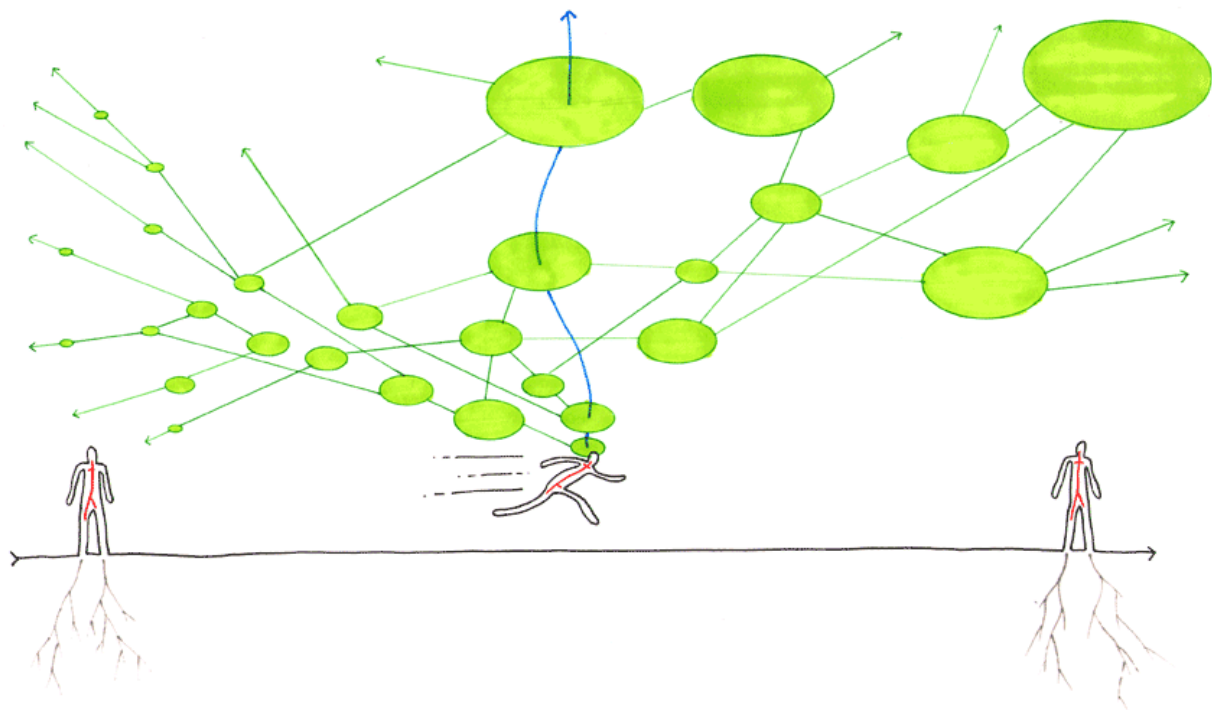


Psychiatry and subjectivity

An enactive phenomenological approach to mental illness

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“Man thinks because he has hands”

- Anaxagoras

“I finally manage to see the daylight through the barrier of myself by dint of renunciations in every phase of my intelligence and my sensibility. It must be understood that what is damaged in me is the living man, and that this paralysis that chokes me is at the center of my ordinary personality...”

-Antonin Artaud

The image on the cover is an original drawing by Marc Ngui, officially for his project of creating a methodical interpretation of the first two chapters of *Mille Plateaux (A thousand Plateaus)* by Deleuze and Guattari, for an exposition in 2006. This particular drawing belongs to paragraph 26 of the introduction.

Table of Contents

Introduction.....	3
1: Enactivism and Being-in-the-world	4
1.1: Dualism.....	5
1.2: The mind embodied and embedded.....	7
1.2.1: brain, body and world	7
1.2.2: Flow of activity and the human transducer	9
1.3: Being-in-the-world	11
1.3.1: Heidegger	12
1.3.2: Merleau-Ponty.....	14
1.4: Enactivism revisited.....	16
2: Mental disorders	17
2.1: Moods, psychiatry and phenomenology.....	18
2.2: The importance of ‘self’ in psychiatry	22
2.3: Case Studies.....	25
2.3.1: Loss of Self.....	26
2.3.2: Alienation	27
2.3.3: Hyperreflectivity and hyperautomaticity as coping strategies	28
2.3.4: Conclusions and interpretation of the case study.....	29
2.4: Feedback	30
3: Explanations, consequences and the limits of enactivism in psychiatry.....	30
3.1: Explanatory use of enactive phenomenology	31
3.2: Prescriptive effects of enactive phenomenology.....	33
3.2.1: DSM, diagnosis and methodology.....	33
3.2.2: Enactive phenomenological therapy.....	36
3.3: Disclaimer: the limits of enactivism in psychiatry	38
Conclusion	39
Bibliography.....	41

Introduction

In the last couple of decades more and more evidence has accumulated to support an enactivist theory of mind. Contrary to individualistic theories such as computationalism, an enactivistic theory of mind sees the brain more as a mediating organ than as the mind 'incarnate'. Instead, it proposes that the mind is embodied and deeply embedded in the world. Such a theory is of great consequence for our view of the mind and as a result for our view of the mind's malfunctions as well. A framework of enactivism would suggest a new way of looking at these malfunctions, or mental disorders; a view that entails that we see a mental disorder not just as a *brain* malfunction, but as a disorder in the subject's Being-in-the-world.

Indeed, the use of enactivism and phenomenology in psychiatry has seen a major rise since the early 2000's. A large amount of work focusses on the role of subjectivity and embodiment in disorders like schizophrenia or depression. This movement leans heavily on 20th century philosophers and psychiatrists such as Heidegger, Merleau-Ponty, Jaspers and Minkowski, but is at the same time supported by modern empirical and philosophical evidence. Although we can trace the direct focus on ipseity (selfhood) in psychiatry back as far as 1927 (Minkowski, 1927), recent publications are exciting because of the new insights that modern psychiatric research has offered. A reason for the recent trend in this phenomenological psychiatry movement is the dissatisfaction with the current leading dogma of internalism and the often inadequate definitions and concepts in the DSM, which result in a lack of scientific progress concerning mental disorders. This lack of progress has been related to the loss of the psychopathological tradition of early European psychiatry, rooted in phenomenology (Sass, Parnas, & Zahavi, 2011, p. 2).

All of this is interesting for at least two important reasons:

First of all, in order to gain a fuller understanding of how something works, it is always of great help to look into the malfunctioning cases and grasp what it is that goes wrong. If we understand why a mental process goes wrong, we may get closer to comprehending how mental processes work in general.

The second major reason concerns the mentally ill patients themselves. If indeed the enactive approach to mental illnesses is correct, then this supposedly allows patients to be treated more efficiently compared to how they are currently being treated. The idea of merely a malfunctioning brain should be discarded; the person as a living subject should be put back into psychiatry. This is

also the general thesis of this paper: *psychiatry will benefit from approaching mental disorders not as purely brain disorders, but rather as disorders of Being-in-the-world, that is, of a disorder in the intricate interplay of brain, body and world, with a focus on subjective experience from patients.*

The first chapter of this paper is focused on enactivism and Being-in-the-world. I will explain what enactivism is and why Being-in-the-world is such an important notion for enactivism. This will serve as a framework for the second and third chapter, which use an enactive phenomenological approach towards psychiatry.

In the second chapter I will show that enactive phenomenology is very useful for understanding mental distortions; describing mental disorders in an enactive way gives us a better understanding of what mental disorders are and how patients experience them.

The third chapter takes this approach to another level; it aims at giving explanatory value for psychiatric symptoms and suggestions for both diagnosing disorders and treating them.

1: Enactivism and Being-in-the-world

What is enactivism? Enactivism is an approach in the cognitive sciences that tries to understand our mental processes in relation to our experiences, our body and our interaction with the world. It is the view that cognition emerges through a dynamic interaction between an organism and its environment. Cognition, in this view, is basically an aspect of dynamic sensorimotor activity. The world that is experienced by an agent is not simply conditioned by the neural activity inside of the brain; it is instead essentially enacted by emerging through the bodily activities of an organism. This implies, among other things, that only an organism with certain bodily features is able to possess certain kinds of cognitive capacities and experiences; human vision can only exist with humanlike eyes.

The word 'enactivism' in this philosophical context was first coined by Varela (1987) and has been further elaborated by Varela, Thompson and Rosch (1991). They proposed enactivism as a conglomeration of five ideas in cognitive science (Thompson, 2007, p. 13):

- 1) Living beings are autonomous and active agents that engage their own cognition by being active and autonomous beings.
- 2) The nervous system is a dynamic system that actively generates and maintains coherent and meaningful patterns of activity of its own, as a circular network and in this way creates meaning.
- 3) Cognition is an active know-how in situated and embodied action.
- 4) A living being's world is a relational domain enacted by active coupling with the environment, rather than an internal representation of an external realm.

5) Experience is central in understanding the mind and should thus be investigated in a phenomenological way.

These five ideas combined then constitute the enactivism thesis, which is clearly closely related to the theory that the mind is embodied, extended and embedded in the world. These three cluster theories, together with enactivism are known as ‘the four E’s’ (Menary, 2010; Ward & Stapleton, 2012). There is a lot of disagreement among defenders of both separate and combined ‘E’s’ theses, but there are a large number of general agreements as well.² When I use the term *enactivism*, I refer to enactivism as the combination of the five ideas as described above. Roughly, enactivism is the view that cognition emerges through dynamic interaction between an organism and its environment. The most important other ‘E’-theses that support enactivism are, in my view, embodiment and embedment, and thus the focus of the first part of this chapter will be mainly on those two theses.

Years before the term *enactivism* was first used, Heidegger introduced the concept of *Being-in-the-world* (*In-der-Welt-sein*), which was then elaborated by Merleau-Ponty (*Etré au monde*). This concept can be seen as a sort of enactivism *avant la lettre*; Heidegger used the term to explain what it means for human beings to exist and argues that we exist primary as beings engaged in the world we are thrown into. Because of the continuing relevance of both *being-in-the-world* and Heidegger and Merleau-Ponty’s thought in general, this is something which this chapter will focus on as well.

The end of the chapter returns to the concept of enactivism, which will be better understood after the foregoing analyses. The chapter starts out, however, with a little background in order to better understand why the idea of enactivism is a radical theory.

1.1: Dualism

For a long time, the idea that there is a clear division between mind and matter has been dominant in Western thinking. This theory is called *dualism*. There is also another type of dualism, namely the dualism between person and world. In this chapter, both will be explained, starting with the first: mind-body dualism.

This idea is most clearly and certainly most famously touched upon by Descartes in his *Meditations* (Descartes, 2010). Descartes thought of the mind, or the soul, as a ghost inside of a machine; the machine being our body. Descartes makes a distinction between the *Res Cogitans* and the *Res Extensa*, respectively the thinking thing (the mental) and the extended thing (matter). Matter does not have thought and the mental does not have extension in space. Although Descartes’ theory has

² For those interested, Menary’s 2010 article is a great introduction on the debate within the four E’s. However, going into this debate is beyond the scope of this paper.

been subject to a lot of criticisms over time and his idea of a transcendental mind has been discarded by most, the mind is still seen as separated from most of our body, even in modern Western thinking. The new dominant theory is that the mind is in the brain. With famous titles such as '*We are our brain*' of popular science books, science seems to take the stand not just that the mind is to be found in the brain, the mind *is* in fact the brain (Swaab, 2010). Everything we do, say and are can be explained on a neurological account. The mind is limited to the brain and is consequentially skull bound. The rest of the body is still perceived as a machine which is controlled by the brain. Thus even though Cartesian dualism is dismissed, there is still a residual dualism; the dualism between brain and body.

The brain is identified as the corporeal part where the mind houses. Or rather, the brain *is* the mind and since the mind is who you are, *you are your brain*. The brain has replaced the immaterial spirit as the ghost in the machine, the difference being that it is now a 'material ghost'. This is what philosopher Daniel Dennett calls 'Cartesian materialism':

"Let's call the idea of such a centered locus in the brain *Cartesian materialism*, since it's the view you arrive at when you discard Descartes' dualism but fail to discard the imagery of a central (but material) theater where it "all comes together"." (Dennett, 1991, p. 107)

Although the division between a *res extensa* and a *res cogitans* is no longer considered viable, we are left with the dualistic theory of Cartesian materialism.

Dualism is a misleading problem, which gives us two alternatives: either the mind is immanent in the body, or the mind is transcendental. As we shall see in the following paragraphs however, neither of these is correct; it is rather a synthesis of the two: parts of the thinking network are located inside of the body, while other parts are located outside of the body, they are embedded in the world (Bateson, 1972, pp. 325-326).

Here we directly start to feel the problem with the second type of dualism, that of the individual and the world. If the mind is embedded in the world, this has consequences for the unity of mind and world. In paragraph 1.2.2 it will be explored how brain, body and world together give rise to an individual's self.

It is often thought that we are autonomous subjects in an objective and neutral world, that is to say: we are self-regulating agents moving around in a world for us to manipulate. In this thought lays a dichotomy between self and world. In first instance, the brain is separated from the rest of the body and seen as 'the seat' of consciousness. Nonetheless, it is sometimes recognized, for instance in law, that there is some sort of unity between brain and body, be it not as strong as I argue it is. This unity

does not have a strong metaphysical sense: the body has no significant role to play in the emerging of the mind.³ But in some practical cases, brain and body together are seen as a person.

Even in these cases however, the dualism of individuals and the world is assumed. The world is seldom recognized as playing a significant role in the emerging of the mind. Human beings move around in the world which they form and not the other way around.

I will argue against this. We are profoundly formed by our environment. We are living beings in an active environment and the interplay between brain, body and world is what constitutes our minds. This will become clear in the following passages.

1.2: The mind embodied and embedded

In contrast to dualistic theories of the mind, the theoretical starting point of embodied cognition is not a mind *an sich*, but rather a living body. The traditional view of various theories in cognitive science took the mind to be an abstract information processor, with connections to the outside world that did not matter much from a theoretical point of view. In order to understand the central cognitive processes, all we need to understand is the brain and its computational workings.

Embodiment, on the other hand, states that human cognition is not centralized or abstract and it certainly is not sharply distinguished from peripheral input and output, but instead is deeply rooted in sensorimotor processing.

1.2.1: brain, body and world

We say that cognition is embodied when the physical body of an agent has a significant role to play in cognitive processing. The embodiment thesis (ET) is generally taken to mean something along the lines of this:

ET: Many, if not all, features of cognition are deeply dependent upon certain characteristics of an agent's body in such a way that the non-neurological part of the body has a significant role to play in the agent's cognitive processing.

The embedded mind theory adds the surrounding environment to that equation, so that we get the following embodied embedded theory (EET):

EET: Many, if not all, features of cognition are deeply dependent upon certain characteristics of an agent's body and environment in such a way that both the non-neurological part of the

³ See for instance Descartes' sixth meditation (Descartes, 2010, pp. 50-62) where he argues that the mind is not in the body as a captain in a ship, for there is more interplay between a mind and a body than a captain and a ship; a mind *feels* the broken parts of a body, a captain has to learn about the broken parts of his ship. Nonetheless, Descartes states that the mind can exist apart from the body, something that I argue against, since on the enactive account the mind is created by the interplay between brain, body and world.

body and the social, cultural and physical environment have significant roles to play in an agent's cognitive processing.

Basically, it is a theory that combines brain, body and world to explain the emerging of the mind. As John Haugeland puts it:

“If we are to understand mind as the locus of intelligence, we cannot follow Descartes in regarding it as separable in principle from the body and the world (...) Broader approaches, freed of that prejudicial commitment, can look again at perception and action, at skillful involvement with public equipment and social organization, and see not principled separation but all sorts of close coupling and functional unity (...) Mind, therefore, is not incidentally but intimately embodied and intimately embedded in its world” (Haugeland, 1998, pp. 236-237).

The idea that the mind is embodied can at least be traced back to William James who said that “*a purely disembodied human emotion is a nonentity*” (1890, p. 307). As we shall see, there are more classical authors who either implicitly or explicitly point towards an embodied mind, such as Heidegger or Merleau-Ponty. But there are a lot of recent thinkers and researches that constitute to this idea as well.⁴ The brain is of course still a central and essential organ of a living being, but it is also just that; an organ of the mind, rather than its seat. The mind is not seated in any single place; it emerges out of the interaction between brain, body and world. If such a dynamic, embodied and embedded view is accepted, the brain becomes a relational organ, a mediator of the mind, rather than its sole creator. The brain mediates and enables interactive processes of the body and the world, but it is also constantly molded and restructured by those processes (Fuchs, 2001). The brain and body are tightly connected in nontrivial ways:

“(…) various centres in the brain stem, hypothalamus, and insular and medial parietal cortex process the neuronal and humoral signals from the body and integrate them into a ‘body landscape’ that is constantly changing. This landscape includes the present state of the inner milieu (hormone concentration, glucose, oxygen, carbon dioxide, pH-value of the blood, etc.), interoceptive signals from the viscera and proprioceptive signals from the whole

⁴ . For example, it is shown that forced smiling while reading a comic actually makes subjects experience the comic as being funnier (Strack, Martin, & Steppers, 1988). More recently it has been shown that ‘power posing’, taking up a confident posture, can affect testosterone and cortisol levels in the brain (Cuddy, Wilmuth, & Carney, 2012; Carney, Cuddy, & Yap, 2010). It has also been shown that the language one speaks profoundly affects the way one thinks about and perceives the world (Boroditsky, 2001). There have been numerous of these kinds of studies in recent years that suggest an important role for factors other than the brain in shaping the mind.

musculoskeletal system including the heart, vessels, skin and vestibular system” (Fuchs, 2001, p. 202).

What becomes clear from this rather jargon-like passage is that the brain and the rest of the body are intimately connected to each other and influence each other in a circuit that is the human being. Our subjective experience is always experience of the interaction of body and brain. As important as the role of neural processes in the neocortex is, they do not constitute a mind without the vital processes of the organism as a whole.

The nervous system does not just give rise to the inner regulation of brain and body; it also connects the organism to its environment. It gives us the possibility to feel and experience the world around us; it makes me feel the water when I swim and as a result enables me to interact with, and exploit the watery environment.

So what does it practically mean when it is said that the mind is not just embodied, but also embedded? A good starting point is a simple example of which it is likely that everyone recognizes something as such; being on a computer. It happens that one has a password for a website and when trying to think of the password with the computer not being present, it does not come to mind. However, when seated behind the computer with the hands at the keyboard, one ‘automatically’ types in the correct password. Or from my personal experience, I used to play videogames when I was a teenager. When I was at the controls myself, things would go smoothly; but I could not tell others what to do if they had the controls in order to get the same results. Even with ‘thinking’ games that involve no fast button-clicking or mouse-sweeping, such as online card games or minesweeper, I would perform a lot better if I had direct controls, compared to telling someone else what to do.

1.2.2: Flow of activity and the human transducer

The suggestion here is that every action is, in a way, *inter*-action, meaning that all activity is a flow of activity: typing the password is my brain interacting with my fingers which in turn interact with my keyboard. This interaction is where the cognitive action emerges and on a larger scale where the mind emerges. The French philosophers Deleuze and Guattari give another example, that of a lumberjack (1980). The act of wood cutting is not something that emerges in the brain, not even in the interplay between brain and body only; it is a flow of activity between brain, body and world. Every cut influences and shapes the next cut. The process is the product of interaction of the complete system, including the tree, the eyes, the brains, the muscles, the strokes, the axe and the relationship between these elements. In the words of Deleuze and Guattari: “It is a question of surrendering to the wood and following where it leads” (2004, p. 451). This is a clear case of why the

mind is both embodied and embedded: both our body and our world constitute a very real part of our cognitive processes and even our consciousness. Our consciousness is never a consciousness in itself; it is never cut off from the surrounding world and as such exists through relations with this world, as we shall see in the next paragraph concerning the concept of Being-in-the-world. To use a beautiful analogy by Alva Noë, our consciousness in this way is like a dance: it is not something we can point at or is 'inside of us'. Instead, a dance emerges during the interaction of people with each other and their environment to create the dance. In the same way, consciousness arises through such interaction (Noë, 2009).

The human being is an interactive being and as such the brain should be perceived as a mediating organ within this interactive being (Fuchs, 2001). The anthropologist Gregory Bateson has explained the human being as an interactive system as well and states that in an interactive system it can never be the case that a single part, in this case the brain, can have unilateral control over other parts of the system and that the mental characteristics are immanent in the "ensemble as a whole" (Bateson, 1972, p. 321). There are all kinds of influences that have their part to play in an interactive system. As an analogy Bateson provides the example of a governor part in a steam engine.⁵ However, 'governor' is actually a misnomer according to Bateson, because 'governor' implies unilateral control, which it does not have, considering that it is a part of an interactive system. Instead, Bateson proposes to call it a 'transducer' that receives the difference between current speed and preferred speed of the system as a whole. The job of the transducer is to send messages to other parts in order for the preferred speed to be reached. The behavior of this transducer is shaped by other parts of the system and by its own previous behavior, just as the lumberjack's cutting is shaped by the previous cuts. There is a constant interaction between the transducer and the rest of the system and as such the transducer is also limited by relations inside the circuit of the complete system that the transducer has no direct control over.

The brain, as a 'human transducer' is limited in a very similar way. The mental characteristics are not just in any one part of the interacting human being, but are present in the system as a whole. The system here is the human being inside his environment. This explanation is relevant to questions whether computers can think or whether the mind is to be found in the brain. The answer to this is a negative one, unless we focus solely on the few mental characteristics contained inside the computer or the brain; a computer may seem to possess some characteristics that we would call mental if we focus on internal variables such as controlling working temperature. But the main business of a computer is the transformation of input differences to output differences, which is not a mental

⁵ Tim Van Gelder (1995) has also interestingly used this example to explain the difference between cognition and computation, where cognition is always in need of a dynamic system.

process by any means. The computer is a part of a larger system, a circuit including human- and environmental effects. According to Bateson, the complete system can be said to have mental characteristics, because it operates by trial and error and has a creative character (Bateson, 1972, p. 323). In this way, the brain is part of a much larger circuit as well: “mind is immanent in circuits which are complete within the system, brain plus body. Or, finally, (...) mind is immanent in the larger system- man plus environment” (Bateson, 1972, p. 323).

This means that the mind is not just a product of the brain, but a product of a human being, brain and body, embedded in his environment. Echoing Merleau-Ponty’s question Bateson asks: “Where does the blind man’s stick end and his ‘self’ begin?” (Merleau-Ponty, 1962; Bateson, 1972). According to both thinkers we should not ask whether it begins at the tip of the stick or at the handle. “The stick is a pathway along which differences are transmitted under transformation, so that to draw a delimiting line across this pathway is to cut off a part of the systemic circuit which determines the blind man’s locomotion” (Bateson, 1972, p. 324).

The stick of the blind man has become a part of the circuit, a part of the system of a human being. A human’s thinking system is not limited by the body; it includes all possible pathways or extensions, such as the stick, along which information can travel.

This disquisition by Bateson is a clear explanation of what it means that the mind is embodied and embedded. The brain is part of a circuit of the body, which is in turn part of a circuit of man in his environment. This final circuit creates man as a *Being-in-the-world* (see next paragraph) and this is where the mind arises. This is where we can perhaps first see the importance concerning the thesis of this paper as explained on page 4. If the mind is not to be found in the brain, but in the interplay between the circuit of brain, body and world then it seems like a logical conclusion that a mental disorder is not just a disorder in the brain, but a disorder in a person’s *Being-in-the-world*.

1.3: Being-in-the-world

Being-in-the-world is a concept we first encounter in Heidegger’s *Being and time* and which is later explored in Merleau-Ponty’s *Phenomenology of Perception*. In Heidegger’s understanding of Being-in-the-world (*In-der-Welt-sein*) we find what it means for us as conscious beings to exist, to live and interact with the world which we are in. Merleau-Ponty brings the focus of Being-in-the-world (*Être-au-monde*) closer to the body, which is “the vehicle of being in the world” (Merleau-Ponty, 1962, p. 94).

The reason for discussing these classic philosophers is not purely historical. The concept of *Being-in-the-world* is a very important concept that lays at the foundation of enactivism. Understanding what

it means, gives us a better way of understanding mental illness as well. I argue that mental distortions are not to be understood as mere brain distortions, but as distortions in a person's *Being-in-the-world*. This is why the focus of the next paragraphs will be on Heidegger and Merleau-Ponty, the two important thinkers concerning *Being-in-the-world*.

1.3.1: Heidegger

In his magnificent work *Being and time*, Heidegger does not ask the question of *beings*, but of *being*. In contrast to Descartes, Heidegger does not believe that an *ego cogito* can exist in itself; it needs to be connected to the outer world (Heidegger, 1977, pp. 89-113). Being for Heidegger means *Being there (Dasein)*. 'There' refers to the world; Dasein is always already thrown into the world, already bound with the world. As such, we exist as a *Being-in-the-world*.

Descartes' famous concept of an *ego cogito* is thus dismissed by Heidegger because *Dasein* is always a Being-in-the-world. This is not a trivial matter; Heidegger's metaphysical system is a revolutionary new and different system compared to the dominant Cartesian metaphysics. Object and subject are not opposed to each other for Heidegger, because in order for a subject to exist, one exists as a Being-in-the-world and therefore in need of objects and other subjects around himself. *Dasein* can never be separated from its world: this is why Being-in-the-world always precedes the *cogito*, in principle. We can never place ourselves as thinking things against the world as an object, because we are always a part of that same world, and necessarily so. Everything I do, think, feel or experience is necessarily a consequence of my Being-in-the-world. We always *exist* in the etymological sense of *existens*, meaning a *standing out* towards the world. Man lives in a world that he gives form through his intentional relations and vice versa someone's thinking, feeling and experiencing can only be understood from the position in one's world. Man forms his world and at the same time is formed by it. Man is not an *ego cogito* that reflects on the world from a distanced and inner consciousness. Instead, man is thrown into a situation that he has not chosen, but that he has to relate to. This world that he is thrown into involves not only objects, but also co-subjects; fellow human beings. As such, the world of a man is not just *his* world. In so far as the world is one's world, it is also the world of others. (Mooij, 2012, pp. 194-195).

Heidegger's *Being-in-the-world* concept understood in this way is the grounding for many theories within and surrounding enactivism. If we are always already there as Being-in-the-world, then that means that our minds are enacted in the world: we are strongly connected to the world. The idea of us not being subjects watching over the world but being *in* this world forms the basis for contemporary theories of embedded and embodied phenomenology, although Heidegger does not put any emphasis on the body in *Being and Time*. Merleau-Ponty famously added the body to

understand Being-in-the-world, as we will see in the next paragraph. Lesser known however, is that Heidegger did so himself years after he wrote *Being and Time*.

Heidegger was asked by psychiatrist Medard Boss to give some seminars to psychiatrists in Zurich, which he did over a ten-year period (1959-1969). Boss had been dissatisfied with the given psychiatric training concerning his patients. Then he read Heidegger's *'Being and Time'* and although he had trouble understanding everything, he felt that Heidegger had profound insights that could help psychiatry. In the seminars, Heidegger gives a sort of 'crash course' of the most important concepts of *'Being and Time'*. He begins by examining what is meant by 'world' and then what it means to be *in* such a world. For Dasein to be in the world three existential components are needed: the first is understanding (*Verstehen*), the component that discloses the world as a totality of meaning, the second is a state of mind (*Befindlichkeit*), which discloses beings in the world through affective disposition, and the third is Logos (*Rede* in German, *λόγος* in Greek), that offers Dasein the possibility of articulating in speech what it affectively understands, letting something be shown in words and as a result being able of interaction with others (Richardson, 1993). Most of this was expressed already in *'Being and Time'*, but then Heidegger moves on to something that was so heavily missing in his *magnum opus*, namely the body. In one documented conversation between Boss and Heidegger, Boss reminds Heidegger of Sartre's critique that *'Being and Time'* only contained six lines on the body. Heidegger replies to this by saying that it was the hardest problem for him to solve and he did not know how to say anything on it at the time (Heidegger & Boss, 2001, p. 292). During the conversation with Boss however, Heidegger did touch upon the way the body is involved in Being-in-the-world:

"We cannot 'see' because we have eyes, rather, we can only have eyes because according to our fundamental nature we come to presence as beings that see. Likewise, we could not be bodily [*Leiblich*] in the way we are unless our Being-in-the-world always already consisted fundamentally of a perceptive-receptive [*Vernehmen*] relatedness to something that addresses us out of the Open of our World, as which we exist" (Heidegger & Boss, 2001, pp. 293-294).

This rather enigmatic quote of Heidegger is trying to say that we can perceive the way we do because it belongs to our very being as being human. We have a 'perceptive-receptive' relation to the world which constitutes our Being-in-the-world. Our being bodily is our way of being thrown (*Geworfen*) into the world; Being-in-the-world is a bodily having a world. But what is our body to us? Heidegger, in line with his mentor Husserl, makes the distinction between the body as subject, 'body' (*Leib*) and the body as object, 'a corporeal thing' (*Körper*):

“Does the volume of my body determine the being-there? Do the limits of me as a corporeal thing coincide with myself as a body? One could understand the living body as a corporeal thing. (...) But then we are not speaking about my being-here, but only about the presence of a corporeal thing in this place. Perhaps one comes close to the phenomenon of the body by distinguishing between the different limits of a corporeal thing and those of the body” (Heidegger & Boss, 2001, p. 86).

There is thus a difference in the limits of the body as subject and of the body as an object; the corporeal thing is confined, limited by the skin, this is the corporeal limit. The bodily limit is extended beyond this. Not quantitatively, however, but qualitatively; the body is *my* body, connected to the ‘I’ that *I am*. My body, as body (*Leib*) is not in that sense ‘a thing’, the living (*Leiben*) of my body is determined by my way of being. Here Heidegger touches upon the relationship between the self and the body as being strongly constituted on each other. The self is necessarily an embodied self. Another point Heidegger mentions in the seminars that is important for the purpose of this paper is when he speaks on being immersed in something:

“To be involved in something “body and soul” means: My body remains here, but the being-here of my body, my sitting on the chair here, is essentially always already a being-there at something. My being-here, for instance, means: to see and hear you there” (Heidegger & Boss, 2001, p. 97).

The reason that this is important for this paper is that what Heidegger describes here is exactly something that mental patients sometimes deal with, in the sense of a distorted ‘body and soul’ involvement. The being-here that is projected at something goes smoothly as it should when it goes the way Heidegger describes it, being-here as seeing and hearing one that is near. However, patients often hear voices and see illusions that are not actually there, yet their being-there is aimed at these delusions. Although these kinds of distortions may partly be described in neurobiological terms, understanding them from an enactive phenomenological point of view will grant us better understanding of the problems. More on this in chapter 2 and 3.

1.3.2: Merleau-Ponty

For Merleau-ponty *Being-in-the-world* manifests itself via the body as well, as being a pre-objective system of reflexes⁶:

⁶ It should be noted here that Merleau-Ponty’s book *Phenomenology of Perception* came out in its original French in 1945: 14 years before the first Zollikon Lecture. Heidegger almost certainly knew the work, but does not refer to it directly in the lectures.

“The reflex, in so far as it opens itself to the meaning of a situation, and perception; in so far as it does not first of all posit an object of knowledge and is an intention of our whole world being, are modalities of a pre-objective view which is what we call Being-in-the-world. Prior to stimuli and sensory contents, we must recognize a kind of inner diaphragm which determines, infinitely more than they do, what our reflexes and perception will be able to aim at in the world of our possible operations, the scope of our life” (Merleau-Ponty, 1962, p. 92).

The body is thus, in being this system of reflexes, an important part in constituting Being-in-the-world, because through it we open ourselves to perceiving and creating meaning. To a higher degree, the body is necessary for Being-in-the-world, for it is through the body as a *living body* that we can see, feel and interact with our environment:

“The body is the vehicle of being in the world [sic], and having a body is, for a living creature, to be involved in a definite environment, to identify oneself with certain projects and be continually committed to them” (1962, p. 94).

In order to understand what Merleau-Ponty is getting at here, we have to see the bigger outline of his work. As the title suggests, the book’s project is to show the phenomenological structure of our perception. We, as living beings in the world, have first and foremost a *primacy of perception* (Merleau-Ponty, 1964). In his discussion on this subject, Merleau-Ponty, just as Heidegger did, argues against a Cartesian cogito. As stated before however, Merleau-Ponty puts a lot more focus on the body than Heidegger did⁷, which is to be found in his critique of Descartes as well. The Cartesian dualism of mind and body is dismissed. The body is ambiguously both object and subject for Merleau-Ponty. It is object in the sense that it is a ‘thing’ in the world, one that persons can perceive themselves and experience as an object, but it is also a subject in the sense that the body has agency and is, in a very real sense, a part of a person. The body plays a very essential role in our perception and as such in our *Being-in-the-world*. We perceive the world through our bodies, we exist (*existens*) as embodied subjects. We are only able to reflect on the world and on our thoughts because we can perceive, via our bodies, first. We are only insofar as we are in perception. This is why Descartes’ *ego cogito* and his division of *res cogitans* and *res extensa* are incorrect. We cannot be a thinking substance disconnected from the world, because we always need perception first:

“The perceived world is the always presupposed foundation of all rationality, all value and all existence” (1964, p. 13).

⁷ At least in *Being and Time*.

In order to explain his ideas, Merleau-Ponty often gives examples of people who suffer from certain maladies that involve the interaction between brain and body, such as problems with speech, or phantom limbs. One of the things that fascinates Merleau-Ponty is that the experience of having a limb does not cease to exist even when patients look at the missing limb and thus see that there is none. Neither is the experience removed by anesthesia (1962, p. 88). This means that neither mental nor physiological solutions alone seem to be able to remove the problem at hand. Therefore we must find the relationship between the psychic and the physical, which is to be found in the concept of *Being-in-the-world*. According to Merleau-Ponty in such a case of the phantom limb it is as if the body refuses to accept the mutilation, and as such reacts towards the world as if all proper functions and possibilities are still able to be performed by the body;

“To have a phantom arm is to remain open to all of the actions of which the arm alone is capable; it is to retain the practical field which one enjoyed before mutilation” (1962, p. 94).

I can still see that something can be utilized, but it is utilizable in principle, utilizable ‘for one’ rather than for *me*. The utilizable objects “appeal to a hand which I no longer have” (1962, p. 95).

This is the way in which we exist⁸; our entire body is geared towards the world in what Merleau-Ponty calls a *body image* (1962, pp. 112-113). When something is malfunctioning, or lost, our body simply refuses to adapt to the present malfunctioning state because of its original harmony with the body image. As the body image requests the assistance of the no-longer existing limb, the missing limb reacts as a phantom limb and it “appears to haunt the present without being absorbed into it” (1962, pp. 98-99).

1.4: Enactivism revisited

Following Bateson, Heidegger and Merleau-Ponty we can conclude that it is likely to be beneficial for the cognitive sciences to no longer assume that brain and mind are identical, or that brain states can be identified as mental states. Questions of the relation between one’s body as subjectively lived and one’s body as an organism in the world are more likely to give us interesting answers than question about mere neurological processes. Only a brain in a body that interacts with its environment can induce the brain to develop the structures necessary for adequate perception (Fuchs, 2001, p. 204). A noteworthy experiment provides us with an example. Held and Hein did an experiment with two groups of kittens (1963). The first group was carried in a basket around their environment, the second group could move freely by themselves. As a result, the first group could only passively receive visual stimuli where the second group could actively perceive their environment. After six

⁸ Again, think of exist as ex-sistere, as a *standing out towards the world*.

weeks, the first group of kittens was released. Because of their lack of active perceiving, the kittens could not find their way and were incapable of any spatial perception.

It seems that the kittens needed their active interaction in order for their perception to be adequate. Living beings enact their world, inseparable from their own structures and actions (Fuchs, 2001, p. 204). A world of an organism is not something external with an inner representation in the brain; it is a relational realm, constituted of the organism's coupling with its environment (Varela, Thompson, & Rosch, 1991; Dreyfus, 1992).

In the skillful handling of tools, we can also experience the enactive self, or what Heidegger and Merleau-Ponty call *Being-in-the-world*: I incorporate my guitar when I play on it. When I ride my bicycle, I connect with it to 'merge' in a new circuit, so to speak, and I feel the wheel touching the smooth asphalt or the rough gravel path, in the same way the blind man feels the ground with his stick (see paragraph 1.2.2). In this interaction between brain, body and world, the mind emerges, the self emerges. It is for that reason that I propose that mental distortions are not just brain distortions: the mind and the self are not to be found simply in the brain. If we want to understand distortions of the mind, mental disorders, we have to understand the self as an enactive self and take into account all these different factors that constitute the mind and the self. In the next two chapters I will explore this new way of seeing mental disorders as disorders of *Being-in-the-world*.

In this chapter I have sketched the contours for a framework of a new approach to psychiatry. The purpose of the explanation of enactivism and *Being-in-the-world* is to create a better understanding of why a good approach is likely in need of a focus on subjectivity and a focus on the interplay between brain, body and world, instead of just focusing on the brain. The concept of *Being-in-the-world* is essential for this understanding, because in explaining what it means to be, it explains how we are so profoundly connected to our environment and what the important role is that our body plays in this connection. This is important for psychiatry because understanding a person not simply as a brain inside a body, but as the combination of that brain and body inside of an environment, gives different insights to what the mind is and as a result gives a different insight to what distortions of the mind might be. Hence, a more holistic approach presents itself, which takes into account a number of different factors, other than strictly neurological factors.

2: Mental disorders

I trust that the preceding chapters have provided a framework that allows the reader to understand the approach of the remaining chapters of this paper. In what follows, mental disorders will be put into this framework of enactivism.

In this chapter, I will explain why the enactivist phenomenology is useful for understanding mental disorders mainly by drawing on a case study that Merleau-Ponty describes in his *Phenomenology of Perception*. I also want to put emphasis on the importance of a patient's selfhood, something that seems to be largely neglected in current psychiatric treatment. In order to make this more concrete, case studies will be provided at the end of the chapter, that show what a loss of selfhood means to patients and why it is so important to take this into account for psychiatric practice.

2.1: Moods, psychiatry and phenomenology

For clarity on the aim of this chapter, I want to start with looking at moods, emotions and consciousness. As Husserl has shown, when we are conscious, we are never conscious as such; consciousness is always directed at something. We are conscious *of something* (Husserl, 1901). This is also true for thoughts and emotions, when we think, love, hate or fear this is, under normal circumstances, always projected at something or someone. Understanding each other is likely to be depended upon shared standards of rational intelligibility or appropriateness (Matthews, 2004).⁹ However, moods such as depression or anxiety do not necessarily have to be directed at something. In fact depressions are often characterized by the fact that, in contrast with 'normal' sadness, it is not triggered by a specific act or object.¹⁰ Instead of being a result of an experience, the mood goes prior to the experience. As the philosopher Eric Matthews puts it: "The mood, we might say, is the particular 'colouring' that *our experience* of the world takes on" (2004, p. 192).

Mental disorders are interesting in this respect. Common symptoms for schizophrenia are false beliefs and hallucinations. Being *mental* disorders, they are thereby disorders of thoughts and emotions, which are generally expected to be rationally intelligible. However, since they are *disorders* they lack the rational intelligibility; a disorder is something that deviates from generally accepted standards. There is quite a difference in someone having the false belief that Picasso was a famous singer and the false belief of a schizophrenic patient that he is followed around by demons. The second one is not simply false; it is unintelligible by normal standards (2004, p. 192). Contrary to typical bodily disorders [e.g. a broken leg, arthritis], we cannot causally explain what is going on in

⁹ There is actually a huge debate in the philosophy of mind, more specifically a debate on the theory of mind which is about whether or not this is actually the way we understand each other. Here I will take the stance that we understand each other based on shared grounds on what is and what is not rational within certain boundaries. E.g. I might not get sad myself if I would drop my ice-cream on the ground, yet I can understand your sadness when this happens to you. On the other hand, I would be surprised and unable to understand you if you would be sad because your ice-cream did *not* fall on the ground. The first example conforms to standards for justifying sadness, the second example does not.

¹⁰ This is exactly why it's often so hard for people to empathize with loved ones that suffer from depression. People often sympathize but do not empathize, i.e.: they feel sorry for the depressed person, but cannot understand, cannot put themselves in the depressed person's position. See for instance the brilliant Stephen Fry documentary: *The secret life of a manic depressive* (Wilson, 2006).

cases of mental disorders. And where we find 'normal' mental states rationally intelligible, whether they are true or false, we cannot make sense of the mental disorders.

Why is this important? Because it is not the neurological process per se that is out of tune, it is rather the patient's relation to something outside of itself and thereby a lack of conformity to normal standards of intelligibility. We cannot help a patient simply by education, because there is not 'just' a false belief. However, because nothing is biologically broken we cannot heal a patient by medicine or surgery:

"[Psychiatry] then becomes nothing more than another branch of medicine, concerned essentially with disorders of the brain and central nervous system, which it treats with the usual medical tools. But [...] this is no solution either, what leads us to call these conditions 'disorders' is not that they are mechanical breakdowns, but that they distort the person's mental relationship to his or her surrounding environment" (2004, p. 192).

This is precisely why enactivism is important for psychiatry: we must not try to characterize every condition in either the mental or the physical; this is a false dichotomy. What is the problem here is not strictly a bodily problem, nor is it strictly neurological. The distortion is in the patient's *Being-in-the-world*. And here Merleau-Ponty comes back in.

According to Merleau-Ponty, we experience both ourselves and others as unified wholes, rather than a *res cogitans* 'inside' of a *res extensa*; the psychic and the physical are inseparable. Interacting with a person is not like interacting with a piece of machinery, we deal with persons; embodied beings, or as this concept is often named in the literature a 'body-subject'.¹¹

It is exactly this concept of a body-subject which is able to solve the problem at hand, to some degree. We do not have to make the distinction of somatic vs psychiatric disorders so sharp that everything is either causally explainable or has to be rationally intelligible. When we try to understand psychiatric disorders, we have to understand both the psychological meaning behind it (such as the meaning behind one's sadness), as well as the causally explainable bodily and neurological causes; the behavior is the behavior not of a spirit, not of a brain, but of a *person*. Of course the neurological processes are important, but they can only be understood if we see the whole picture; that is a body-subject's Being-in-the-world.

To help make this clear, one might think of Wittgenstein's *meaning-as-use*. According to Wittgenstein, we cannot make sense of what something means unless we see the context and the

¹¹ For instance in Matthews 2004. Merleau-Ponty himself never uses this term in *Phenomenology of perception*, but I think it is a good concept to describe what Merleau-Ponty is getting at.

usage of the words that are uttered (Wittgenstein, 1953). Much in the same way, we cannot understand the mental distortion in a person merely by looking at his neurological activity, but only by seeing in which ways the neurological activity is connected; the context of it all.

Merleau-Ponty also touches upon this point by bringing attention to the case of a patient he refers to a number of times in *The Phenomenology of Perception*; a man named Schneider. Schneider has sensorimotor problems:

“[When] his head, arm or leg is touched, he cannot identify the point on his body; he cannot distinguish two points of contact on his skin even as much as three inches apart; and he cannot recognize the size or shape of objects placed against his body (...) the same subject who is unable to point to order to a part of his body, quickly moves his hand to the point where a mosquito is stinging him. Concrete movements and acts of grasping therefore enjoy a privileged position for which we need to find some explanation” (Merleau-Ponty, 1962, p. 118).

Apart from these sorts of problems, Schneider also has problems recognizing situations as being sexual and has a lack of spontaneous sexual arousal in himself. This may be seen as a mechanical failure, but only if we understand it within the context of Schneider’s life it becomes a mental disorder:

“[Schneider’s] problem is not simply a mechanical failure of the equipment to function, but the problem in his existence as a human being which that mechanical failure represents. (...) Human sexuality is not simply a mechanical system; it is a central part of the life of a human being, which has a certain meaning for us in virtue of that, and it is the distortion of that meaning which is what has gone wrong for Schneider” (Matthews, 2004, p. 195).

One might object that we can give a scientific explanation to what is going on, which is essentially causal. There are different factors which influence Schneider that together make him act the way he does. Perhaps this is the case. However, as Merleau-Ponty states, understanding the problem of this behavior cannot exist of merely giving the conditions that make the behavior possible; what is necessary as well is the meaning for the person himself. In Schneider’s case, he has lost the ability to “project before himself a sexual world (...) the very word satisfaction has no longer any meaning to him” (Merleau-Ponty, 1962, p. 181). It is not just a mechanical problem, it is a problem of a lack of meaning; the meaning of the erotic is lost for Schneider.

It is then not just a matter of knowing what the causal reasons for the disorder are; it is also a matter of understanding the context and the meaning that the patient *as a person* is related to and experiences. It is a question of a person's total *Being-in-the-world*.

So the problem is not something that can be fully explained bodily, nor is it something that can be explained purely in terms of the mental states. The problem has to be explained considering both bodily aspects and mental aspects, as well as the relations between the two and the lived world.

This is what is essential: treating these kinds of disorders *as disorders* means that we make sense of what is going on, on more than just a neurological level; it is significant for the human being as a whole, as a person and significant in the way that this problem *is* a problem in his life and world. This is where the patient needs help;

“[We] can help him [a mental patient] only if we understand his problem as that of a human being, like ourselves, whose whole relation to his or her world has become disordered”
(Matthews, 2004, p. 196).

Of course, psychiatric disorders come in many different forms. In some cases, such as dementia, the sole cause of the disorder may be in the neurological mechanics (Matthews, 2004, pp. 196-197).¹² Dementia consists of a breakdown of normal body functioning. Nonetheless, for a lot of disorders this will not be the only cause that triggers it. Take for example clinical depression.¹³ It is not just a breakdown of normal body functioning, it has to be explained in terms of the patient's moods and relations to his social environment. We regard clinical depression as a disorder because it isolates the patients from a 'normal' relationship to the people around him. The strange utterances by a dementia patient can be explained, more or less, in the same way as we can explain the disability to walk of a patient with broken legs. In the case of depression, it is different. The moods of a depressive often are without intentional objects and are empathically ungraspable for bystanders, just as the moods of a dementia patient. However, unlike the dementia patient, there is an understanding to some degree. We may not understand the reasons for a depression, but we can understand the utterances a patient makes about his depression, they are not meaningless to us

¹² Even in a case such as dementia however, it is likely to be profoundly connected to the connections of a patient to his world, and the losing of these connections. From experience I know that there are patients suffering from dementia that fall back into their old patterns: they think that people who have died long ago still live and sometimes even seem to forget their current language and suddenly speak the language that they spoke as a child.

¹³ As opposed to the non-clinical sense of depression. The non-clinical version is usually somewhat intelligible and is basically a very profound sadness, whereas clinical depression is not always intelligible and much more extreme.

which those of a patient with dementia often are. We can understand the meaning of thoughts about suicide, even if we cannot grasp the reasons for these thoughts.

All of this suggests, again, that the problem should be understood as a problem of existence, rather than a mere neurological disorder. It seems that many cases of depression are triggered for a large part by traumatic-life experiences rather than just by neurological failure. If the causes are not simply neurological, then perhaps physical treatments such as drugs cannot make a patient fully recover. If we dismiss the breakdown as being simply mechanical, a more successful treatment might be the combination of drug treatment and psychological behavior therapy, on which more in a later chapter.

In order to defend this claim, it is interesting to look at MRI-scans of schizophrenic patients that hear voices. It seems that neurologically speaking, the same is happening when people perceive voices that are not actually there, compared to the activity in the brain when people are actually spoken to (Allen, et al., 2012; Badcock, 2010). It is therefore unlikely that the cause of this delusion is anything purely neurological; if it would be, one would expect to be able to locate a neurological difference between the two. It is plausible that the disorder is not just in the neurological processes, it is in the relation of those processes to the world. We cannot treat patients as neurological mechanisms; we have to treat them as persons with real existential problems.

Here the relevance is to be seen for enactivism, starting with Merleau-Ponty's idea of a body-subject, in the practice of psychiatry: it combines a humanistic approach to mental disorders, combining pharmacological treatment with psychological help. Treatment can be successful "by seeing human beings neither as disembodied minds nor as complex machines, but as living organisms whose mental life is embedded in their biological existence" (Matthews, 2004, p. 198).

2.2: The importance of 'self' in psychiatry

Treating patients as persons means to take into account the 'self', the ipseity of the person. After all, several psychiatric illnesses, such as personality disorders, deal with the self directly.

However, subjectivity and self-experience seem to have lost their central place in psychiatric practice. Terms like 'subject' or 'self' are hard to work with and in order for psychiatric diagnoses to be more trustworthy, contemporary psychiatrists often try to use objectively observable criteria (Andreasen, 2007). In search for this trustworthiness, the distinction between the psychiatric illness

and the person that has the illness is often made in psychiatry. It is of course questionable if such a distinction can truly be made at all (Sadler, 2007).¹⁴

Indeed, leaving the subject out of the equation when trying to conceptualize an illness seems impossible when dealing with disorders such as borderline or schizophrenia.

In fact, the very word *schizophrenia* derives from the Greek words of *'skhizein'* (to split) and *phrenos* (heart, mind), suggesting a disorder in the unification of self. Throughout the modern history of psychiatry we find the self as the center of psychiatry as well. We have seen that Merleau-Ponty puts the self in the form of the body-subject to the front of psychiatry, but there are many others who have done so. Karl Jaspers, for instance, describes disorders such as schizophrenia *'Ich-Störungen'* (Jaspers, 1913), and Eugène Minkowski says that the madness consists of a disturbance of the structure of the intimate ego (Minkowski, 1927).

To bring this focus on the self back into psychiatry, the first-person perspective is added onto the third-person perspective that is customary in the general scientific methods, but which does not have direct access to personal experiences (Fuchs, 2002) (Gallagher & Sahavi, 2008). It is the person himself that has access to such experiences.

In psychiatric practice this means that psychiatric symptoms are approached in a more phenomenological way; the goal is not simply to describe experiences, but to understand what is beneath these experiences (Van de Kaats, De Haan, & Meynen, 2012). It is about finding the connection between psychiatric symptoms as expressions of a distorted structure of Being-in-the-world. Not only is this interesting for new insights in symptoms, but it can give insight to patients as well, in order for them to articulate and analyze their experience (Van de Kaats, De Haan, & Meynen, 2012, p. 1023).

This subjectivity and the uniqueness of each patient are of course also causes that make psychiatry such an incredibly hard field to work in. In 'normal' medicine, one can more or less follow the rulebook; if a patient has a broken leg, treatment will be marginally different from the last patient with a broken leg. The causes of the broken leg do not matter all too much as long as it is clear where the bone is broken and with what kind of fracture is being dealt with. In psychiatric practice however,

¹⁴ One of the reasons that this distinction is made, is because psychiatrists feel that it is dehumanizing to say that a person 'is' a schizophrenic instead of saying that he suffers from schizophrenia. However, it feels sometimes as if it has the exact opposite result, see for instance the reaction of the psychotic patient when she is being told that 'it is not her fault, it is an illness' in the play 4.48 Psychosis by Sarah Kane (who herself suffered from psychosis and depression): "It is not your fault, that's all I ever hear, it's not your fault, it's an illness, it's not your fault, I know it's not my fault. You've told me that so often I'm beginning to think that it is my fault" (Kane, 2001, p. 220).

there are so many causes that may lead to certain distortions and it is important to know them in order to be able to be of service to the patient. Traumatic experiences, social-economic problems or distortions in the balance of neurotransmitters can all lead to seemingly the same psychiatric problems, but they have to be dealt with in very different ways. It is very hard to find out how even one of these problems causes an illness, and harder still to understand all of them and find out what problem is to be dealt with. What is of help and what worsens the situation? There are numerous ways of different therapies or medications, but as a psychiatrist one needs to find out what specific treatment fits with a specific patient in a specific situation.

It is not hard to see the help that enactivism can offer here. Enactivism understands the mind as an intricate interplay of brain, body and the relationship to the world from the start, not just the distorted mind. An enactive approach puts emphasis on “the intrinsic interaction between the experiential, existential, social-cultural and biological dimension” (De Haan, 2013, p. 137). There are many of these dimensions that make up the system of our mind. A change in one dimension means a change in the system as a whole. This is why we should not think of a consideration between therapy and medication as a consideration between an intervention in the body against intervention in the mind; understood from an enactivistic framework, they are not separate entities but rather a connected system. Changing the body means changing the mind and vice versa (De Haan, 2013).

Considering this tight connection between the mental and the physical suggests that patients with a mental disorder may have a distortion in their feeling of oneness with their body and a distortion in their Being-in-the-world. Since the mind and the self are embodied and embedded in the world, it seems indeed that certain patients experience a fundamental alienation of reality in its entirety (Fuchs, 2005, p. 136). As psychosomatic professor Gerd Rudolf puts it:

“[Patients with severe personality disorder] live in a body which often keeps alien to them, which they often treat like a slave or an enemy, and which rises anxiety and pain by its malfunctioning. Their body seems to be an outer object more than an aspect of the subjective self” (Rudolf, 2010, p. 252).

The reports of patients themselves support this idea:

“[Patients] report that their self is fragmented into parts; it is no longer experienced as a whole. Moreover, there is a split from the body: the body is not sensed, it feels alien, or not even alive, and acquires a mechanic quality. Thirdly, there is a distance between the experiences and the experiencer: [patients] do not coincide with their perception, but were observing the perceptual process from a distance” (De Haan & Fuchs, 2010, p. 330).

So according to the patients themselves they feel as if they are no longer one with their body and they have problems with a continuity of self. This is what an enactivist would indeed predict.

2.3: Case Studies

Everything that is discussed until now has been rather theoretical. However, there has been done some research with actual patients that I would like to focus on in this part of the paper. This will provide some very concrete information that shows how patients themselves experience their mental disorders. The philosophical theorizing as done in the preceding paragraphs will be more convincing and graspable when combined with knowledge of the patient's experience. This paragraph also serves to show how concrete complaints and symptoms of mental patients might be understood in the light of enactive phenomenology. Taking into account the patient's experience is the first step in taking the ipseity of the patients serious as well, which, as I have been arguing, is so important in an enactive approach to psychiatry. Understanding the patient's experience is necessary for being able to provide good treatment.

There are some descriptions available from writers who have suffered mental illnesses themselves. There is, for instance, the playwright Antonin Artaud who compares his own 'weakness' with that of other authors in a letter to Jacques Rivière:

“Nevertheless, the fact is that they do not suffer and that I do, not only in my mind, but in my flesh, and in my everyday soul. The unrelatedness to the object which characterizes all literature is in my case an unrelatedness to life. I can truly say that I am not in the world and this is not a mere mental attitude” (Artaud, 1965, p. 20).

Here we can see very clearly the suffering of Artaud as a consequence of his mental illness, which is felt throughout his entire body. He also states quite literarily his distance to his own life and his feeling of not being in the world, which is so strong that he characterizes it even specifically as “not a mere mental attitude”.

Actual studies with patients confirm this kind of distancing from life, from experience. The distance between the experiences and the experiencer, mentioned before in paragraph 2.2, becomes very clear and concrete as described by a delusional schizophrenic patient from Klosterkötter who says:

“All seemed ever more unreal to me, like a foreign country... Then it occurred to me that this was not my former environment any more. Somebody could have set this up for me as a scenery. Or else someone could be projecting a television show for me... Then I felt the walls and checked if there was really a surface” (Klosterkötter, 1988, p. 69).

The patient does not seem to 'live' his experience as 'normal' people do, but instead experiences his experience from a distance as it were. The patient is distanced from his own environment, as if watching 'a television show'. He loses the direct personal, familiar meaning of things. The patient may still see the significance of things, he understands that a wall is a wall, but it is no longer a wall *for him*. As I sit in my room right now, I see my laptop as a laptop *for me* to type on as are the chairs and the table *for me* to use. When I watch a television show, I can see for instance a laptop in the show and understand what it means, but it is not there as a laptop *for me*. For a schizophrenic person, the whole world is distanced in this sense; "With the subject being detached and alienated from his own perceiving, the significances remain abstract and arbitrary. They may be known to him as before, but they have stopped to *mean* anything to him" (Fuchs, 2005, p. 136). This again signifies the importance of the ipseity in psychiatry.

More recently De Haan and Fuchs have done a case study concerning disembodiment in two schizophrenic patients (De Haan & Fuchs, 2010). In this study, patients would report their experiences which suggested that problems such as a loss of self, loss of common sense and intentionality disorders are closely linked with a detachment from the lived body. To cope with these problems, patients use mechanisms that go into hyperreflectivity and hyperautomaticity, which also show a split between body and mind.

Three distinct problems that are mostly focused on are loss of self, alienation and hyperreflectivity and hyperautomaticity.

2.3.1: Loss of Self

The patients were being interviewed and often gave clear signals of their worries on self and personhood. One patient, referred to as L.N., said, for instance:

"I don't know [who I am]. I have difficulties to determine who I actually am, because in different situations I feel very different and I also behave very differently. I experience myself as individual parts, not as a complete thing. Not as a person, as a whole person. I feel as parts of a whole person, but never at the same time" (De Haan & Fuchs, p. 329).¹⁵

And a quote from the other patient, referred to as S.N.:

"With everything that I do, it seems to me as if that person were not really me. Something forged. That is how it is: I am not me, like I am sitting here right now" (p. 329).

¹⁵ In the quotes from this study, whenever there is ' ... ' means that some words of the patient are skipped over in the original text, whereas when I put this between brackets, ' (...)' then I myself have skipped words.

In both of these quotes we can clearly see a loss of self in the sense that the patients still somehow 'experience', or understand, things that they do and that happen to them, but they do not experience it as truly happening *to them* as a person. These are cases of disturbed ipseity.

2.3.2: Alienation

Both patients that were interviewed described severe estrangement from other people, from the surrounding world but also from themselves and their bodies. S.N. describes his loss of contact with his body as follows:

"In general, I didn't have a sense of my body anymore; this completely vanished at some time. My face became increasingly strange to me, as it still is today. My voice too, because I talked much less. Just an extreme self-estrangement" (p. 329).

And his estrangement from the world is described as such: "The world is not really tangible anymore, the world is just... I don't know what. If you cannot be part of it, the world automatically feels different. I cannot describe it" (p. 329).

Both patients feel so alienated from the world, that they do not have the feeling of actually being in the world, in a literal sense. Both describe their experience as being far away from the perceived, and as though they did not themselves experience what was seen, but were sent the information by cameras:

L.N.: "I feel as if I am sitting on some distant planet and there is somehow a camera in my head and those images are sent there. As if I am completely far away from here, where I am sitting right now" (p. 329).

SN.: "For me it was as if my eyes were cameras, and my brain would still be in my body, but somehow as if my head were enormous, the size of a universe, and I was in the far back and the cameras were at the very front. So extremely far away from the cameras. And I walk, and I look around... and I'm dizzy, and all is like a machine... I just didn't have much control over myself. Or at least, that's how I felt. And also, everything was hard. Suddenly, I felt an inhibition. I was scared to do things. For instance, when I was walking at the central station, there is a group of people and there is a bench, I have this robot-like feeling in my head, to be looking through cameras, and you observe your whole body, and the steps you take towards the bench. The gazes of the others almost physically affect you. You can feel the gazes" (pp. 329-330).

Here we can see that the, under normal circumstances, taken-for-granted unity of self with the body is completely disturbed. Where normally we perceive the world as a lived body, these patients perceive it as being distanced from their own bodies, distanced from the world around them. They do not perceive their world from a first-person perspective, but from a third-person perspective, where they see themselves walking and they 'see' others watching them from behind. This distortion causes the patients to be fearful because of a lack of control and a lack of unity with their own body.

2.3.3: Hyperreflectivity and hyperautomaticity as coping strategies

Patients who suffer from schizophrenia and the accompanying deficiencies as described above usually go into two modes of coping strategies; hyperreflectivity or hyperautomaticity.

Hyperreflectivity means that everything one does, he does deliberately; everything takes conscious attention.

S.N.: "There were periods in which I felt extremely badly coordinated, when I just made a movement with the arm and the arm had moved further than I wanted it to move. But I also found myself to be extremely clumsy, somehow, when walking. I therefore constantly observed my walking and my movements" (p. 330).

L.N.: "I just observe everything I do and everything that is happening around me very closely." (p. 330)

This first coping mechanism, hyperreflectivity, makes the distortion of Being-in-the-world even bigger in a sense, by distancing themselves even more from their surroundings and their bodies. Earlier I gave an example of becoming a new circuit of me and my bike together when I am skillfully interacting with it to such a 'taken-for-granted' level that I feel with the bike and that I unconsciously do things with my bike as I would with my own body, such as hitting the brakes, moving the pedals, steering etc. The patients in the above examples completely have lost this ability, not just for interaction with things, but even with their own bodies. Instead of 'just' walking, they have to think consciously about every single step, every movement of every muscle, as if they were not *one* with their body, but controlling it from a distance.

The other coping mechanism is the exact opposite. Hyperautomaticity means surrendering to the bodily memory that is still available (p. 330). Contrary to hyperreflectivity, hyperautomaticity can sometimes be a pleasant experience, as it is a kind of letting go, a certain kind of relief.

S.N.: "Sometimes I really got into [work], and I completely switched off, my mind was totally away from my body, and I just worked. Sometimes it did me really good, to be away from it

all. And I thought, when I can still achieve that, that it all goes automatically, then there has got to be a way for me to feel better again” (p. 330).

This coping mechanism is another way of a distortion in the Being-in-the-world. There is still no unity of the self and the body, for the body as a lived and subjective body is let go, it becomes a sort of machine, something that moves on pre-given instructions, but not in interaction with the self.

The ‘normal state’ is something in between the hyper-reflectivity and –automaticity. But patients are unable to reach this middle-point:

L.N.: “Everything I do, I do with logic and reconsideration. Almost nothing works naturally of its own accord... However, I can also do things without even noticing (...) It is a combination of both: either complete automatism, or complete control” (p. 330).

2.3.4: Conclusions and interpretation of the case study

These seem to be very clear examples that indeed show the mental distortions to be distortions in the interplay between the patient and his world. However, we should of course be very careful with the interpretation and conclusion drawn from this. First of all, we are dealing with a very small study concerning only two subjects. With so few subjects, it is not really a possibility to draw a scientific conclusion from it. Then, we have to remember that the researchers conducting the study were looking for evidence to back up their hypothesis concerning embodiment and schizophrenia. When looking for this, it is very easy to interpret everything the subjects say in a way that strengthens your hypothesis, as I did with my interim conclusions. It is also possible that the researchers have ‘cherry-picked’ the quotes that fitted their hypothesis and discarded the ones that weakened it.

That being said, it remains interesting to see that both patients report the same kind of experiences concerning their feelings of not actually *being there*. They have the same way of coping with it as well, and seem to have the same sort of feeling towards coping in that way. Also, the quotes of the patients do fit the idea of mental disorders as disorders in Being-in-the-world surprisingly well. Of course these were just two patients, but their reports are very characteristic for the behavior of schizophrenic patients in general.

Even though we have to be careful with drawing conclusions from this study, it certainly is an interesting start in what can be a series of studies on embodiment and psychiatry. A study like this can be done, for instance, with a relevant number of subjects and also letting the subjects perform certain tasks in order to see to what degree their distortion has effect on their bodily capacities and their *Being-in-the-world*.

2.4: Feedback

In the introduction I stated that understanding mental disorders as disorders of a person's *Being-in-the-world* is valuable for two reasons. One reason is that it is valuable in our understanding of the mentally healthy mind. Understanding what goes wrong, gives us an understanding of what should go right. Indeed, I propose to understand mental disorders as disorders of the interplay between brain, body and world, because the mind emerges from this interplay. This means that when we look for the mind, we must not limit ourselves in looking at brain scans. A more holistic approach is in order, one that sees the brain as one part of a system, with the body and the environment as other important parts of the system, which are all important factors in constituting the mind.

The second reason concerns the mentally ill mind: the new way of understanding mental disorders helps us not only to *understand* the mentally ill mind, but also gives us suggestions for treatment of mental disorders. When we look at the case studies we can clearly see the problems that patients deal with. When perceived in the light of enactivism, we can understand these problems as problems of the interplay between brain, body and world as well as problems of ipseity. This is very different from perceiving these kinds of problems as mere brain disorders. Hence it is plausible that diagnosis and treatment of mental disorders should differ from how they are currently being diagnosed and treated, since the current focus is on the brain. This new way of dealing with mental disorders will be explored in the following chapter.

3: Explanations, consequences and the limits of enactivism in psychiatry

At the beginning of the paper, the thesis was formulated as follows: *psychiatry will benefit from approaching mental disorders not as purely brain disorders, but rather as disorders of Being-in-the-world, that is, of a disorder in the intricate interplay of brain, body and world, with a focus on subjective experience from patients.*

At this point in the paper, I have explained what enactivism is and have connected this to mental disorders. I have argued that the ipseity of patients is important and relevant to psychiatric practice. I have also given examples of patients that suggest that mental disorders deal with disembodiment and a general feeling of not being in the world, which supports the idea that enactivism is relevant to psychiatry. Most of it has been descriptive or, if it was prescriptive (par 2.1 & 2.2), it was still just scratching the surface; suggesting that ipseity and subjectivity should move to the forefront. In this part of the paper there will be more depth regarding these points. I will argue that next to the descriptive function, enactivism in psychiatry also has explanatory and prescriptive value. The explanatory use is aimed at showing that enactive phenomenology does not just *describe* the symptoms of mental disorders, but explains how these disorders take form in the first place. The prescriptive use will focus mainly on making diagnosis and on suggesting types of treatment for psychiatric patients.

3.1: Explanatory use of enactive phenomenology

Looking back on paragraphs 2.2 and 2.3, the importance of self in psychiatry and its presence in the accounts of schizophrenic patients, it becomes clear that some symptoms are extremely difficult, if not impossible, to explain with just a neurobiological account. It seems that the subjective dimension is needed in order to explain certain mental illnesses. Neurobiological explanations are not excluded; they still have a very important role in the overall understanding of mental illness, but they do not suffice by themselves. Subjective experience has an important causal role in the progressive experiential transformations in a schizophrenic illness in development (Sass & Parnas, 2007, p. 86).

For example, alienation and hyper-reflexivity as presented in paragraph 2.3, can not only be described in terms of enactivism, but can also be explained through enactivism. Instead of seeing both aspects as outcomes of separate processes we can see them as two aspects of a unity. Hyper-reflexivity makes something that is normally tacit and unconscious into something explicit and conscious, whereas alienation does something complementary to this; what was once tacit becomes no longer available as something that is taken for granted (Sass & Parnas, 2007). Hyper-reflexivity and alienation are aspects of a fundamental disturbance of awareness and ipseity. A disturbance of this kind gives rise to both alienation and hyper-reflexivity as well as a range of other disturbances. This suggests that there is one overarching explanation for both of these symptoms.

The enactive phenomenology behind this is in the notion of 'normal' ipseity that is disturbed in schizophrenic patients. This ipseity is the grounding for human motivation and our experiential world, giving objects their significance for us as being obstacles, tools, etc. (Sass & Parnas, 2007, p. 78). The absence of this significance means that thought, perception and experience have to bear the brunt. No more significance means that there is no longer a meaningful world, no longer a common-sense reality and no more normal relationship to the self. These are indeed symptoms that we find in schizophrenic patients; their experience of spatial and temporal dimensions stops working properly, they have a blurred self-world articulation, they feel distanced from everything, including themselves, etc. An enactive phenomenological approach offers the possibility of understanding of anomalies such as hyper-reflexivity as being expressions from this kind of schizophrenic characteristics.

Theo Rudolf Payk has written a chapter regarding the blurred temporal dimensions in mental patients, also known as '*chronopathology*', in his book *Mensch und Zeit* (man and time) (Payk, 1979). In it, Payk quotes a patient that describes her feeling of time: "The clock runs empty...everything stands still... the time is lost" (Payk, 1979, p. 75). This kind of distorted temporal experience is very common with mental patients. It is also indicative of the importance of subjective experience in

understanding patients; the clock runs empty *for her*, the time is lost *for her*. In order to understand the complaints of these kinds of patients, the focus needs to be on their ipseity. Only from that starting point can one begin to understand the distorted space-time experiences, and other symptoms.

There are many more delusions and symptoms of schizophrenia and other mental illnesses that can be understood, and hence explained, in an enactive way. Take for instance Victor Tausk's patient Natalija who had the delusion that she was, on the one hand, a godlike and almost solipsistic entity with the entire world existing just for the purpose of serving Natalija. On the other hand, she felt she was herself a passive entity within the world, with a purpose of being used, manipulated, by other subjects (Tausk, 1933). Sometimes, these two seemingly conflicting views would even be experienced at the same moment. This can be understood if it is recognized that both forms of this self-experience are already implicit in a hyper-reflective focus on the way the mind functions and constitutes an experiential world (Sass & Parnas, 2007, p. 80); only by accepting the strong altered subjective experience of patients is it possible to understand this kind of delusions. For a mentally healthy person, it is hard to understand how one could have such conflicting views and even experience them simultaneously. But this is because a healthy person does not have the blurred relationship between self and world that schizophrenic patients experience. Only from this distorted ipseity can a delusion such as that of Natalija arise. A lot of disturbances common in schizophrenia can find their basis in disruptions of the act of awareness, meaning an altered sense of self-presence and presence to the world. It is only possible to be emotionally or mentally affected by something in a process concerning ipseity; the experience has to be felt, in a sense, as relevant *to me*, as something that is happening *to me*. In order for something to be experienced in this way one requires a sense of unity with oneself, one's acts and one's awareness. A distortion in this sense of self is disruptive of affective and conative processes, because there is no grounding for spontaneous response; if the feeling of oneness with self and world is distorted, one feels no longer embedded in the world and cannot respond to the surroundings. This results in emotions and thoughts losing their spontaneity and thus makes normally automatic and spontaneous actions into deliberate and conscious acts that require effort (Sass & Parnas, 2007, p. 83). These kinds of symptoms are more than merely neurophysiological; they have to be explained in terms of the subjective dimension.

In a broader sense, enactivism has an explanatory power by offering a different viewpoint towards mental illnesses in general. Approaching mental illness as a distortion of Being-in-the-world instead of a mere brain distortion gives us not just descriptive value but is a different explanation of the origins of mental illnesses as well. Instead of explaining mental illness only in neurobiological terms, enactivism offers a broader explanation. The origin of mental illnesses should be found in the

interaction between brain, body, the patient's self and its relation to the world. This offers a new understanding of how mental illness arises. This is quite a useful explanation, because explaining this offers new solutions to the problem of mental illness. If a problem has a different origin than had previously been suspected, it is usually the case that new treatments to this problem should be applied. This is the prescriptive consequence that enactive phenomenology offers.

3.2: Prescriptive effects of enactive phenomenology

Phenomenological investigation is, or should be, “un-folding the different facets of conscious life or activity in order to provide a richer grasp of its lived texture and internal structure” (Sass & Parnas, 2007, p. 81).

The main focus of enactivism in psychiatry is, as stated before, that psychiatric patients should be treated with a focus on their person and their subjective experience. However, long-term acquaintance with patients has become exceedingly rare in modern psychiatry. As a result, the professional understanding of psychopathological phenomena has decreased and is greatly simplified (Parnas & Sass, *The Spectrum of Schizophrenia*, 2010; Andreasen, 2007).

3.2.1: DSM, diagnosis and methodology

One of the reasons for this simplification arises from the DSM, the *Diagnostic and Statistical Manual of Mental Disorders*. The DSM itself is not the main problem, the overreliance on it in psychiatric practice is. The first time the DSM was published with the intention of being an actual textbook on psychiatry was with the DSM-III in 1980. That version came with an important note:

“Making a DSM-III diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a DSM-III diagnosis will invariably be necessary” (American Psychiatric Association Committee on Nomenclature and Statistics, 1980, p. 11) .

This comment was important because it kept the focus on the patient as an individual. The DSM should be used as the first step in a diagnosis, not as a holy grail. Criteria include some characteristic symptoms, just enough for a diagnosis, but were not meant to provide comprehensive descriptions. It seems, however, that is exactly how it is used since the DSM-III; knowledge of the DSM criteria is the basis for most exams and phenomenology in psychiatry is mostly ignored (Andreasen, 2007, p. 111). A very important problem with the overreliance on DSM that Nancy Andreasen points out is that the central evaluation tool in psychiatry, ‘history taking’, is often reduced to empirically going of checklists from the DSM (Andreasen, 2007). Empirical as it may be, this method fails to take into account the patient as an individual self. Another serious issue is the validity of the DSM diagnoses.

The DSM provides standardized diagnoses of which the validity is often questioned. Andreasen is a famous critic of the DSM, but she is far from alone; in 2013, Thomas Insel, director of the NIMH, *National Institute for Mental Health*, has stated that the institute would stop funding research projects that relied too heavily on the DSM, because of its lack of validity (Insel, 2013). He went so far as to say:

“While DSM has been described as a ‘bible’ for the field, it is, at best, a dictionary, creating a set of labels and defining each. (...) In the rest of medicine [diagnosing according to DSM] would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever” (Insel, 2013).

He continues to say that symptom-based diagnosis is old-fashioned in other areas of medicine, since it is now understood that symptoms alone hardly ever indicate the best choices of treatment. So why still use this method for patients with mental disorders? After all, it seems that just as with other areas of medicine, it is the case with psychiatry as well; symptoms are not the best indicator for a decision of treatment.

Although the DSM-IV (1994) and recently the DSM-V (2013) have extensively revised certain diagnoses, the problems remain.

Instead of the structured DSM check-list interviews, a better way would be to interview patients in a conversational phenomenological way (Nordgaard, Sass, & Parnas, 2013).¹⁶ DSM-based interviews consist of asking the patient prefixed questions in a prefixed order which is then to be rated as positive, negative or threshold (First, Gibbon, Spitzer, & Williams, 2002). However, ‘yes/no’ answers are often, if not always, insufficient. A conversational interview based on phenomenology would offer the patient explanations and exemplifications. Spontaneity and reflection should be an important part of psychiatrist-patient interviews; what is being dealt with is the patient’s subjective and personal experience, hence the spontaneous sharing of experiences can often help the interviewer. Certain patients have been interviewed in the ‘structural’ way first and later again in the ‘conversational’ way. Patients give way more information about their experiences in the second case. Delusions of the patient stay unknown in the structural interview, while they are being stated explicitly in the conversational one. Not only would this be suggested by the fact that the patient is more likely to give more information by being given the opportunity to explain himself; it is also likely

¹⁶ Josef Parnas and others have proposed the EASE: *Examination of Anomalous Self-Experience* as a symptom-checklist for semi-structured phenomenological interviews as a basis to help psychiatrists towards this goal (Parnas, et al., 2005)

that patients do not give the information in the structural interview because they simply do not recognize their experience in the direct formulation of the structured questions (Nordgaard, Sass, & Parnas, 2013, p. 356).

The structured interview uses a lot of typifications; instead of writing out complete sentences or complaints of patients, these complaints are often summarized in a typical way, such as 'diminished interest' or 'loss of joy'. The problem with these kinds of typifications is that often they become stereotypes. Psychiatrists can be expected to find certain symptoms and as a result ignore important information. By using a phenomenological and conversational style of interview, clinical investigation can gain more individualized understanding of patients and can avoid problems of the structured interview.

Of course, typifications are very important in the diagnostic process and should not be trivialized; certain typifications are needed to give meaning and order to separate symptoms complaints by connecting these symptoms. But the point I try to stress is that it is important that psychiatrists test their own typifications by asking questions that may strengthen, or indeed call into question, their ideas. This is one of the reasons why it is so important that patients can elaborate on their experiences: it is, among other things, a test for the typifications of the psychiatrist. Conclusions are sometimes quickly drawn. If the patient reports that he does not sleep at night, 'insomnia' can be written down as a symptom. In the conversational interview, this could be tested by asking further questions on the specifics of this behavior. Does the patient sleep during the day? Why does he not sleep at night? This helps for a better understanding of the patient and tests the probable typifications of the symptoms in a scientific way.

The interview is conversational because, instead of a structured prefixed checklist, the interview moves more freely and goes with the flow of the conversation in which the patient may elaborate and provide examples. It is named phenomenological as well because, contrary to the structured variant, it focuses on the ipseity of the patient in order to create a personal rapport. In the phenomenological interview the psychiatrist tries to dismiss assumptions of 'reality' in order "to allow for the comprehension of lived worlds in which other ontological dimensions or presuppositions, for example, other forms of space, time, or causality might prevail" (Nordgaard, Sass, & Parnas, 2013, p. 360); meaning, basically, that the patient's subjective experience is taken seriously. Of course the patient is still a patient of which it is recognized that he has mental illness and thus that his experiences may very well be delusional. However, they are very real *to him* and as such should be taken seriously. The conversation should be in the first place about how the patient experiences himself and the world around him and only in a later stage, where the patient is not

present, should the reflection of the conversation be about the morbidity and about 'objective' reality.

3.2.2: Enactive phenomenological therapy

The proposed interviewing technique focusses mainly on the ipseity. For therapy however, it is important to look at the other aspect of enactivism as well, which is that the self is always an *embodied* self. This implies practical usage concerning therapy, because body- and movement-oriented therapies could be able to lessen the disembodied feeling patients often have.

If a patient experiences great feelings of hyperreflectivity for instance, it is perhaps possible to help him cope with this by going into therapies that focus on this hyperreflectivity. In addition to talking therapies, patients with disembodiment disorders could probably benefit from body- and movement therapies. This suggestion is speculative and is based on the enactive ideas as described earlier in this paper; There has not been a lot of relevant scientific research into these kinds of therapies. What would show to be useful in practice is yet to be seen. Here lays a giant possibility for future research. Different kind of therapies can be tried out with a relevant quantity of patients in order to test the usefulness. This is what Gallagher and Zahavi call *front-loaded phenomenology*: using phenomenological analyses for the designing of experiments (Gallagher & Sahavi, 2008). The theories can improve experiments this way and the experiments could test and strengthen the theories as well.

The search for new treatment is not just a nice way of empirically strengthening enactive phenomenology. It seems that new ways of approaching treatment for mental illnesses are quite needed; current intervention avert just 13% (!) of schizophrenic burden (Andrews, Sanderson, Corry, Issakidis, & Lapsley, 2003).

Röhricht and Priebe (2006) have experimented body-oriented psychological therapy (BPT) on schizophrenic patients and compared the result to that of patients who received only supportive counseling. Both therapies were done in small groups and were an addition to the usual treatment. The results were that patients receiving the BPT actually attended more therapeutic sessions and their negative symptoms were significantly lower than they had been before, a result which lasted even after a follow-up test 4 months after the original test. This suggests that BPT is likely to be an effective treatment for patients dealing with schizophrenia. However, as the researchers themselves already state, more research is needed and with preferably bigger groups.¹⁷ Also, even though negative symptoms of schizophrenia decreased, other aspects of subjective life quality did not

¹⁷ The group receiving BPT consisted of 24 patients in this research.

significantly change after the treatment. This suggests that the treatment is on the right track, but can possibly be improved in terms of effectiveness. So what happened in this treatment?

There were five sections in the treatment. The first section was the 'opening circle' in which patients were asked where their 'center of body-awareness' was and where small activities and communication tasks were performed, such as throw over with balloons.

The second section was warming up: swings, stretches, jumps, walking, crawling. Also body awareness exercises focused on physiological functions as breathing and pulsation were performed.

The third section was the structured task section, which consisted of the following:

“exploring immediate vicinity from small to big and in all three dimensions; demarcating own boundaries with props, e.g. rope. Identifying a partner, defining demarcation of own boundaries in response to feedback. Mirroring exercises copying each other's movements; leading and following from a stationary position and then travelling with the purpose of exploring the body-ego as consistent, self-evident and active ; exploring emotionally equivalent movements, i.e. stamping, stroking, hiding away, defending. Creating body image sculptures on paper or in partners and comparing internal with external body-schema“ (Röhrich & Priebe, 2006, pp. 671-672).

This is a very important part of the treatment and it covers many areas of schizophrenia: feeling of spatiality and temporality, communication with others, reflection through feedback, a sense of self, and a sense of unity with the body. There lays an obvious phenomenological basis at this section of the treatment and as such it is useful to look at if one wants to test phenomenological treatment in psychiatry.

The fourth section of the treatment consists of the patients moving in a group circle, having them mirror movements and having them reflect on the feeling of it; do they experience stress or other discomfort or actually pleasure or other comforts during either the leading or the following actions?

The fifth and last section is closing the meeting by having patients reflect on their group experiences and re-focus on their self by “performing simple body-oriented exercises such as self-touch [and] verbal integration” (Röhrich & Priebe, 2006, p. 672)

Compared to the control group which got supportive counseling instead of BPT, there are a few important differences. Although the patients of both groups reported to be positive about the therapy without a significant difference, there was a significant gap in patients actually attending the therapy sessions. 8.33% of the patients did not attend the BPT sessions, compared to 33.33% of the

patients in the supportive counseling group.¹⁸ This suggests that a body-oriented therapy is preferred by patients over therapies that are not body-oriented. The other difference is perhaps even more important, which is that, as stated, patients of the BTP showed a significant decrease in schizophrenic symptoms, while patients in the supportive counseling group did not show this decrease.

Reflection on this study indicates that indeed a focus on embodiment and ipseity is beneficial for schizophrenic patients. This in turn suggests that indeed an enactive phenomenological approach towards psychiatry would be helpful for the field.

It has to be noted that this research was done with schizophrenic patients only, so it is possible that other patients suffering from other mental illnesses would have less benefit from these kinds of therapies. To make the scientific claims concerning the conclusions of this research stronger, of course it has to be replicated and preferably with more patients.

Nonetheless, the fact remains that the research of Röhrich and Priebe does show that there is a significant difference in psychiatric symptoms, which is a very supportive fact for the thesis of this paper.

3.3: Disclaimer: the limits of enactivism in psychiatry

Most of the psychiatric cases discussed in this paper have been cases of schizophrenia. There are numerous other mental disorders and it is important to keep in mind that not all mental disorders deal with distorted ipseity and a lack unity in the same measure. An enactive phenomenological approach will presumably be of better help for some diseases than for others. Therapy as suggested in paragraph 3.2.2 is focused on patients with a feeling of disembodiment. Disembodiment is not always the problem for every patient with mental distortions, since mental distortions come in a wide variety. There are also patients who are so confused that they are not able to think straight at all and as a result are not capable of communicating their experiences. Ordered thought, at least in minimal proportions, is needed for speech that makes any kind of sense. In cases where this is entirely absent, it is simply impossible to help patients with an enactive phenomenological approach; without being given access to one's subjective experiences, there is no way of understanding their mental disturbances from a personal level. Even though I have been arguing for an enactive phenomenological approach in psychiatric practice in a rather enthusiastic way, I do not claim that such an approach will deal with every issue in psychiatry. People will still get terrible diseases, with or without enactivism, and there is, in the distant future, nothing to be done about this.

¹⁸ In exact numbers: 2 out of 24 patients did not attend the BTP therapies, compared to 7 out of 21 of the supportive counseling.

Psychiatrists should offer help in the best way they can and I believe this involves an enactive approach. There will still be patients that cannot be cured at all. There will also be patients that can be cured, but not just by approaching their ipseity and putting their subjective experience at the forefront. Mental illnesses cannot be fully explained in neurological and biological terms. Nonetheless, the neurological and biological processes are still a very important part of what is going on and as a result, medicine will often still be needed in order to cure patients, or help them cope with their disease. With nothing that I have said do I want to suggest that medicine is not potentially helpful. Medicine can help with problems such as a chemical imbalance in neurotransmitters. I do not propose to replace medicine in full by therapies such as described in the foregoing paragraph. Instead, what will most likely lead to the best result is a combination of therapy and medicine.

There are also those who romanticize psychosis and madness¹⁹, I am definitely not arguing for that position. Mental disorders are often horrible diseases that make people suffer to suicidal degrees. Instead of romanticizing mental distortions, I suggest another way of looking at these distortions that is beneficial for patients and psychiatrists. Beneficial in a way that the psychiatric symptoms and the accompanying suffering can be lessened or, hopefully, even cured by putting a focus on a patient not as a brain, but as a person with lived experience and by taking into account the patients relationship to his world.

Conclusion

At the beginning of this paper, the thesis was formulated that psychiatric practice would benefit from an enactive phenomenological approach. In the first chapter it was explained what enactivism is, in order to approach psychiatry in an enactive phenomenological way in the second chapter. There it was shown why it is important to apply the notions of enactive phenomenology such as embodiment, subjective experience and ipseity, to psychiatry for a better understanding of mental illness compared to the one that is currently dominant. I have referred to a case study by De Haan and Fuchs that is illustrative for the way embodiment plays a part in schizophrenia. In the third chapter the focus lay more on explanatory and prescriptive power of enactive phenomenology in psychiatry, compared to the more descriptive chapter 2. In chapter 3 I have suggested enactive methods for diagnosing disorders and for giving therapy to patients suffering from mental illness.

¹⁹ See for instance Kusters (2014) who states that his book “puts madness where it belongs: not between diabetes and broken legs, as a lot of psychiatrists would make us believe, but between special experiences of wisdom, mysticism and creativity.”

This paper is by no means conclusive. As has been suggested in the second and third chapter, there is a lot of research to be done in order to empirically test, and hopefully support, the theory of enactivism, especially in psychiatry. I hope to have given some handles for researchers to give form to experiments.

I am looking forward with huge and enthusiastic expectancy to what new philosophical and scientific research will bring to the field of psychiatry. It is a thrilling idea that the ideas that philosophers have pondered upon from behind their desks can be taken out of the ivory tower of academic philosophy and might be of actual help to patients in the real world, with real-world problems. If a single patient benefits from the enactive phenomenological approach, I am satisfied. It is my hope and expectation however, that this approach will become a dominant one in psychiatry and consequently will be able to lessen a lot of psychiatric suffering.

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