unconscious; the conscious components of the self are built upon the id (Freud 17-18), which is concerned with our internal world (19). These parts of the self exist to serve specific functions, allowing us to better satisfy our needs and desires while maintaining relationships with other people (35-36). The ego as a differentiated part of the id gives us the ability to sense and interact with objects (19) while the superego allows us to uphold the moral norms and rituals which allow society to exist (33-34). In addition, these parts of the self conflict with one another. The superego is borne out of the repression of the Oedipal Complex, for instance, and issues commands to restrain the ego (30). It was created by the ego to keep the id in check, but soon comes into conflict with the ego. In addition, the ego represses conscious thoughts into the id and attempts to forcibly keep them from rising back up to

[17] The id – *das Es* (Freud xxxii) – can also be translated as *the it*, while the ego – *das Ich* (xxxiii) – can be translated as *the I*. That is, the self is primarily built upon an unconscious thing, upon which our conscious thoughts and moral judgments exist.

consciousness (17-18). This can lead to neuroses as repressed thoughts interact with the id, causing unconscious psychic forces to influence our conscious thoughts (8-9).

This view of the self already accepts that the self is composed of multiple parts. The self is divided into the id, ego, and superego, each of which plays a separate role in our mental life while allowing us to interact with the external world. The minimal-, autobiographical, and narrative selves could be described as picking out relevant features of the id, ego, and superego. For example, the superego allows us to maintain relationships with other people by issuing commands to control our immediate desires, serving a function necessary for the narrative self to exist. The minimal-self would pick out psychic processes in the id which are unconscious and make my experiences mine. Thus, Freud's view can describe the self as made of multiple functional components.

Second Implication – The Self is Vulnerable

Another important feature of the self this discussion reveals is that the parts of the self are vulnerable to disruption. As I have argued, schizophrenia should be understood as a disruption of the minimal-self which has wide-ranging consequences for a patient's experiences. Disruptions to the minimal-self change how I relate to my experiences – how I experience them – altering my self in the process. The same is true of other parts of the self. The autobiographical and narrative selves are disrupted by amnesia, causing a person to lose who they are and who they are socially connected to or, in the case of anterograde amnesia, to become stuck in the past in a sense. The ecological self, which Neisser defines as our basic awareness of ourselves as embodied agents embedded in our environment (Zahavi 2008, 199), can be disrupted by losing a sensory modality we oriented ourselves around or by losing our sense of embodied subjecthood. We gain information about the world by moving through it, becoming aware of the external world as well as our own nature as embodied beings within it (199-200). Losing a sense which we used to

determine our position in the world, like our sight, would harm our ability to understand how we are situated relative to other objects, which could vitiate our sense of corporeality. More dramatically, a lost or vitiated sense of being an embodied subject, which can occur through depersonalization or derealization (APA 291, 302-303), would unmoor a person from the world, undermining their sense of being a self capable of acting. The parts of the self are vulnerable to disruptions which affect important functions we normally take for granted.

This also shows us that the self as a whole is resilient and can endure disruptions. A disruption to the minimal-self can radically alter my experience of myself and the world, and a disruption to the narrative self can affect my memories and relationships with others. However, the self endures all these disruptions. While I would be subject to dramatically different experiences after parts of the self are disrupted, *I* am still the one having those experiences. That parts of the self can be disrupted, thereby changing how a person experiences the world, also reveals that the self as a whole can survive these changes.

This view that the self can be disrupted was not explored thoroughly before the second half of the 19th century. In the *First Meditation*, for instance, Descartes raises the possible doubt that he is insane before claiming that he could be asleep, having a vivid dream (13). He initially rejects the possibility of being insane out of hand but recognizes that we should seriously consider the possibility that we are dreaming, since dreams can seem life-like while we dream (13). Tekin claims that Descartes does not consider the possibility of a disordered self, given that the possibility of insanity is not examined in depth (2020, 2). Since the possibility that he is insane and all his perceptions are merely images his own mind produces is quickly dismissed, Descartes does not imagine the possibility of a non-normal self (2).

While I agree that Descartes does not seriously consider that the self could be disrupted, his treatment of mental illness seems more complicated than a simple dismissal. While asleep, we

can have the same – or more fantastical – experiences as "madmen," so we have reason to doubt our senses according to Descartes (13). Descartes quickly dismisses the possibility of insanity because using insanity as a model for the state we are in would be "equally mad" (13). However, this quick dismissal is recognized as too hasty and serves as a springboard for enumerating reasons why being asleep gives us reasons for doubt (13). Within the structure of the *Meditations* as *meditations*, as a path we should seriously attempt to lead our minds down, noticing that *we* are too quick to preserve the truth of our senses helps us bring them into doubt. In this limited way, Descartes' brief mention of mental illness is essential to his project. It remains the case, however, that Descartes does not treat disturbances to the self as possible, treating mental illness as an edge case we can ignore.

Most philosophers prior to the 19th century treated mental illnesses as exceptions to the norm in thought experiments to prove or disprove philosophical models. Locke does so when discussing his psychological continuity thesis, arguing that we should not punish "the mad man for the sober man's actions, nor the sober man for what the mad man did" (Quoted in Tekin 2020. 3). Madness is used as a possible condition which makes one not oneself without seriously inquiring into what the self looks like in mentally ill people (3). Serious philosophical attention to views that the self (and any of its parts) is vulnerable began in the late 19th century along with the development of psychology and psychiatry as fields of study (3-4). William James argued for a four-part self and claimed that disruptions to these parts causes mental illnesses (3-4). Psychiatrists and psychoanalysts also argued that the self is vulnerable to disruption. As I stated in chapter 1, Bleuler described schizophrenia as a change in associations, which alters the pathways down which psychic pathways travel (Bleuler 68). This should be understood as a disruption to the self; the normal constitution of the self is altered, changing how the patient thinks about and interacts with themselves and the world. Just as changes to the minimal-self are disruptions which alter how we regard our experiences, changes to associations should be seen as

disruptions affecting the entirety of psychic life. Freud and other psychoanalysts viewed the self as vulnerable to upwellings from the unconscious (Tekin 2020, 3) as well as reversions to earlier developmental stages (Sass 1987, 5-6). The view that the self and any of its parts is vulnerable to disruptions is a recent innovation which has gained popularity as psychology and psychiatry have developed as fields.

Deleuze and Guattari's view of the self as a multiplicity seems ill-suited to describe parts of the self as vulnerable for two reasons. First, the vulnerability of the self is an implication of the discussion framing schizophrenia as a disruption of the minimal-self, whereas Deleuze and Guattari hold a fundamentally different view of schizophrenia. For them, schizophrenia marks a return to the primordial freedom of humankind (Wolves 34, Sass 1987, 7-8) and a breaking out of oppressive social systems through to the real world (Schizophrenia & Society 25-27) rather than a disruption. The schizophrenic retains their individuality instead of being submerged into the mass, remaining in close contact with the real world (Wolves 34). They serve as "the limit of our society," marking the boundary between human and non-human, occupying a position which allows – and forces – them to contemplate the nature of reality (Schizophrenia & Society 28). Schizophrenia is thus a return to humanity's original state, a state of freedom which reigned before social conventions restrained human instincts and desires (Sass 1987, 7-8). Since schizophrenia is supposed to reveal the vulnerability of the self, and Deleuze and Guattari do not view schizophrenia as something disruptive in the required sense, they may not agree that the self is vulnerable in the way I have discussed.

A more significant issue with describing the self as vulnerable on this view is that the self as a process and a multiplicity is something ephemeral rather than vulnerable. Since the self is a rhizome, it is always changing as connections are made and broken within the rhizome and with things in the world (Wolves 30-31). Changes to part of the multiplicity changes the multiplicity as a whole *as well as all of its parts* (31). Considered as a multiplicity, a swarm of bees and the bees

within it are constantly changing (31); when a bee in the swarm moves, the positions of every bee relative to the first bee changes, so the swarm as a whole changes slightly. The movements of the swarm changes the positions of the bees, and the movements of the individual bees changes the location and composition of the swarm. Similarly, a change of perspective, a new thought, or a new connection between mental states changes the self. As a multiplicity, the self is always changing, with selves quickly giving rise to new selves. On this picture, describing the self or its parts as vulnerable misdescribes the nature of the self. The self is ephemeral, constantly changing as changes to the environment and to our mental processes are made.

Modifying this view to describe the process which creates the self may be possible, in the sense that the multiplicity could be radically altered such that the selves the process produces are significantly different. For example, trauma may affect how connections between points of the rhizome are formed or make some connections easier or harder to form, shaping the process such that any selves which are produced are significantly different than what would have been produced. That is, the selves a person experiences after suffering trauma are significantly different than the selves they otherwise would have had. While describing the self as vulnerable in a counterfactual way may be possible, the view Deleuze and Guattari provide does not obviously provide such an account.

While a Freudian view of the self can describe parts of the self as vulnerable to disruption, the kind of vulnerability involved is different from the self-disturbances described by the ipseity disturbance model. According to the model, disturbances to the minimal-self caused by schizophrenia detract from the minimal-self's functioning. That is, the minimal-self is vulnerable in the sense that its ability to give us experiences in the first person can be diminished, which has consequences for our experiences and sense of self.[18] Similarly, disruptions to the

[18] Notably, Deleuze and Guattari may object to this characterization of the disturbances in schizophrenia (Schizophrenia and Society 26-27). This characterization presents the disturbance of the minimal-self as a

autobiographical self – in amnesia or widespread forgetfulness – takes something away from us, taking away our ability to have continuous memories and a continuous personality. The kind of vulnerability involved is thus a vulnerability to losses of functions required for normal self-function. Freud and other psychoanalysts describe the self as vulnerable in a different sense, however. On their view, schizophrenia indicates that the self is vulnerable to reversions to an earlier developmental state (Sass 1987, 5-6). Schizophrenia is supposed to be a reversion to an infantile level of cognitive development before a self-non-self distinction is drawn, that is, before the ego is differentiated from the id (5). The self is thus vulnerable to "a lowering of the psychic level" to an earlier developmental stage (26) rather than a loss of functionality. The self and its parts on this view are vulnerable to deterioration, like a weakening of boundaries between the ego and id, which is more destructive than a mere loss of functioning. In a sense, the Freudian self is *more* vulnerable to disruption; the self is a developmental achievement which can collapse.

Third Implication – Disruptions Affect Automatic Processes

The final implication my discussion of schizophrenia has for our understanding of the self is that change to parts of the self affect largely automatic processes, making alterations more difficult to notice. In schizophrenia, disruptions to the minimal-self vitiate one's sense of self and change which features of oneself and the world appear significant, thereby changing which things one attends to (Sass 2014, 7). Diminished self-affection and hyperreflexivity are automatic processes, changing a person's perspective by making different things "pop-out" (7) as important without any conscious effort. These changes significantly affect how one understands and interacts with the world; new objects and ideas begin appearing as especially salient while one's previously assumed sense of agency fades away. This can lead to personality changes (See Stanghellini & Ballerini) as these perceptual changes sediment into actional and attitudinal

taking away of function, whereas Deleuze and Guattari believe schizophrenia must be described "in positive terms" (26).

changes, and could cause hallucinatory experiences as percepts take on added significance. Thus, disruptions to the minimal-self affect automatic processes which underlie our normal [self-] perceptions, which has wide-ranging consequences for our personality, sense of self, and perceptions of the world. The changes to the patient wrought by schizophrenia do not need the patient's active participation to occur. Rather, the automatic processes making perceptions mine and a sense of self possible are altered, creating a cycle which changes what a person attends to while alienating them from the world.

Since these changes to the self affect automatic processes, they can be difficult to notice, especially if the changes occur over a longer period of time. While the changes in schizophrenia are dramatic when compared to our normal experiences, these changes can also be insidious, possibly taking years to fully manifest (Møller & Husby 228). This helps explain why noticing the development of schizophrenia in another person is so difficult; the changes are slow and not necessarily noticed by patients as symptoms worth reporting (218). Externally, changes in people's behavior brought on by self-disruptions can happen slowly, making them difficult to notice. Internally, these changes are often experiences as subtle and hard to describe (Sass & Parnas 437-438), making them difficult to pinpoint as indications of a mental illness developing. In the moment, subtle changes to what stands out to you or a subtle lack of felt agency would be difficult to notice. Since disruptions to parts of the self affect automatic processes, noticing these changes would be difficult.

Deleuze and Guattari's view of the self is amenable to the claim that changes to the self primarily affect automatic processes and are therefore difficult to notice. Since the self is a process, changes to it would involve changes to the mechanisms which produce the succession of selves arising as the rhizome creates or breaks connections. The changes in our attention or thoughts which create new connections are automatic to a significant extent, as we are constantly thinking and taking in sense data, and what we find worthy of attention is largely automatic based

on our present mental states. In this way, changes which affect the self are constantly occurring beneath our notice; the self is always in flux because of the automatic processes which bring the self into existence. In addition, disruptions to the self caused by schizophrenia can be understood as changes to how we automatically "structure" our consciousness. According to Deleuze and Guattari, the schizophrenic is like a wolf in a pack; they are part of a group but reside at its edge, constantly moving (Wolves 29) and redefining themselves in light of their surroundings. This is different from organizing as a mass, an organization in which one's identity is sublimated unless individual action is required for a defined purpose (34). Packs and masses form the two poles around which one's self as a rhizome can organize (33-34). That is, the self can organize itself and interact with the world in more pack-like or mass-like ways, which would affect the selves which are produced. In schizophrenia, there is a shift towards the pack-like end of this pole (Wolves 33-34), which for Deleuze and Guattari means the schizophrenic is organizing their self in a way that connects them with reality (Schizophrenia and Society 26-27). In this way, the self is a process which can slide towards or away from poles of organization, changing how connections between things are made, thereby changing how the self is produced and functions.

The Freudian view of the self as a single, differentiated entity also has the resources to describe changes to the self as affecting automatic processes. Profound changes to the self which cause a reversion to an earlier developmental phase alter how a person automatically understands their experiences as well as their ability to reflect on themselves. Normally, we automatically understand whether sensations originate from within ourselves or from something external, as well as the distinction between self and other. In schizophrenia, these distinctions can be vitiated, which represents a psychic regression and weakening of the ego according to psychoanalysts (Sass 1987, 6). This affects the processes which automatically interpret sensations as external, and which separates the self from its environment. As a kind of reversion, the disturbances to the self caused by schizophrenia can be seen as disturbances to automatic processes which help us

understand our perceptions. Other sources of self-disturbances, such as repressed psychic forces affecting the conscious mind (Tekin 2020, 3), are also explicable as changes to automatic processes in the self. For Freud, traumatic events (Tekin 2020, 3) and other memories repressed by the ego fall into the id and are actively kept out of the conscious mind by "the resistance of repression" (Freud 17-18). However, these repressed mental states can still communicate through the id to the ego (18), causing problems for the person affected. This conflict between the conscious and unconscious mind can lead to neuroses (9) which can affect how a person automatically views themselves, possibly leading to unconscious negative self-judgments (21). Attempts to think about the repressed source of the neurosis or concepts associated with it are met with resistance, which often goes unnoticed by the person affected (8). These processes are automatic, occurring in the unconscious and affecting our behavior. Thus, disturbances to the psyche can be understood as affecting automatic processes in the unconscious, making them difficult to notice.

Summary

My discussion of schizophrenia showed us that the self is composed of multiple parts, that these parts are vulnerable to disruption, and that these parts are responsible for many automatic processes which underlie important aspects of our lives. I described a Deleuzian and a Freudian view of the self in order to show multiple ways in which views of the self can – or cannot – accommodate these insights. While both views understand the self as multifaceted and as underlying automatic processes which can be disrupted, they understand the self as vulnerable differently than how I argued the ipseity disturbance model presents the self as vulnerable. Importantly, since Deleuze and Guattari present their views in opposition to Freud (Wolves 28-30),[19] discussing these views allows us to begin sketching the landscape within which other views

[19] As Sass argues, both views present schizophrenia as a return to a more primitive developmental stage, before we can self-consciously regulate our behavior (1987, 7-8). Deleuze and Guattari view this reversion

of the self fall. By understanding how the Deleuzian and the Freudian views describe the self and account for its aspects, we gain insight into explanatory strategies other views can use as well as general categories these views can belong to. For instance, we might describe the Deleuzian view as a "process view," in which the self is generated by a process rather than existing as an entity. Any views falling within this category need not conceptualize the self as a rhizome or accept Deleuze and Guattari's pack-mass dichotomy, but they would understand the self as generated, in some sense ephemeral, and have access to resources I presented in this chapter. Likewise, views similar to those espoused by Freud need not commit to the existence of the id, ego, and superego, but they would describe the self as a psychic entity of some kind with multiple parts. My discussion of these implications for the self thus gives us a preliminary sketch of the landscape we can plot views of the self upon as well as the means to classify them.

to a pre-civilized consciousness as quasi-volitional and a good thing (8), whereas psychoanalysts view this change as a reversion to an infantile level of development, which they see as bad (5-6).

CHAPTER V

CONCLUSION

In this thesis, I have attempted to present a model which allows us to understand the profound changes brought about by schizophrenia and to show how these changes can inform us about the nature of the non-disordered self. In the first chapter, I presented a brief history of how schizophrenia as a diagnosis developed. I argued that schizophrenia as a diagnosis shifted from one primarily concerned with cognitive decline to a psychotic disorder concerned with additions to a patient's 'normal' experiences. In particular, I discussed the contributions Eugen Bleuler and Kurt Schneider made to the diagnosis, contributions which form part of the basis for the ipseity disturbance model which I discussed in the second chapter.

In the second chapter, I presented and defended the ipseity disturbance model, which describes schizophrenia as a disruption of the minimal-self. The minimal self-is a thin concept referring to my pre-reflective sense that my experiences are *mine,* that they are given to me in the first person. It is concerned with the form my experiences take, making them experiences *for me* rather than experiences of another kind. According to the ipseity disturbance model, schizophrenia is primarily a disturbance of the minimal-self, which affects how patients view themselves as agents by impairing their pre-reflective sense that their experiences are first-personal. This disruption causes patients to explicitly attend to previously implicitly lived aspects of their experiences, further alienating patients from themselves and separating them from the

meaningful, intersubjective world. This vicious cycle is supposed explain the varied symptoms of schizophrenia – like hallucinations, delusions, anhedonia, etc. – and should be detectable before the onset of psychosis through subtle changes in a patient's experiences. Schizophrenia thus alters the form of one's experiences by vitiating their first-personal character, which has wide-ranging consequences as one's way of engaging with oneself and the world shifts in an attempt to compensate.

In the final chapter, I argued that describing schizophrenia as a disruption of the minimal-self shows us that the self contains multiple parts, that these parts are vulnerable, and that these parts underlie important automatic processes. Since schizophrenia disrupts the minimal-self and this disruption affects some – but not all – of the functions the self performs, we should conclude that the self contains multiple parts. Put another way, the self performs multiple functions and groups of these functions can be disrupted without affecting other functions, implying that the self contains different parts which govern different groups of functions. This also shows us that these parts can be disrupted, since we know that there are multiple parts *because* the minimal-self is disrupted in schizophrenia. Additionally, these parts control automatic processes, since disruptions to these parts affects aspects of our experiences like which percepts we automatically attend to. I also articulated two opposing views of the self – a Deleuzian and a Freudian view – to demonstrate how views of the self might grapple with my claims and to begin sketching a landscape within which different views of the self can be placed. By showing how these two diametrically opposed views understand the self, we gain insight into how other views can articulate what the self is and see how some strategies for accommodating or resisting my claims about the self function.

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