THE EXTENDED MIND HYPOTHESIS, SELFHOOD AND SCHIZOPHRENIA

How can the pathological experiences of a schizophrenic’s selfhood be interpreted, and, do particular treatments of these pathologies accord with Clark and Chalmers’ extended mind hypothesis?

Submitted by Timothy Edward Shute to the University of Exeter as a thesis for the degree of Masters by Research in Philosophy.

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ABSTRACT

This thesis explores the pathological experiences of selfhood in schizophrenia and how this can be applied to a model of ‘mind’ in which ‘mind’ is constituted of both the biological brain and external materials. The aim of this paper is not to provide a systematic taxonomy of schizophrenia (i.e. a psychological assessment), although such discussion is included. Rather, its focus is on how schizophrenic symptomology can manipulate and disrupt the self-world relations with which humans are so accustomed. Firstly, it explores how this mental illness can disrupt the first-person perspective and the implications this entails for ‘selfhood’, leading this paper to advocate an embodied form of selfhood: ‘the SCALED self’. Secondly, it investigates how the schizophrenic’s ‘mind’ and/or ‘selfhood’ becomes coupled to therapeutic strategies during psychotherapy and bodily-orientated therapy and argues for possible cases of extended SCALED selfhood. Finally, it argues extension occurs during a newly-developed clinical treatment: avatar therapy. An application of extended mind theory to schizophrenic pathologies within this text brings to fruition new additional conceptual resources for phenomenological psychopathology. It further explains how patients develop different kinds of cognitive capabilities and behaviours during therapies, ultimately explaining their success.
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CHAPTER 1 INTRODUCTION

1.1 THE EXTENDED MIND
Since Clark and Chalmers’ (2010) paper *The Extended Mind* (1998), modern cognitive philosophy has witnessed an expansion in what is classified within the concept of ‘mind’. Externalists suggest objects, cultural elements and even other people, may partly constitute a person’s ‘mind’. This claim goes beyond a relationship of X * aiding* Y to achieve Z, to a relationship where X *is part of* Y that achieves Z. Clark and Chalmers suggest external elements can be as much part of one’s cognitive apparatus or selfhood, as any lobes or neurons of the brain (Bray, 2008: 8). “In these cases, the human organism is linked with an external entity in a two-way interaction, creating a coupled system that can be seen as a cognitive system in its own right” (Clark and Chalmers, 2010: 29). The entirety of this coupled system (X+Y) constitutes the cognitive system, rather than a causal sequence consisting of Y using or being influenced by X. The interactive link itself between the organism and objects *is* the cognitive processing. Therefore “cognitive processes ain’t (all) in the head” (Clark and Chalmers, 2010: 29). This thesis endorses this position, and applies the externalist account of mind to schizophrenia. Like myself, Bray (2008: 8) thinks claims of extension have consequences not only for cognitive science, but also for how we envisage selfhood.

1.2 THE SELF
‘Self’ is a term frequented in the English Language, and means something to those using it, contrary to Kenny’s (2000: 83) claim that “grammatical error… is the essence of the theory of the self”, based on misunderstandings of the reflexive pronoun ‘I’ (Strawson, 1999: 1). I share Strawson’s intuition that it is implausible that the problems of characterising ‘selfhood’ arise purely from a linguistic disparity between our human experiences and languages. The meaning of ‘self’ arguably stems from an independent notion that selfhood is an ontologically distinct thing. We have a distinct sense of an ‘I’, or experiencing as ‘a self’, to which certain things may be attributed. This is an intuitive, natural sense of self, and those who accept this feeling hold that this is not “delusory” (Strawson, 1999: 2).
Nevertheless, Lysaker and Lysaker (2008: 21) admit the “‘sense of self’ is a slippery phrase”. Therefore, to better understand what the ‘sense of self’ is, I now disambiguate this concept, highlighting the different dimensions commonly associated with ‘selfhood’, and situating my thesis within this vast array of literature.

**Persistence.** Discussions of personal identity commonly ask, ‘what makes me the same ‘I’ today, as ‘I’ was yesterday and will be tomorrow?’ Locke (1894) questions how the same self can remain, despite qualitative psychological changes and numerical physical changes occurring over time. This question concerns two contrasting forms of continuity: synchronic (short-term) and diachronic (long-term).

From moment to moment one seems the same person, who upholds the same beliefs and attitudes for example. This synchronic self seems stable and uninterrupted. However, we can reflect on our diachronic selves, questioning whether we are the same self as one year ago, or after long periods of unconscious, dreamless sleep or a medically induced coma. If person P1 and time T1 is numerically identical to person P2 and time T2, this means they are physically one and the same entity. Numerical identity, i.e. physical identity, is distinct from qualitative identity, a psychological, mental continuity. P1 and P2 are qualitatively identical if they are indistinguishable, namely possessing the same mental properties. Now, seeing as objects’ properties change over time, for example in cases of unconsciousness, numerically identical earlier and later objects (P1 and P2), will not usually be qualitatively identical (Dainton, 2014: 50).

Such discussions raise questions about whether ‘persons’ even are substantive entities persisting through time; with some philosophers (Dennett (1992), Siderits (2011) and Metzinger (2011)) arguing ‘selves’ are illusory. To hold that ‘selfhood’ is myth is to be an Irrealist about its ontological existence. Others, like myself, hold Realist positions that the self truly exists and is epistemically experienced through our self-consciousness (Maiese, 2016: ix). The experiential validation of the self’s ontological existence highlights a second dimension associated with selfhood.

**Knowledge.** Debates surrounding ‘selfhood’ seldom are without epistemological connotations: ‘how do I know who I am, how can I attain a sense of selfhood?’ Cartesian philosophy suggests such knowledge is gleaned from introspection, namely turning one’s attention back on itself and considering the first-person
perspective through which we encounter the world. In *Meditations on First Philosophy*, Descartes (2013) worries he is being deceived by a malicious demon, resulting in the possible fallibility of all his sensory beliefs. Nevertheless, Descartes (2013: 41) says, “I certainly *seem* to hear and to be warned. This cannot be false”, asserting he cannot be deceived about the contents of his own mind. Consequently, he thought knowledge of one’s own mental properties is therefore infallible: error and ignorance are eliminated. However, errors are possible regarding one’s sense of one’s physical body. For example, one can be deceived about the felt location of one’s limbs, when illusions such as the ‘rubber hand’ (Tsakiris and Haggard, 2005) disrupt the three-way modal interaction between vision, touch and proprioception. Thus, possibly one’s knowledge of body *is* corrigible, and can be reformed (Cassam, 2011: 151), whilst some mental states, such as self-awareness or specific sensations of pain enjoy intuitive infallibility (Kind, 2016).

The first-person perspective contrasts with the third-person perspective, namely knowledge of others. Introspection cannot reveal another subject’s mental properties; if two people, A and B both pierce their hands with pins, A cannot know B’s mental properties based on her introspection alone and vice versa. They must ask one another, giving A and B privileged positions to judge their own mental states, since they are fallible with regard to judging one another’s. However, it seems plausible that if they believe they themselves are in particular pained states, then they *are* in pain. Yet, I think endorsing infallible self-knowledge remains overly optimistic: Although suggested that introspective knowledge of one’s mental properties is epistemically privileged and thus incorrigible and infallible (Descartes, 2013), because it is knowledge of facts that are self-intimating, philosophers and psychologists alike now almost uniformly reject this position. Churchland (1988: 76-79) for example argues against the infallibility thesis, suggesting that especially when sensations are presented to us momentarily, mistakes are inevitable. He provides an example of a captured spy, whose interrogators repeatedly torture him with a hot iron. After many instances of experiencing pain, if the iron is replaced with ice, since the victim expects to feel sharp pain, Churchland (1988: 77) suggests the spy’s immediate response will not significantly differ; the spy will mistakenly think he is pained.
Consequently, my thesis does not allude to the infallibility of one’s knowledge of one’s mentality. Rather, my work endorses the ontological commitments of thinking itself. In the Second Meditation, Descartes (2013: 35) presents his notorious line of reasoning, ‘Cogito ergo sum’: I think, therefore I am. Even if an all-powerful demon could deceive Descartes about the external world, it could never bring about that Descartes was nothing, provided that he thinks that he is something. Therefore, Descartes can conclude with certainty that he exists (Kind, 2016). His existent selfhood is found in the structural entailments of his experience. This is the experience-experiencer thesis, put straightforwardly by Frege (1918: 27) in his statement, “an experience is impossible without an experiencer”. Shoemaker (1996: 10) endorses this, stating it is an “obvious conceptual truth” that any experience is necessarily the experiencing by a subject of that experience. Experience involves a subject as intimately as sunlight involves the sun. Consider the pain A feels when the pin pierces her hand. It essentially is a feeling, namely a ‘being felt’, and this felt pain cannot possibly exist without the existence of A as something that is a feeler. The “...experience is necessarily experience for—or experience for or on the part of someone or something” (Strawson, 2016: 270).

Identity. Selfhood also concerns the identity of this experiencing thing. Humans talk about individualisation, using the words “I”, “you”, “we”, and “he/she”. When questioning ‘what is the self?’ one often aims to answer ‘who am I?’ This metaphysical question asks what sort of things are we, if at all, and is commonly answered with reference to necessary and sufficient conditions. We separate ourselves from other artefacts in the universe, drawing borders between subjects (‘selves’) and objects. As Burkitt (1991: 1) says, “the view of human beings as self-contained unitary individuals who carry their uniqueness deep inside themselves, like pearls hidden in their shells” is deeply embedded. This concept of an individuated subject arises from our first-person experience, leading Damasio (2000: 12) to argue consciousness is “an entirely private, first-person phenomenon”. In James’ (2001) conception of the complex self for example, the “I” is equated with the self as knower, or, self as subject. A feeling of distinctness from others, namely experiencing individuality, is a necessary condition of substantive selfhood, and characterises this subjective nature of the “I”, known to oneself (Herman, 2011: 655). When I say human selfhood is essentially individualised, I mean the first-person
perspectival experience of one’s selfhood is unique. Within this first-person acquaintance, the body plays a crucial role. The skin becomes a boundary between inner and outer: everything happening outside the skin becomes ‘other stuff’, whilst everything happening within this boundary becomes one’s embodied first-personal world. Within the body, Sampson (1993: 34) suggests three natural ideas rule:

1. The individual’s boundary is indistinguishable from the body’s boundary.
2. The body is a container, housing the individual.
3. The individual is best conceived as a self-contained entity.

If we approach the body as if a container for the self or individual, then the necessary conditions for that individual’s continued existence are physiologically and psychologically confined within the body. Wilson (2004) argues individualism is a widespread assumption within cognitive, biological and social sciences, and assumes that in order to explain certain phenomena, one needs to explain what happens inside individual entities: “individualism is the thesis that psychological states should be construed without reference to anything beyond the boundary of the individual who has those states” (Wilson, 2004: 9-10). This is expressed in Sampson’s (1993: 36) claim that:

“…an individual has an inside that contains all the important features that comprise the person – everything that the person owns – and that this is distinct, separate and cut-off from all that is not part of the person, located outside the container”.

Within cognitive science, individualists claim that one’s mental states, processes, and capacities supervene on the intrinsic properties of that individual, most commonly the individual’s neurology or nervous system. Individualism may suggest for example, a person’s pain supervenes on the firing of the individual’s c-fibres, and this internal, physical subvenient base is metaphysically sufficient for the pain. This is the physical constitutivity thesis: realisers of states and properties are exhaustively physically constituted by the intrinsic, physical states of the individual to whom those states and properties belong. Consequently, individualists advocate what Jerry Fodor (1981) called ‘methodological solipsism’, bracketing off the world beyond the
individual by individuating and characterising cognitive states and structures. This thesis ultimately opposes this view.

Nevertheless Chapter 3 argues that the individual is essentially embodied, and thus distinct from all worldly artefacts. The overall structure of first-person experience is necessarily determined by our bodily dynamics as embodied individuals. Like Maiese (2016: ix), I endorse the view that this conscious experience with which each individual is tacitly acquainted is subjective, insofar as it necessarily involves an egocentrically centred, single experiential viewpoint that is spatio-temporally located wherever one’s body is. Therefore, this thesis answers the question ‘what am I?’ by suggesting humans are fundamentally embodied subjects. However, the latter half of Chapter 3 argues that our identity as individuals has a certain vitality and thickness. I propose this awareness of one’s body is complemented by a multiplicity of narratives that emerge through our interpersonal interactions and environmental engagement. Consequently, my own favoured account of selfhood, which builds on the theories of Sass and Parnas (2003), Maiese (2014, 2016) and Lysaker and Lysaker (2008, 2011), concludes that a holistic account of selfhood requires many layers. I term this theory of selfhood ‘the SCALED self’, explicitly referring to the different yet necessary levels that constitute what I am; fundamentally rooted in our embodied, biological nature.

In line with Wilson (2004), this thesis adopts a pluralistic position: the SCALED self accepts that whilst some states, processes, and structures are best understood as internal (e.g. pain, bodily sensation), it urges us to move beyond the biological boundary of the individual and recognise that some states are widely realised. Furthermore, it goes beyond Wilson, and argues that the self can extend and is widely realised by non-biological parts. Yet, I reiterate throughout; SCALED selfhood remains anchored in an embodied subject, and therefore cognition and selfhood remain “organism centered” (Clark, 2008).

1.3 THESIS OUTLINE

Schizophrenia is widely considered the most ‘philosophical’ of all mental disorders, as its pathologies of the self challenge the philosophical theories of selfhood grounded in the first-person perspective. Therefore, schizophrenia is the empirical foundation for this paper. It is suggested that some schizophrenic psychoses are
disorders of pre-reflexive self-awareness (Sass and Parnas, 2003), thus challenging fundamental assumptions within philosophy of mind, including the Cogito. I think clinical characterisations of schizophrenic persons may profit from philosophical understandings of the syndrome’s symptoms and from clear definitions of philosophical concepts such as ‘subjectivity’, ‘intersubjectivity’ and ‘minimal self’ (Stanghellini and Fulford, n.d.). Equally, the empirical evidence the syndrome supplies enables philosophers to gain further insight into consciousness and test the adequacy of philosophical theories of selfhood. Therefore, this thesis draws upon multiple testimonies detailing first-hand experiences of schizophrenia.

In order to better understand what schizophrenia is and how schizophrenic symptoms manifest, the following chapter explores literature on this pathological illness. Firstly, I discuss its history and its problem of definition. To qualify for a diagnosis of schizophrenia a person must exhibit at least two characteristic symptoms (Lysaker and Lysaker, 2008: 3). I secondly explore each symptom, discussing both positive symptoms (delusions, hallucinations, disorganised speech, catatonic or unorganised behaviour), and negative symptoms (i.e. a diminishment in one’s immediate acquaintance with his/her experience). I endorse Owen’s (2009) claim that there is, “something fragile about phenomenology: it requires a kind of living contact with thinking and clinical experience to be at its best”. This thesis takes a phenomenological approach, considering like Parnas and Sass the first-person perspective to be the “ultimate arbiter of validity” (2011: 522), thus Chapter 2 explores schizophrenic symptomatology with case studies that exemplify how patients have undergone these categorised symptoms. This chapter thus serves as a foundation for my discussions of schizophrenia.

In Chapter 3, I argue, “not only the sense of self, but also the self itself [is] essentially embodied and rooted in our biological nature” (Maiese, 2016: x). Arguing for what I term ‘the SCALED self’, I ground Sass and Parnas’ (2003) theoretical arguments for three dimensions of selfhood that come apart in schizophrenia, in the neurobiological dynamics of our embodied subjectivity. I suggest selfhood consists of multiple levels, some of which can extend, that build upon one another and originate from a perspectival subjectivity. Here, I draw upon the works of Albahari (2006), Sass and Parnas (2003), Lysaker and Lysaker (2008), and Maiese (2016).
Chapters 4 and 5 explore the complementary disorders of ipseity, firstly diminished self-affection and then hyperreflexivity, in relation to the SCALED self. Chapter 4 firstly sets out conventional arguments for extended mind, and the subsequent natural recognition of extended selves. I then explore diminished self-affection, and argue that the schizophrenic’s recognition of mental states as ‘theirs’ can be widely realised by psychotherapy’s specific languaging. Therefore, I argue the SCALED self’s personal ownership can extend. Finally, I explore some questions surrounding the self’s extension. I notice a disparity between Clark’s (2003) claim that the self is illusory, and his (2008) claim that the self is nevertheless “organism centered”, reaffirming that the SCALED self is grounded in desiderative bodily feelings. Chapter 5 firstly consolidates the notion that the first-person giveness of experience is body based. Via an analysis of hyper-reflexivity, I consider whether this symptom of schizophrenia results from a disruption in essentially embodied consciousness, and thus evaluate the SCALED self’s notion of foundational embodied subjectivity. I argue it nevertheless remains the core of subjectivity. However, unlike Chapter 4, I suggest bodily-orientated treatment strategies cannot constitute a part of a schizophrenic’s return to a ‘healthy and normal’ selfhood, but rather support rehabilitation, therefore distinguishing between extended and embedded cognition.

Strengthening arguments for extended SCALED selfhood, Chapter 6 explores a new treatment for auditory hallucinations: avatar therapy. I propose this therapy exhibits a clear extension of mind, providing multiple arguments that suggest similarities between Clark and Chalmers’ (2010) examples of cognitive extension and how patients approach the therapy. I argue parts of the therapy accord with the trust and glue conditions Clark and Chalmers (2010) provide as necessary requirements for extension, and suggest it can be subjected to manipulation to elicit specific cognitive responses that the patient alone cannot achieve. When patients engage in this therapy, I propose they form coupled systems that, understood holistically, are cognitive. I then make the final necessary step from extended minds, to extended SCALED selves. This chapter presents a unique contribution to the philosophy of psychiatry. Whilst Chapters 4 and 5 include current debates about the role embodied cognition can play in refining existing strategies and exploring new body-based therapies (Maiese, 2016; Fuchs, 2005), as yet, I am unaware of philosophical investigation into patient-avatarar relationships within this therapy. Thus whilst this
chapter remains somewhat speculative, it provides systematic discussions where further research is also possible.

But can the treatments I discuss ever ‘repair’ a schizophrenic self? Chapter 7 reflects upon what SCALED selfhood implies for therapeutic treatments. As human subjectivity is fundamentally embodied, to regain the personal ownership that one normally tacitly experiences, I propose that treatments should firstly seek to transform individuals’ “overall bodily and neurobiological dynamics” (Maiese, 2016: xxii). Secondly, as one’s ‘full’ or ‘thick’ sense of being comes from phenomenologically informed dialogical narratives, I propose that treatments should enable intersubjective couplings between patients and others. This will invariably lead to the notion of extended selves. Arguably, the positive results of avatar therapy suggest alternative modes of ‘extended therapies’ deserve further consideration. This thesis concludes that body, mind and world are invariably interconnected, and therefore all three must feature in schizophrenic recovery.

1.4 WHY THIS RESEARCH?
Davidson (2003) suggests the experience of severe mental illness like schizophrenia does not just involve alienation and uncertainty, but also patients will lose first-person authority with regard to their sense of self. These people may stop seeing themselves as “somebody, somewhere about whom a story might be told” (Davidson, 2003: 221). Arguably this loss occurs because schizophrenia “involved alterations in the core of a person’s subjectivity” (Lysaker and Lysaker, 2008: 1). However, what exactly is lost is something of debate amongst philosophers and psychologists alike: Sass and Parnas (2003) suggest the minimal self (Zahavi, 2005), namely the first-person perspective, can be disrupted and come apart in schizophrenic episodes. However, Lysaker and Lysaker (2008: 2) maintain schizophrenics retain an irreducible first-person dimension. Adequate conceptions of schizophrenia must therefore track the self’s fate throughout the illness, and determine what part(s) of human selfhood are disrupted. This thesis categorises these levels of disrupted subjectivity via my conception of a SCALED self.

This research has empirical implications. Presently, sustained recovery occurs in less than 14% of patients within the first five years following a psychotic episode (Robinson et al., 2004). Yet, new non-pharmaceutical treatments like avatar therapy
can boast success rates of 61.6% immediately after implementation, with a pilot study of twenty-six patients showing sixteen benefiting from significant reductions in the frequency and intensity of their auditory hallucinations of voices (Leff et al., 2014: 168). Insel (2010: 191) hopes the continued expansion in knowledge of schizophrenia and recognising that furthering understanding and treatment strategies may, and can, come from distant fields in science that as yet, have not engaged with this debate.

At present, one is diagnosed ‘schizophrenic’ after exhibiting late symptoms that emerge in a psychotic episode where the schizophrenic displays abnormal rationality and/or behaviours. Current treatments aim to reduce these psychotic symptoms. However, developments in discovery technologies continue to transform our understanding and treatment of other medical disorders that can revolutionise our understanding of schizophrenia. Less acute features of schizophrenia, such as social and behavioural deficits, and genetic vulnerability (Insel, 2010: 190) may be more noticeable, and treated by focusing on the cognitive deficits schizophrenia causes. The ultimate goal is for cognitive science to enable personalised care and therapeutics on a one-to-one basis that assess and serve the individual needs of each patient; I suggest such treatments can extend the cognitive capabilities of the patient concerned. This means not identifying possible pre-psychotic symptoms and responding accordingly, but ensuring every patient has access to intervention strategies and care, and ensuring full social inclusion for all people, anywhere on the schizophrenic spectrum (Insel, 2010: 191).

Rehabilitation literature suggests an important observation: schizophrenic patients can recover more empowered selfhoods “through the active construction of narratives regarding both their illness... and their relation to it”, if those constructions are enhanced by on-going environmental interactions and engagements (Lysaker and Lysaker, 2008: 30). I explore a rethinking of common therapeutic practices, and consider the phrase “on-going interactions and engagements with the environment” to allude to two-way interactions between the schizophrenic and the world, creating coupled systems that can constitute more empowered first-person perspectival experiencers to whom narratives can be attributed. I think developments in personalised care should acknowledge the schizophrenic’s unique relationship with
the world, and their subjective experiential viewpoint. This is demonstrated in one 30-year-old man’s statement that “If you had been able to talk with the “me” that knew how frightened I was... then we could have handled that [first person subjectivity]” (Anderson and Goolishan, 1992: 25).

Therefore, this thesis’ exploration of schizophrenic patients’ on-going interactions and engagements with the environment has practical applications. I argue extended mind theory accords with the narratives surrounding rehabilitation, and can explain why treatments such as psychotherapy and avatar therapy are successful. Consequently, this thesis should explain the reasons why interventions that include an “aggressive focus on cognition…” may prove surprisingly effective for pre-empting or forestalling psychosis. I therefore agree with Insel’s (2010: 191) statement that, “[i]f the preemptive interventions are as effective as what we have today for coronary artery disease and if these are widely deployed, by 2030 we should expect a profound reduction in first-episode psychosis.”
2.1 THE HISTORY OF SCHIZOPHRENIA

Bleuler (1911) and Kraepelin (1919) first conceptualised schizophrenia almost 100 years ago. These authors are credited with documenting and linking the disturbances now regarded as characteristic symptoms of the illness (Lysaker and Lysaker, 2008: 9). The non-specific concept of madness has existed for thousands of years, with historical evidence traceable back to Pharaonic Egypt, in the second millennium before Christ. Further brief descriptions of an illness resembling schizophrenia are found in the Hindu Ayurveda, 1400 BC. However, the earliest and unambiguous descriptions of schizophrenia were made in the 18th century, and it was still unclassified as a distinct mental disorder until 1887 by Emil Kraepelin (Kendell, 1993: 397). He first distinguished between what he called ‘dementia praecox’ and manic depression. Kraepelin considered dementia praecox primarily a disease of the brain, specifically, a form of dementia. He called it ‘dementia praecox’, meaning early dementia, or ‘premature deterioration’ (Roe and ben-Yishai, 1999: 371), to differentiate it from other types of dementia like Alzheimer’s. Then, in 1911, Bleuler used the word ‘schizophrenia’ (Schizophrenia, n.d.). This term intended to capture the meaning underlying his theory (‘schizophrenic’ deriving from the Greek ‘skhizo’ [split] and ‘phren’ [mind]). Bleuler did not intend for his term to convey the idea of split/multiple personalities, commonly associated with schizophrenia today (Birchwood et al., 1989: 16).

2.2 THE PROBLEM OF DEFINITION

Since Bleuler, the definition of schizophrenia has continued to morph, as scientists attempt to more accurately delineate the different types of mental diseases. Bleuler was first to describe the symptoms as “positive” or “negative” (Schizophrenia, n.d.). He thought that the loosening of associations is the essential feature of schizophrenia. The definition of schizophrenia is disjunctive in nature; it is defined according to multiple sets of characteristics. Thus, there are no necessary or sufficient identifying conditions. Consequently, two patients, both classed ‘schizophrenic’ may exhibit no common symptoms. Whilst this might appear counter to a definition’s function, disjunctive definitions are not unusual; few definitions are based on necessary and sufficient conditions (i.e. ‘monothetic’ definitions).
Birchwood et al. (1989: 17-18) explain how in zoology the classification of animals is ‘polythetic’, meaning that they are defined by the presence or absence of sets of features, none of which are essential for class inclusion. For example, we define one-legged feathered creatures as ‘birds’, despite most featuring two legs. A disjunctive definition is useful when defining schizophrenia because it is inclusive to multiple symptoms. Family resemblance, discussed by Wittgenstein in Philosophical Investigations (2009: 76) suggests that things thought to be connected by one common feature alone are actually connected by multiple, overlapping similarities with no singular feature common to all, as schizophrenic symptomology illustrates.

Yet, it is questionable, ‘where’s the schizophrenia that exists beyond the presence of these unusual experiences?’ Szasz (1978) for example, suggests schizophrenia has no substantive existence as an illness beyond the minds of psychiatrists; its biological character is unlike other “organic” diseases (Szasz, 1979: 90) such as cancer’s ontological existence, and patients suffering from schizophrenic episodes should be considered primarily as individuals, not lumped together as class members bearing a family resemblance. (Members of a class would be the ‘idiopathic’ approach). However, this claim is ultimately erroneous; medical classifications like the (DSM) IV-TR sufficiently determine a class relationship within a group of patients where individual members may nevertheless be symptomatically isolated.

2.3 SYMPTOMS OF SCHIZOPHRENIA

In the twenty-first century, the conception of schizophrenia has become so pervasive approximately 1% of individuals may be labelled ‘schizophrenic’ during their lives (Bentall, 1990: 23). This statistic holds for both industrial and Third World countries. Schizophrenia manifests in numerous ways with varying degrees of severity, meaning ‘schizophrenia’ is ultimately a descriptor that signifies a conglomoration of symptoms. The diagnosis of ‘schizophrenia’ relies upon observations that illustrate a change in the patient’s experiences; specific perceptions, behaviours, thoughts or emotions may drastically diminish or magnify over the course of many months (Lysaker and Lysaker, 2008: 2-3).

Within present psychiatry, three major diagnostic classification systems are used. These are: the ICD-10 (World Health Organisation, 1992), the Diagnostic and
Statistical Manual (DSM), and the Research Diagnostic Criteria. The ICD-10 is more prevalently used throughout Europe whilst the United States more commonly relies upon the DSM-IV. They have similar criteria for diagnosis, both consisting of primary lists of symptoms. To qualify for a diagnosis of ‘schizophrenic’ according to the Diagnostic and Statistical Manual (DSM) IV-TR (American Psychiatric Association, 2000), an upgraded version of the DSM IV, a person must exhibit at least two characteristic symptoms from a list of five:

a) Delusions
b) Hallucinations
c) Disorganised speech
d) Grossly disorganised or catatonic behaviour
e) Negative symptoms

Furthermore, there must be continuous signs of disturbance for six months or more, and the characteristic symptoms must last for one month, unless treated. These symptoms cannot result from intoxication or drug use or be attributable to depression or other distinct medical conditions (Lysaker and Lysaker, 2008: 4).

Schizophrenics undergo changes in their mental and social functioning. Sometimes these changes are transient, but most commonly these changes are episodic or permanent. It is estimated less than one third of patients can expect to return to ‘average’ levels of functioning (Birchwood et al., 1989: 4). It varies how and when symptoms manifest in patients; it is not uncommon to first manifest in adults over 45 years (Jeste et al., 1997), although women tend to have relatively later onset than men. Males also have significantly higher rates of schizophrenia than women: 2.4% vs. 0.9%. For men, earlier onset seems to correlate to poorer long-term outcomes, whilst women who experience earlier onset may face a better prognosis (Lewine, et

1 I recognize the DSM IV-TR has since been updated to the DSM V in 2013 with modifications to its definition of schizophrenia: “Specific changes in its definition include elimination of the classic subtypes, addition of unique psychopathological dimensions, clarification of cross-sectional and longitudinal course specifiers, elimination of special treatment of Schneiderian ‘first-rank symptoms’, better delineation of schizophrenia from schizoaffective disorder, and clarification of the relationship of schizophrenia to catatonia” (Tandon et al., 2013: 1). However, as my research includes literature predating this recent publication, I refer to the DMS IV-TR for consistency. Nevertheless, schizophrenia’s fundamental nature that this thesis discusses remains understood in the same way in 2016.
It also occurs in children, although rarely (Asarnow et al., 2004). I now explore the characteristic symptoms the *DSM IV-TR* highlights for diagnosing 'schizophrenia'.

**a) Delusions**

Schizophrenic delusions involve odd, bizarre thoughts that other people consider incredulous. They represent beliefs that are unshared by the individual’s cultural peer group (Birchwood, 2001: 2). Examples might include: thinking one’s relatives are poisoning them, believing that signs or traffic patterns hold special messages for them alone, or even believing their heart is stone, or that they were raised by radioactive sharks (Lysaker and Lysaker, 2008: 3). Characteristically, schizophrenics tend to be “unshakable” in their faulty beliefs while ‘normal’ people commonly change their beliefs according to new information (Bernheim and Lewine, 1979: 26).

One 23-year-old schizophrenic reported:

“…I began to get delusions… I kept thinking the Mafia were after me, and the FBI were protecting me, ready to send me away to get trained… I made a false confession of murder so that they [the police] would incarcerate me and protect me from the Mafia” (Birchwood and Jackson, 2001: 2-3).

There are three main types of schizophrenic delusions. The schizophrenic may believe and feel his behaviour is being influenced or controlled by external forces (delusions of influence and control). Equally, he may feel that thoughts he does not own are put into his mind (thought insertion), or conversely that his own thoughts are being removed (thought withdrawal) (Kendell, 1993: 401).

Lysaker and Lysaker (2008: 8) provide testimonies illustrating this schizophrenic symptom. One unnamed man had been married and employed for years, then became ill, experiencing delusions of control. “One day, he would attribute his actions to commands sent to him through electrical currents [(a sensory hallucination)] by non-corporeal spirits. A month later, he could coherently talk about his past and future and argue there was no reason to defend his previous belief about spirits”. Then, one month on, he destroyed his furniture and starved himself to punish the spirits he believed were guiding his actions. Two months later his beliefs
again vanished and he reorganised his life, yet soon after he was arrested for shoplifting from a department store, claiming he needed items for a ritual to honour the spirits controlling his actions. This report illustrates that schizophrenic symptoms are stable traits, but can dramatically fluctuate over short time periods. The subject’s interpretation of these delusions, arguably depends on the individual’s cultural background. For example, Europeans afflicted with thought disturbances may attribute their source to God or the Devil, whilst Africans and West Indians may cite spirits or witchcraft. In the 21st century, inhabitants of modern industrial countries may attribute their thought disturbances to technologies capable of broadcasting information, such as laser beams, televisions and satellites (Kendell, 1993: 401).

Schizophrenics can secondly experience delusions of persecution, believing they are being watched, followed, or persecuted somehow (Birchwood et al., 1989: 6). Such delusions illustrate the unpredictable nature of the schizophrenic mind. The halo effect is how we unintentionally but unavoidably bias our feelings towards someone. For example, if we dislike someone’s overuse of ‘like’ in their conversations, this dislike will carry over, against reason, to our judgement of other things they do. This is a negative halo effect. A halo effect can also occur in positive ways; Bernheim and Lewine (1979: 26) give the example “love is blind”. These are normal biases operating against objective information. Whilst most people can learn to overcome the pull of the halo effect, the schizophrenic struggles: they can be swept away by biases and are unmindful of appropriate actions. They might, for example, interpret the person’s over-use of ‘like’ to be deliberately trying to bring about their demise.

Finally, schizophrenics may experience delusions of identity; losing their sense of identity or purpose and believing they have abnormal powers or abilities (Birchwood et al., 1989: 6). This could include believing one’s thoughts are accessible to others and are broadcast externally. Joe, a 22-year-old diagnosed with schizophrenia for example reports, “I avoided going out because people on the street could read my thoughts. My mind was transparent…” (Birchwood and Jackson, 2001: 1).

The experiences described by one schizophrenic, Frank, epitomise in parts all three forms of schizophrenic delusions. He first developed symptoms at around twenty-one, having already been in psychotherapy to discuss his uncertainty about the course of his life regarding work and love. Having had a normal upbringing, he
expressed frustration at his financial dependence on his parents and shame concerning his lack of effort in school. During a family vacation, having taken a break from therapy, Frank developed serious psychosis and experienced delusions both of persecution (believing the spouse of a former teacher was arranging his assassination) and of influence and control (thinking road signs showed him sexual feelings that had been inserted inside him). Despite immediate pharmacological intervention, his psychosis did not cease. Several months later Frank still thought his demise was coming. He believed if he stopped thinking about his persecution, everything became unbearable, and he would lose a sense of purpose. “Without these thoughts, he felt only ‘emptiness and nothingness’, a subjective state infinitely more painful than fearing a death he might still avoid” (Lysaker and Lysaker, 2008: 37).

Frank’s fluctuation between feelings of diminished self-affection and delusions of both persecution and thought insertion evidences a first-person perspective to Frank’s illness that requires philosophical investigation. Third-person analyses of his schizophrenic episode would be incomplete, failing to account for the reflexive dimension of his symptoms, which for Lysaker and Lysaker (2008: 38) “disclose to him a sense of his own welfare in the world”. Such accounts would overlook how Frank underwent these symptoms as a part of his illness. Therefore, Owens (2009) says there is “something fragile about phenomenology: it requires a kind of living contact with thinking and clinical experience to be at its best.” I follow Sass and Parnas‘ (2003: 427) standard philosophical use of the term ‘phenomenology’, referring to the subjective dimension of schizophrenia. Phenomenological feelings of persecution structurally entail a subject finding him/herself persecuted. This implicates other phenomena. For example, for Frank to experience persecution, regardless of this delusion’s truth, there is a subject he associates as ‘himself’, which is, from his first-person perspective, persecuted. I reemphasise this because it implies that should an account of schizophrenia fail to acknowledge the first-person perspective experiencing thought insertion, persecution or auditory hallucinations, then the account for that symptom is incomplete. Consequently, “one cannot do justice to schizophrenia unless one addresses its manifold first person dimensions” (Lysaker and Lysaker, 2008: 38). My endorsement of this approach does not entail a rejection of third-person biological and psychological classifications, but only
reiterates that the lived phenomenological dimension must be deeply considered in this investigation.

b) Hallucinations
Coupled with delusions, hallucinations form a set of ‘positive symptoms’ because they represent sensory experiences not shared with most people in the absence of appropriate external stimuli. Hallucinations range in content, severity and form, and can involve voices or sounds, vivid visual imagery, odours and/or bodily sensations, all of which lack discernible external causes. Only sometimes are patients aware their experiences do not match reality, which if they can, may enable them to ‘ignore’ the disruptive hallucinations more or less successfully. Some schizophrenics for instance can continue their activities whilst hearing voices, reminding themselves that they are illusory. This however is difficult, and others carry out the voices’ commands to hurt themselves, refuse to speak, or engage in other inappropriate behaviours.

Bentall (1990) used research into ‘metacognition’ to explain why patients hallucinate. Experimental psychologists use the term ‘metacognition’ to explain the mental processes involved in knowledge about one’s mental processes: such processes enable humans to guide and command their thinking (Flavell, 1979: 906), as well as introspect. Research implies that one uses inferential skill to discriminate between ‘imaginary’ and ‘real’ experiences; perceived events are not automatically endorsed as self-generated or externally generated phenomena. One’s available evidence informs our guesses between these possibilities. According to this view, hallucinations occur when someone wrongly infers that internally generated cognitive states (Bentall, 1990: 36), such as feeling electric charges run down one’s spine, are generated externally by ‘real’ stimuli. Another example is thinking someone else spoke one’s verbal thoughts. Evidence supports this hypothesis: Heilbrun (1980) discovered persons prone to hallucinations are relatively poor at identifying their own previously recorded thoughts. By asking 20 patients (12 hallucinators) on a short-term psychiatric inpatient unit to identify lexical, semantic, and syntactic properties of their own thoughts expressed one week earlier, the hypothesis that the hallucinators were less able to do so was demonstrated. Bentall and Slade (1985: 160-163) also used a signal-detection task to demonstrate those most prone to hallucinations are
biased towards attributing experienced phenomena to external sources when uncertain of their origin (Bentall, 1990: 36).

c) Disorganised Speech
Schizophrenic patients have difficulty organising and directing their thoughts towards goals, thus their thought processes lose their logical continuity; associations become ‘loose’. For example, if asked ‘how old are you?’ a schizophrenic may answer, ‘I’m 46, 4 less than 50, which is half 100, but double 25’. Bleuler (1950: 22) describes the disorder as such:

“in the normal thinking process, the numerous actual and latent images combine to determine each association. In schizophrenia however, single images or whole combinations may be rendered ineffective, in an apparent haphazard fashion. Instead, thinking operates with ideas and concepts which have no, or completely insufficient connection with the main idea and should therefore be excluded from the thought process. The result is that thinking becomes confused, bizarre, incorrect, abrupt.”

Those affected by disorganised speech lose their train of thought during conversations, make loose associations between topics, and give unrelated answers to questions, with thoughts simply connected because they occur simultaneously. (Bernheim and Lewine, 1979: 27.) The schizophrenic may speak continuously, yet provide numerous irrelevant details and never reach the fundamental point. Occasionally, speech becomes so disorganised that it becomes an unintelligible ‘word salad’ devoid of discernible meaning, despite being full of words (Nemade and Dombeck, 2009).

Normal thinking follows logical rules. It had been suggested that perhaps schizophrenic thought processing was guided by different logical rules, which, if discovered, could explain its disorganised associations. Take the statements ‘all librarians work in the library’ and ‘Rose works in the library’ for example. These statements suggest no relationships between librarians and Rose. However, if schizophrenics typically concluded Rose was a librarian, this would demonstrate schizophrenics used different logical rules to predicate logic. Yet, when comparing schizophrenics to non-schizophrenics of similar intelligence, no consistent
differences in logic were found (Broen, 1968). This lack of consistency illustrates the diversity of ungoverned schizophrenic thought processes psychiatrists must try to decipher.

**d) Grossly Disorganised or Catatonic Behaviour**

Lysaker and Lysaker (2008: 4) define this symptom as, “acting in ways that are frenetic and chaotic, without any apparent purpose, or having no behaviour at all”. The person may just stand or sit as if frozen. “A person in a catatonic state might rigidly sit for an hour with a blank expression, as if made out of plastic.” Disorganised behaviours may range from simple problems like sustaining goal-directed self-care such as washing or dressing appropriately for the weather, to sudden, socially inappropriate outbursts. Mismatches between the subject’s emotional responses and the setting or topic of conversation are possible; giggling through important or distressing events such as during a funeral being the most common example (Kendell, 1993: 402). The patient thus exhibits an ‘emotional blunting’. This is connected to the affective flattening patients may feel, discussed under ‘negative symptoms’.

Catatonic motor behaviours are a type of disturbed behaviour that can occur when schizophrenia goes untreated. In catatonia, the schizophrenic’s engagement with their surroundings noticeably decreases. They may assume rigid postures, and then remain motionless for extended periods, even resisting efforts to move them. “Waxy flexibility” is a psychomotor symptom of catatonic schizophrenia (Ungvari et al., 2009). The patient may allow themselves to be moved into positions, but not self-actuate their movement. If one were to reposition the arm of someone with waxy flexibility, it would remain there until moved again, as if it were wax. Usually, this is not ‘pretend’, but rather a genuine and unpremeditated symptom of schizophrenia the patient cannot help. This disturbance in motor control is also linked to other disorders, for example mood disorder with catatonic behaviour (DSM-IV TR). However, catatonia now occurs less frequently in schizophrenia due to advances in treatment (Nemade and Dombeck, 2009).

**e) Negative Symptoms**

Comparatively little progress has been made in understanding negative symptoms compared to other psychotic phenomena. Part of the problem of explaining negative
symptoms is the lack of clear understanding of what these symptoms are and how they relate (Bental, 1990: 47). Nevertheless, there is general consensus that there are three ways negative symptoms may manifest. As the name suggests, these symptoms represent a loss of the individual’s functions, particularly relating to emotions and motivation. Firstly, patients may experience an affective flattening, namely a reduction in the range and intensity of their emotional expression. Patients experiencing affective flattening have fairly unresponsive facial expressions, frequently accompanied by poor or unnatural eye contact and diminished body language or movement. Such individuals might withdraw from social contact and find themselves overcome with a sense of emptiness, listlessness and find it difficult to sustain their attention (Birchwood et al., 1989: 6-7). The following schizophrenic narrative describes one experience of negative symptoms:

“… I used to like football... I’d sit up late and watch it, if it was on. But now, it’s as if I don’t care... And him (pointing to infant son, aged 5) well of course, I still love him, but I don’t feel it in here, inside. Even a drink… It’s as if I can’t get drunk any more, well… I don’t seem to get hungry either. I eat OK, but I can’t get, well, really hungry… There’s not much difference between being awake or sleeping” (Birchwood et al., 1989: 6-7).

This testimony further points to a second aspect of negative symptoms: avolition. This is the inability to initiate and persist in goal-directed behaviours, and when misinterpreted, can be mistaken for deliberate disinterest. The patient above exemplifies this, describing how he lost interest in activities that he previously enjoyed. He lost motivation for life, and expressed indifference towards his family. In extreme cases, avolition becomes catatonic (Nemade and Dombeck, 2009).

Similarly to avolition, alogia describes a lessening of the schizophrenic's sociality and wholeness of experience. Alogia refers to difficulty speaking; there is a lessening of speech fluency and productivity. Some schizophrenic patients demonstrate alogia by answering questions with short, empty replies, and their fluidity of speech is impaired. The following imagined conversation illustrates how alogia affects one’s speech output:
<table>
<thead>
<tr>
<th>Normal speech</th>
<th>Alogia</th>
</tr>
</thead>
</table>
| Q: Do you like animals?  
A: Yes, I’ve a dog and two cats.  
Q: What are their names?  
A: Snowball is my dog, my two cats are Hairball and Fluff.  | Q: Do you like animals?  
A: Yes  
Q: What do you like?  
A: Dogs and cats  
Q: Do you have any?  
A: Yes  
Q: How many?  
A: Three  
Q: Are they dogs or cats?  
A: One dog and two cats  
Q: What are their names?  
A: Snowball, Hairball, and Fluff  
Q: Who is “Snowball”?  
A: The dog |

Negative symptoms all imply a diminishment in the patient’s self-affection; i.e. their self-worth. Ultimately, these negative symptoms may cause significant strain on the patient’s family. Social withdrawal, emotional detachment and staying in bed may cause families to have experiences akin to those expected if the schizophrenic person was deceased. One mother of an adult schizophrenic stated, “…She just sits there… they can’t bring my daughter back. Sometimes my husband and I just want to cry.” (Birchwood and Jackson, 2001: 5).

2.4 CHAPTER SUMMARY

- Schizophrenia is a disorder of the first-person perspective, characterised by an experienced distortion of reality, impaired experiential immediacy to one’s actions and emotions, erroneous thought processes, and debilitated sociality.
- Hallucinations and delusions are commonly thought to be core symptoms of schizophrenia (Birchwood and Jackson, 2001: 20).
- Schizophrenia is disjunctive by nature, and two schizophrenics may have no similar symptoms.
Despite theories of madness prevailing throughout the centuries, only with modern classification systems such as the *DSM IV-TR* have psychiatrists been able to reliably diagnose somebody ‘schizophrenic’.

The diagnostic criteria the *DSM IV-TR* uses has some overlaps; for example, catatonic behaviour and experienced emotional blunting form parts of negative symptoms.

Acknowledging and investigating the first-person perspective is an essential way to understand the experiential feelings schizophrenia elicits, and what exactly it is that requires treatment.
CHAPTER 3. SELFHOOD AND SUBJECTIVITY

3.1 INTRODUCTION
This chapter firstly explores the nature of the first-person perspective, discussing the different constitutive parts of one’s self experience. I argue the first-person perspective is comprised of both a reflexive experience of being a subject, grounded in one’s sensorimotor experiences of one’s embodiment, and a reflective notion of being an “I” who identifies and thus owns the experience. I reject theories of selfhood that neglect the bodily dimension of reflexive experience or suggest the body is a mere “…vessel for the mental thing that one really or most essentially is” (Strawson, 1999: 3). Secondly, this chapter develops a multidimensional notion of selfhood, ‘the SCALED self’, using three approaches as my orienting framework. These are the phenomenological, enactive and dialogical approaches. I argue the self requires a ‘thick’ description, incorporating aspects of these different approaches. Specifically, this chapter combines the transcendental conditions of sensorimotor subjectivity self evident in experience with a dialogical world-involving self, which I argue arises through how one enact[s] one’s world. I evaluate these different views and weave them together into a more substantial model of selfhood. I also suggest this self’s relation to extended mind theory, so that, moving forward in this thesis, my conception of SCALED selfhood is compatible with extended models of cognition, and ultimately, extended selfhood.

3.2 WHY IS SCHIZOPHRENIA PHILOSOPHICALLY INTERESTING?
Schizophrenia has both descriptive and heuristic value. Firstly, we can use schizophrenia to test the adequacy of philosophical concepts of selfhood and see if our descriptions of consciousness and self-experience are reflected in the forms of consciousness that patients demonstrate. Empirical investigation and observation enable one to challenge one’s understandings of the basic structure and conditions of consciousness to accommodate the first-person narrative accounts of these experiences. Secondly, schizophrenia is heuristically valuable as it enables deeper understanding of consciousness. Schizophrenic abnormalities illuminate the ‘deep structure’ of selfhood, namely the self-manifestation of consciousness including affectivity, intentionality, temporality and corporeality. These things fragment in
schizophrenia and highlight the inherent fragility of subjectivity, which, consequently, can fracture or break.

Bleuler and Kraepelin both considered pathologies of selfhood important components of schizophrenia; Bleuler (1911: 143) noted that the patient’s ego tends to undergo “the most manifold alterations” including an experiential splitting of their selfhood or passivity and disconnect from the world and their emotions. Kraepelin (1896) also suggested a core feature of schizophrenia was “a loss of inner unity”. However, neither presented concrete and systematic clinical descriptions of anomalous self-experience.

3.3 THE PHENOMENOLOGICAL VS. THE EMBODIED, ENACTIVE APPROACH

Sass and Parnas (2003; 2011) adopt a phenomenological approach to the self. Their objective is to better grasp the self’s phenomenology holistically, taking lessons from schizophrenia and generalising this to a phenomenological conception of selfhood beyond schizophrenic pathologies. Nevertheless, they primarily focus on achieving a better understanding of the psychopathological architecture of disordered schizophrenic self. For them, schizophrenia is:

“… a self-disorder or, more specifically, an ipseity disturbance in which one finds certain characteristic distortions of the act of awareness. Ipseity refers to the experiential sense of being a vital and self-coinciding subject of experience or first person perspective on the world (ipse is Latin for "self or itself")” (Sass and Parnas, 2003: 428).

When Sass and Parnas discuss disruptions of minimal selfhood, this refers to the minimal sense of being an experiencer. They propose three dimensions of ‘self’ that can separate in schizophrenia. I endorse these descriptions, but argue the ipseity disturbances described are grounded in more general descriptions of embodied selves and sensorimotor subjectivity. Sass and Parnas do not develop notions of enaction and interaction in ways this chapter does, favouring instead individual analyses of mental subjectivity. However, I will argue selfhood is grounded in one’s “unique continuing essential embodiment” (Maiese, 2016: 50).

I accept the implications this brings. Most notably, by acknowledging the extent to
which consciousness is a dynamic process animated by precognitive habits and sensibilities of the lived body, this means an envatted brain would have radically different experiences. Its inability to experience via a proprioceptive sensorimotor system or kinesthesia would radically alter its subjective experiences, as its mode of interaction with its environment would substantially differ, making many normal perceptions and motor actions impossible. If embodiment is a necessary condition of consciousness, “then there can be no such thing as an envatted brain with a consciousness like ours” (Maiese, 2016: 26).

3.4 SELF-REFERENCE

The first dimension of selfhood Sass and Parnas discuss refers to primitive, basic self-awareness: ipseity. Within every conscious episode, one has a sense that one’s mental state is immediately recognised as given to one’s subject. It is a matter of experience ‘offering to’ and “imposing itself upon” one’s subject (Maiese, 2016: 6). This givenness of experience is not an additional phenomenological layer that one’s experience could lack. It is a transcendental condition of any experience that is mine, namely it is precisely its first-person givenness that makes the experience subjective. “Experience is familiar with itself or knows itself… consciousness is in some sense intrinsically reflexive” (Parnas and Sass, 2011: 525).

Self-reference is considered non-propositionally. We do not have to consider the ‘I’ reflectively, which would be to have the perceptual experience and reflect upon the ‘I’ having the experience. Rather, self-reference is pre-reflective. One cannot objectify one’s own basic self-awareness. “In other words, a subject cannot simultaneously be given as his own object” (Parnas and Sass, 2011: 526). This is because if we were without the subjective presence of perception by way of objectifying it, nothing else could be experienced, because its subjectivity is a transcendental condition of experience. Consequently, subjectivity is inherently elusive.

On the level of first-order experiences, we are the self-present subjects of our own experiences; conscious experiences are intrinsically reflexive. It is our basic experiential structure; all experience points back to the subject having the experience. This is the experience-experiencer thesis. Strawson (2011: 253) says, “Concretely occurring experience can’t possibly exist without the subject of experience existing”. This is logically coherent. Firstly, there are experiences (P);
e.g., when I cut myself, I feel my broken skin and experience discomfort. Secondly, ‘experiences’ are experienced by something (Q), namely the discomfort of the cut is given to me. Finally, experiencers experience (R): this is a tautology; by definition, to be an experiencer is to be a subject that is undergoing or has undergone experience. The logic below demonstrates Strawson’s experience-experiencer thesis:

1. \( (P \rightarrow Q) \)
2. \( (Q \rightarrow R) \)

\[ \therefore (P \rightarrow R) \]

This hypothetical syllogism necessitates that if something is an experience, then something must experience the experience, and secondly, if something experiences it, that thing is an experiencer. Strawson (2011: 254) says “Experience is experiencing: whatever remains if experience remains, something that is correctly called a subject must remain.” It is possible to reach this conclusion without endorsing any ontological categorisation of what the nature of the “subject” is. All the above logic demonstrates is that a self-referential “I” is implicated in experiences. This is the minimal self for Sass and Parnas; the irreducible subjectivity that must remain once everything other than experience has been stripped away.

Yet, this minimal self is nevertheless grounded in its embodiment. For example, when I cut myself, and am tacitly aware I am feeling something, this feeling originates from a bodily sensation of my cut skin. Therefore, when the tactile sensation is given to me as the ‘thing-in-discomfort’, one is necessarily acquainted with the subjective experience in its embodied felt first-person mode of presentation. Therefore, awareness of oneself is to be in cohesion with this embodied subjectivity illustrated in Fuchs and Schlimme’s (2009: 571) statement that “[t]he subject body functions as the medium and background of our experience”.

The phenomenological approach to selfhood suggests that the self is not to be apprehended outside of this necessary experience/experiencer relationship. The first-person perspective moulds the structure of self-reference; tangible sensations of matter cutting my skin are given to me: an intangible perspectival source of my discomfort. I agree, but argue the ‘source’ is an essentially embodied sense of self,
which is intrinsically reflexive and involves an “egocentrically structured standpoint that constitutes our embodied spatio-temporal orientation…” (Maiese, 2016: 50).

Maiese (2016: 51) suggests the self is metaphysically real, in the sense of being empirically real. I interpret this as implying the self is a robust “thing” in the world, existing independently of our thoughts of it and whose nature is not reliant on how (if at all) we conceive it. We can only deal with experiential phenomena, and, at times, we can call our perceptions of phenomena objective. This is because the mode in which we perceive the world, namely through sensorimotor subjectivity, is a necessary element of being human, and therefore is common and consistent to all. We cannot experience in any different manner. The embodied ‘source’ of subjectivity is therefore necessarily as it is, and thus empirically real. However, it is not ‘truly real’ in the way Noumenal Realists describe: the self is not some kind of substantial entity that exists separately from one’s embodied feelings. The self is not a transcendental ego, or some other kind of separately existing substance that serves as a stable basis for our experiences. So, the self-reference cannot be apprehended outside of its embodiment. But it is not nothing: therefore Maiese (2016: 50) proposes both one’s sense of self and one’s ‘self itself’ are real, in virtue of being essentially embodied phenomena rooted in our biological nature. This is to hold an empirical realist position about the self.

I endorse this idea of the self: it exists but does not subsist as an entity divorced from the neurobiological dynamics of its embodiment. Yet, I have, and continue in this analysis to use the phrase “transcendental condition of experience/subjectivity”. I must clarify how I use this term. By “transcendental condition” I mean something that is a necessary product (i.e. way) of our human, embodied condition. So, when I say “the experiencer is a transcendental condition of experience”, I simply imply a relationship of necessity: an experiencer must exist for the experience. For us, there is no possibility of experiencing things outside of this relationship. However, this is a contingent feature of our world as human entities. Perhaps, in another world, humans similar to us could experience without this subjectivity, but for us, locked within this transcendental condition, it remains inconceivable how this would occur. The embodied ‘experiencer’ present within the mode of giveness of all experience I now discuss in the following section.
3.5 FIRST-PERSON PERSPECTIVE

Sass and Parnas propose a second dimension of self-consciousness, namely a first-person perspective. Their discussion relies upon a distinction they set out with reference to Albahari (2006) who differentiates between perspectival ownership and personal ownership. *Perspectival ownership* refers to an intrinsic form of givenness of all experience: all experience necessarily has a ‘for me’ character, namely a first person perspective. This equates to the discussion of self-reference in 3.4. *Personal ownership* however refers to a more complex, rich experience. This type of ownership comes from identifying perspectival ownership with particular mental contents, which are then experienced as ‘mine’.

3.5.1 PERSPECTIVAL OWNERSHIP

Perspectival ownership is the inherent form or mode of givenness of experience (i.e., the ‘for me’ character). This is what Parnas and Sass have in mind when considering the first-person perspective. Experience always points back to a subject, following the experience-experiencer thesis. Hanna and Maiese (2009: 81) explain this, saying that for a conscious episode to be immanently reflexive is:

“…for it to include an immediate sense of self, or for it to be directly aware of itself in a wholly first-order sense—that is, to be folded back upon itself, to be directly attentive to itself, and care directly about itself, without any division or opacity between itself and the content of its own experience”.

For an experiencer to own something in a perspectival sense is for that thing to manifest for the subject seemingly in a way that it can appear to no other subject. All mental states such as thoughts, intentions and perceptions, at least as they appear subjectively qua subject, will be perspectivally owned by that subject. This means

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2 To understand this distinction in detail, one must note how the term ‘ownership’ is used. Buddhism regards ‘ownership’ to refer to a broad mode of recognition, in which a subject understands itself to possess the functions or aspects that constitute the sentient being, that underpin its role as ‘owner of X’. A subject’s assumption of aspects of itself rightfully being ‘theirs’ or ‘belonging to them’ demonstrates that subject’s presumed identity as the ‘owner’ of those traits. In Buddhism the ownership mode of identification is essential to comprehending selfhood, such that if a person’s self exists, i.e. a ‘me’, then things belong to that self as ‘mine’, thus necessarily meaning a ‘self’ or ‘me-as-owner’ exists. Self qua owner comes in two contrasting forms: ‘perspectival ownership’ and ‘possessive/personal ownership’ (Albahari, 2006: 51-3).
that I, as a conscious subject, experience my mental states from my first-person perspective.

Extended worldly objects external to one’s inner subjectivity will not be owned; but, what will be perspectivally owned is the way these objects are impregnated in the experiencing subject’s subjectivity (Albahari, 2006: 54). This means that the givenness of a perceptual object is always perspectival. Husserl presents a metaphor modelled on ocular optics: the perspectival self is a centrally located ego that emits centrifugal intentional rays, and is subjected to worldly content converging on its spatial location. The perspectival subject does not present itself relative to objects as something disembodied. The location from which we experience will always be from somewhere, unlike Nagel’s (1986: 61) claim that we can apprehend the world from a “perspectiveless” vantage point, thus for Parnas and Sass (2011: 528) perspectival subjectivity includes the experience of spatial character and embodiment. The uniqueness of one’s location is explicit in perspectival ownership, with nobody being able to simultaneously witness the world from the same space that one experiences from. I accept one necessarily witnesses from spatio-temporal perspectives (Albahiri, 2006: 8), illustrated by Merleau-Ponty’s (2012: 84) statement, “I am conscious of my body through the world... [it] is the unperceived term at the center of the world towards which every object turns its face.” When encountering the world, our perspectival-ownership is spatially located, one experiences from certain angles, giving one self-specifying information about one’s embodiment.

“The first-person perspective in perception is thus not a free-floating, experiential configuration but a function of the lived body, moving in space. This form of embodiment helps to constitute the sense of self, of being a substantial (spatial) subject” (Parnas and Sass, 2011: 528).

This sense of self is necessarily egocentrically structured in the sense that it has an inner source point to which the organism can relate all of its experiences. There are two distinct ways that bodily awareness is part of this egocentrically structured

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3 Although I characterise Parnas and Sass as providing a purely phenomenological perspective, they do not completely neglect the body from their analysis. Nevertheless, their overall taxonomy of the self in schizophrenia applies to more abstract conceptions of selfhood. Mere mentions of experiential spatiality are not sufficient; I am explicitly arguing the minimal self is grounded in embodied sensorimotor subjectivity.
awareness involved in perspectival ownership. The body is ontologically ambiguous; it has both a subjective dimension as it is lived through from the inside (body-as-subject), whilst understanding body as spatially situated is to conceive oneself as an object in space (body-as-object). Firstly, as a subjective object, one experiences oneself as impacted on by external objects. As described, I might cut myself, and therefore recognise the spatial location of my body relative to the sharp object. Nonetheless, it is notable that one’s awareness of one’s body-as-object is not identical to one’s awareness of other worldly objects. My awareness of my bodily location is richer and fuller than that of the awareness of a chair’s physical location to me. I propose this is because one also experiences one’s bodily sense of self as a subjective subject: body-as-subject. One experiences oneself as the agent and source of one’s bodily movements. The sense of self lives through the body; actions seem to originate from within the body. One immediately feels oneself stand in direct and intimate connection to the movements, vital systems, processes, and overall condition of one’s own living body, despite the possibility of having no explicit or thematic awareness of one’s self or body. The body is transparent, meaning that often, we are unaware of body-as-object, it is experientially invisible in the sense that one looks through it to the world (Legrand, 2007: 504). Both types of these experiences grounded in bodily awareness are parts of the “egocentrically structured awareness involved in immanent reflexivity” (Maiese, 2016: 71).

The ‘zero point’ for all first-person experience is grounded in the processes and dynamics of living organisms (Maiese, 2014: 323). The organism’s autonomy and autopoiesis (i.e. self generation) entails that it produces and maintains a dynamic identity when faced with a changing environment and thus establishes a distinction between self and environment. An internal pole of identity relative to an external pole of an outside world is created in response to the organism’s internal relations that self-sustain its existence and define the living system as a unified whole. As the organism’s generative activities delineate what counts as components of the living system and what is environmental matter, it possesses “an essentially self-constituted identity that it affirms by differentiating itself from its surroundings” (Maiese, 2016: 23). There is an asymmetry between one’s organismic subjectivity and the environment such that an organism realises an internal viewpoint from which it interprets and understands its surroundings, resulting in an “inwardness" present
Importantly, the capacity for sensorimotor subjectivity does not rest on an individual’s ability to have conscious meta-representational states or thoughts about oneself and one’s own mental states, making it possible to possess the capacity for sensorimotor subjectivity even if one is incapable of self-reflection (Maiese, 2016: 7-8). Therefore, returning to the self-reference, which I equated with perspectival ownership, I suggest self-reference is also pre-linguistic; from birth humans experience with an immediate form of self-acquaintance. Whenever someone experiences, they are simultaneously given to themselves as a subjective presence having the experience, which involves an awareness or intuition of one’s existence as a singular, unified and temporally persisting subject (Albahari, 2006). This subjecthood is an integral part of the experience. Bodily self-awareness is developmentally basic. The “rooting response” illustrates this: new-born infants intentionally turn their heads toward things stroking adjacent to their lips, like another person’s finger (Prechtl, 1958: 217). Rooting is present from birth and disappears at around four months New-borns have limited mental awareness, yet respond to sensory tactile modalities, demonstrating bodily awareness. However, they do not respond when someone takes their own hand and brushes their cheek with it. Despite how behaviourally fragile new-borns are, they recognise the hand as perspectivally owned as a subject. The shape and position of their finger is dictated to the infant by how their skin is stretched across their bone and tissue, and how receptors in the joints and muscles yield information about how their limbs are distributed in space. This tells them the tactile sensation on their cheek consequently is not a food source. This demonstrates embodied perspectival ownership as the infant proprioceptively perceives from a “my perspective” (Albahari, 2006: 56); and suggests that not all first-person content requires expertise in using the concept “I” or first-person semantics (Maiese, 2016: 63).

So far, I have suggested that all conscious thoughts and sensations involve an immanently reflexive, implicit sense of self that is bound up with bodily awareness. Consequently, I propose the perspectival subject (perspectival ownership) is a necessarily embodied subject, therefore rejecting Strawson’s (1999: 3) claim that one fundamentally is a purely mental thing. Yet, I am not rejecting Sass and Parnas’
(2003) phenomenological conception of the self, or the experience/experiencer thesis (Strawson, 2011: 253). It is true there is a reflexive subject, but importantly, this experiencer is an embodied being.

3.5.2. THE NECESSITY OF PERSPECTIVAL BODILY AWARENESS

The reflexive subject is necessarily embodied. Self-consciousness is present in bodily experience: within the never-ending flow of sensations originating from the sensorimotor body’s environmental interactions, we see the self-conscious body is the foundational level of subjectivity (Maiese, 2016: 68). This view contrasts with Descartes’ (2013) arguments, where mind exists independently from body. This suggestion of dependence is modal, namely the dualist suggests his ‘self’, (for my argument’s purpose, I equate this with perspectival ownership), could exist even if his body did not. Dualism is a claim of possibility: disembodiment is possible (Hart, 1994: 265). Hart (1994: 267) argues that we can rightly imagine being disembodied: imagine waking up and opening one’s eyelids in front of a mirror, yet when one does, one’s eyes are missing and only the empty sockets remain. Equally, we can envisage taking a surgical saw and removing the top of one’s head, yet inside there is no brain, just an empty hole. Hart says that by imagining this, one has now successfully “imagined seeing [this in the mirror] without the two body parts... most people think crucial to seeing” (1994: 267). The rest of the body is inessential to sight, so can equally be disbanded. As Hart suggests, we have already removed the essential body parts required for sight, yet can still see, meaning that no physical form is necessary for our perception. One would only see the room’s reflection in the mirror; therefore perspectival selves are not necessarily tied to one’s embodiment. However again, one’s perspectival visual experiences will change, depending on one’s movements within the room: the perceived angle of the mirror relative to the position your disembodied perspectival experience specifies embodiment via the continual relational flow of your position and how objects appear.

Evidence suggests one’s sense of spatiotemporal location is present even within the first weeks of life; infants as young as 18 weeks engage in visually guided reaching in predictive ways, suggesting this ability is, “at least partly, prewired”, (Hofsten, 1980: 369). Spelke et al. (1989: 189) demonstrated that the position of objects elicited different reaching-like behaviours in infants. Reaching pattern appeared to be
influenced primarily by the adjacency or separation of two test objects. When adjacent, the infants perceived the objects as a single unit, grasping any of the external borders of the two-object display. However, when separated, the infants tended to reach for the closer of the two vertically separated objects (Spelke et al., 1989: 186-188). This elicited behaviour is not unconscious or reflexive in Legerstee’s (1999: 662) view; but rather implies that infants perceive the distance of the object relative to their own bodily form. Therefore this suggests relative spatiotemporal location is an integral part of perspectival awareness.

However, one can investigate cases of sensory deprivation, asking whether these examples counter claims that all consciousness involves bodily consciousness. Ian Waterman’s case exemplifies this. Aged nineteen, Waterman suffered a deafferentation (i.e. a destruction of afferent connections of nerve cells) of his body from the neck down, resulting in almost total loss of proprioception (McNeill et al., 2010: 519). Consequently, his pre-reflective awareness of bodily movement was no longer operative and his body-schematic system never updated, so he lost all embodied motor control. Nevertheless, Waterman still relied on compensatory visual proprioception and cognitive agency, meaning he had to visually locate his limbs in space, suggesting that one’s embodiment remains an integral part of perspectival ownership.

Yet one may imagine cases of total sensory deprivation, where one is blinded, muted, locally anaesthetised and paralysed to avoid any body parts touching one another. The closest example of this degree of disembodiment is perhaps sleep paralysis, a phenomenon where persons either during falling asleep or awakening, temporarily experience an inability to move, speak, or react. Their bodies appear absent from consciousness, yet they still experience this situation, suggesting perhaps not all perceptual experience requires embodiment. Yet, Maiese (2016: 70) asks, “wouldn’t one’s heart continue to beat in one’s chest (perhaps more rapidly), and wouldn’t one continue to experience one’s own breathing?” Despite a reduction in sensorimotor experience affecting the fullness of bodily consciousness, e.g. being unable to feel where one’s limbs are, embodiment remains present in other forms. For Maiese (2016: 70) “It simply is not clear that it is possible to remove all proprioceptive data”. Furthermore, I am willing to accept that if this is possible,
having rejected what Strawson (1999) considers the “core self”, what would remain is not something remotely like perspectival awareness. Perspectival awareness is necessarily embodied.

3.5.3. PERSONAL OWNERSHIP

Sass and Parnas’ first-person perspective however is not just the reflexive subject of experience: as subjects we commonly identify perspectival ownership with mental contents, which are then felt as ‘mine’. Personal ownership requires an additional step: not only is the experience given to a first-person perspective (perspectival ownership), but it is then identified as belonging to the subject. One’s “…subject identifies as a personal owner” (Albahari, 2006: 55) over the experience.

This heavier notion of ownership is explicit in how we own external objects. For a subject to own something possessively requires them to regard that thing as ‘theirs’ by right or social convention, actual or ideal. Albahari (2006: 54) says that in relation to possessively owned objects, the subject can be described as a ‘possessive owner’. Whenever there is a possessively owned thing or a sense of ‘mine’, there must be a personal owner-self. Similarly to how experiences necessitate an experiencer, any my-ness towards some X, necessitates a self as a possessor, a personal self. Personal ownership thus involves a subject whose identification with various mental states reflects its overall self-identity as a personal owner. If the subject is indeed an owner-self, the sense of self experienced introspectively must be grounded in an owner-self that is felt phenomenologically. If the first-person perspective is not an owner-self, then the sense of self one experiences will not be grounded in an owner-self that is sensed.

These two dimensions of Sass and Parnas’ first-person perspective can decouple in schizophrenia. Normally, the first-person perspective inherent in instances of thinking is simply the quality of ‘me-ness’. There is no distance between my thoughts and myself; the perspectival and personal selves are intertwined, meaning there is no requirement to have to justify one’s ownership over one’s thoughts. The first-person perspective is a unified “me-ness”. However, in some schizophrenic episodes, while sensations, perceptions and thoughts necessarily present a unique perspectival aspect to the subject, as a transcendental condition of experience is an operative perspectival experiencer, the subject feels as if the very same mental episodes do
not belong to it. Schizophrenics may lack the ‘belongingness’ of personal ownership. They will experience the experience, but it is alien to them, it is not something with which they identify. There is either no attempt to appropriate the experience, namely identify with it, or they will attribute it to an external agency, for example in cases of thought insertion.

On this account, we can hold onto what Billon (2013) calls the “Cartesian principle”, affirming that if a thought is conscious, then it is subjective; as consciousness entails subjectivity. Even though there are disruptions of self-experience, the subject nevertheless is capable of subjectivity insofar as the thoughts in question are presented in the first-person; it is a thing having the experience. Thoughts are therefore ‘inside’ the subject, but lack acknowledgement of them belonging to the subject as ‘his’ or ‘hers’. Resulting from this breakdown in personal ownership, the schizophrenic fails to identify the thoughts as theirs but they nevertheless remain aware of where the thoughts occur, namely within their mind. Thought insertion is an unusual phenomenon because it presents a case in which a subject introspects and experiences subjectivity, but nevertheless does not acknowledge their ownership over their internal mental phenomena.

In order to understand why this is, one must investigate what enables a sense of ownership. The self can be defined in terms of personal ownership, for example in Buddhism, and thus, in terms of identification (Albahari, 2006: 56). This involves the subject assuming that various psychophysical attributes are somehow incorporated within its being. Albahari thinks it is therefore important to draw a further distinction between firstly, identifying AS, which describes the subject’s action of thinking itself to be assimilated with the attributes, and secondly, identifying WITH, which describes the state of affairs the subject assumes true; namely, the subject experiences itself as assimilated with various psychophysical attributes which are therefore its true state of affairs (Albahari, 2006: 56). However, just because a subject identifies itself with some X does not imply the subject truly is identified with X, rather it is simply the subject’s possessive identification with said X. (Albahari, 2006: 57) Identifying WITH can be illustrated with regards to the body. The person or subject assumes various aspects of the body or mind to be the self. So if we think ‘I feel tired today’, it seems misunderstood to analyse this as 'the body feels tired' or
'witnessing from the first-person perspective feels tired' (Albahari, 2006: 58). Rather, by identifying oneself with the tired body, the subject takes the body to be the 'self', the "I". Albahari (2006: 59) then suggests from this sense of self in the capacity of "body/mind-as-subjectivity" will emerge assumptions of personally owning the aspects of sentient beings relative to this assumed identity WITH. If buying fitted shoes, one’s prior identification as a bodily self now supports the experienced my-ness directed towards the shoes. Distinct from simply possessing these objects, there is a sense of personal my-ness that reflects the subject’s identification as a person who owns the shoes. Here, the subject identifies WITH the possessive owner of the shoes by identifying WITH the aspects of the body/mind-as-subject that harvest the idea of possessive ownership, and therefore identifies AS being their personal owner. One’s selfhood in this context refers to a subject AS a personal owner, namely the possessive owner as assimilated with the subject.

However, I think this explanation is overly intellectualistic; whilst Albahari claims that whether a mental state is experienced as mine or not depends on whether one identifies WITH and AS the owner of it, she does not acknowledge how these experiences are grounded in more general systems of subject-world interaction. Both identifying WITH and AS require impressions of one’s entitlement to it. One feels entitled to identify WITH one’s mental states if the subject experiences sadness for example, one cannot say ‘the witnessing perspective is sad’; rather, one is entitled to say “I am sad” because the thing purporting to feel sad is something like the “intellectual-capacity-as-subject” (Albahari, 2006: 58). Likewise, one feels entitled to identify AS a personal owner because of the felt entitlement of the possessive owner. Bortolotti and Broome (2009) suggest entitlement is a matter of self-ascription: the subject acknowledges the thought as his/her own and can provide reasons for endorsing the content of thought, which one can give when that thought is causally integrated within the relevant contextual information. Maiese (2016: 163) distinguishes between phenomenologically intrinsic perspectival subjectivity, and the relational nature of personal ownership: whether mental states are mine or not depend on whether they are causally integrated within the relevant contextual information. Because a schizophrenic’s gestalt organisational processes are impaired, such that they struggle integrating contextual information into various domains, they experience “basic deficits in the perceptual organisation processes
that normally bind elements into a context-appropriate whole” (Martin and Pachiere, 2013: 114). Such “a context-appropriate whole” is one governed by a sense of entitlement: personal ownership.

3.5.4. AFFECTIVE FRAMING

Affective framing is a natural, non-inferential and developmentally basic way of sifting through the overwhelming clutter of sensory information impregnated upon us by our senses, and allows us to filter and condense this information “to something first-personally manageable and confer upon it specific cognitive importance” (Maiese, 2016: 38). What Maiese describes as affective framing is therefore a pre-reflective biasing device that involves background patterns of bodily attunement and results in carving out feeling-contoured patterns of discrimination, attention and comprehension. It selectively attunes the organism to its environment such that certain objects take on particular “affective prominence” (Maiese, 2016b: 127) in light of its particular needs, body size, ways of moving and current situational factors. This selective attunement to the environment “operates at the level of pre-reflective bodily consciousness, so that the animal makes sense of its surroundings through its affectively aroused body” (Maiese, 2016: 39).

Maiese (2016: 80) suggests the body is the locus of desiring and caring. I have already explored how the body is the centrifugal point of convergence for perceptual experience: for objects and events to matter there must be an “I” to whom they matter. The body is the locus of convergence between perceiving worldly events and willing events to happen, thus taking action. Therefore one’s basic self-experience consists in desiderative bodily feelings that enable the subject to care about its surroundings and will its felt body to move in goal-directed ways (Maiese, 2016: 81). A person’s various affective frames constitutes a kind of ‘survival map’ that enables them to navigate the world, making sensory data intelligible and meaningful to that subject; it is a personal viewpoint from which environmental artefacts take on significance (Maiese, 2016: 85).

In cases of thought insertion, schizophrenics believe thoughts are not theirs, arguably because these thoughts do not occur against the backdrop of affective framing and subject import (Maiese 2016b: 127). Inserted thoughts are both unintended and lack a sense of personal ownership. The subject’s sense that the
inserted thoughts are alien results from a failure to integrate the relevant contextual information within their pre-reflective psyche. In schizophrenia, one’s egocentricity and background bodily orientation is severely crippled, and when thoughts arise without background bodily wants and needs, thoughts seem contextually disengaged as the information received is not framed in an embodied organismically-centred way. The self-origin of thoughts becomes unnoticeable. Therefore, one can consider inserted thoughts that are decoupled from personal ownership as “decontextualized” because “they do not occur against the backdrop” of that subject’s implicit affective frames (Maiese, 2016: 168).

Once again, I have shown how Sass and Parnas’ (2003) phenomenological investigation is actually grounded in embodied subjectivity. One feels entitled to one’s personal ownership over one’s first-person perspective, and this reflective entitlement is grounded in contextual information that arises through how one perceives one’s body in the world.

3.6. PHENOMENALITY

The third dimension of the minimal self Sass and Parnas (2011) discuss is ‘phenomenality’, referring to the ‘what it is like’ character of experience (Nagel, 1974). It is the qualitative feel of experience. Conscious mental states are those that feel like something to have. A mental experience’s ‘vitality’ or ‘thickness’ is sometimes described in phenomenology.

The sense of self that emerges is not purely a minimal self, namely an “empty structural feature of consciousness […] which alone cannot[…] exhibit phenomenal character” Krueger (2011: 51-52). Mind’s transcendental structures need phenomenologically “filling in” through the reciprocal interaction between one’s experiential embodiment and the world (Maiese, 2016: 73). The phenomenality or feel of experience is thus not (just) a feature of individual mental states, but rather the qualia of phenomenality is tied to the basic structure of consciousness. Albahari (2009: 39) explains this relationship using a metaphor of light and illumination: light is required to illuminate objects perceptible to us, yet the light beams themselves are (normally) invisible. Nevertheless, they exist. Analogously, consciousness is ontologically autonomous and self-subsistent. A phenomenological version of the light metaphor is a flame’s luminosity. For Parnas and Sass (2011: 531), the minimal
self is flame like in nature; illuminating itself and other objects around it. The source of the feeling of experience is consciousness as subjectivity, meaning that the subject is the medium (or ‘vehicle’) of the manifestation of feeling.

3.7. THE DIALOGICAL SELF

Lysaker and Lysaker (2008) talk about a kind of phenomenality of the self. Our experience of the self has a certain kind of thickness. For example, when we are happy, we experience as ‘self-as-happy’. If one is transsexual, one experiences from the first-person perspective as ‘self-as-transsexual’. Their conception of selfhood is more substantial than the form of selfhood I have been advocating; the self is not just one’s embodied self, reflected through experience and supplemented by affective framing; they suggest that we have a multiplicity of different narrative selves. “[W]e sense ourselves within and through encounters that are at once intra- and interpersonal, and that reflect complementary and dissonant facets of our being” (Lysaker and Lysaker, 2008: 70).

A ‘dialogue’ is typically something external, a process carried out between subjects conversing through interaction. ‘Dialogue’ is an appropriate term to describe this self, as different and semi-independent self-positions interact, bringing about a sense of self (Lysaker and Lysaker, 2011: 200). Accordingly, the self is “…a disclosure of a being to itself through an interanimating play of multiple, often partially discontinuous self-facets within shifting worldly context” (Lysaker and Lysaker, 2008: 70). Importantly, these self-positions may be complementary, for example, self-as-barista and self-as-labourer, dissimilar, e.g. self-as-barista and self-as-criminal, or even contradictory as schizophrenic cases may illustrate. The self is populated by a multiplicity of self-positions with the possibility to entertain dialogical relationships with one another. The dialogical conception of self infuses the external and internal. Therefore, the self is considered ‘extended’, as external parts of the world, for example individuals and groups, are incorporated within the boundary of the individual self.

I now intend to integrate my embodied rethinking of Sass and Parnas’ (2003) phenomenological approach in terms of embodiment and enactivism with this dialogical approach. This is fruitful to my analysis as I show how when living organisms enact their world through environmental engagement and inter-subjective
interactions, this is a kind of dialogue, which I term a ‘worldly dialogue’. To achieve this, I firstly explore the dialogical model of selfhood.

Lysaker and Lysaker (2008: 70) suggest, “meaning emerges from these dialogues because shifts in positions prove both responsive to world situations and more or less internally coherent, if occasionally dissonant.” This implies that the “interanimating play of self-positions” (p. 70) emerges from our interactions in the world. The relationship between the Lysakerian self and the world is therefore one of dependence: the sense of self depends on the experiences the person has in the world. For instance, whilst on an international business flight, one’s dialogical self could emerge from the interactions between one’s sense of self as ‘excited’, ‘a successful businessman’, ‘apprehensive about presenting one’s paper’, ‘missing a partner’ and so on. The interactions among these different facets may change depending upon external changes to one’s environment, for instance if a fellow passenger begins conversation, if a meal is served, or, if the oxygen masks dropped suddenly, resulting in alternative self-facets such as ‘self-as-scared’ or ‘self-as-endangered’ coming into play. Again, the sense of self described here arises out of exchanges between these individual facets in particular contexts. Consequently, “for dialogical psychology, the sense of self is not given in an intuitive introspective grasp of a stable core self, but in a disclosure of some facet of the temporal, polyphonic constellation that each of us is” (Lysaker and Lysaker, 2011: 201).

To clarify, the perspectival minimal self Sass and Parnas (2003) discuss, is not dependent on experience to be moulded. Rather, it is the ineffable subject that is reflexively experienced as a transcendental condition of the experience. The same idea here applies to my re-thinking of the minimal self in embodied terms; the embodied sense of self does not arise as an after-effect of one’s engagement with the world, but rather is a transcendental condition of human experience: one’s subjectivity is embodied from its immediate existence. Evidence supports this, (Butterworth (1999), Legerstee (1999), Rochat (1998)). All imply one’s core fundamental mode of conscious self-awareness is physically tied to the neurobiological dynamics of one’s living body (Maiese, 2016: 3). I make this distinction between being bound up with the experience (transcendentally) and emerging from the experience because of the type of emergence Lysaker and
Lysaker seem to endorse. This is important because it means that the dialogical self is *not* as fundamental as an “essentially” (Maiese, 2016: 2), (i.e. necessarily) embodied self.

I propose Lysaker and Lysaker’s emergence is a form of diachronic emergence, as opposed to synchronic emergence. In synchronic emergence, the higher-level emergent phenomena are simultaneously present with the lower-level phenomena from which they emerge. Common in the philosophy of mind, this form of emergence describes the simultaneous supervenience of mental states on the brain’s neurons. This means higher-level mental states coexist with brain states. Strong ontological emergence is thus usually understood to be synchronic, vertical emergence. Diachronic horizontal emergence however evolves over time: the structure of the lower-level properties from which the novel properties emerge exist prior to higher-level properties emergence.

Arguably, this definition of diachronic emergence characterises what happens during the self’s dialogical emergence: the structure from which the novel property (self-as-X) emerges exists prior to its emergence. Think about the self-position, ‘self-as-barista’. For a ‘self-as-barista’ self-facet to develop, it must be cultivated through engagement with the world. This might include working as a barista, learning how to make various drinks, and developing customer service skills. Even once all aspects have been covered, only after much repeated engagement in the world for the person to confidently fulfil this role, does the dialogical ‘self-as-barista’ emerge from these structures.

One may respond to this description of the dialogical self by suggesting this slow diachronic emergence of novel selves only covers more ‘complex’ self-facets, such as those including jobs, sexuality or personal narratives like self-as-mother, where prolonged worldly engagement is required to develop an identity as ‘self-as-X’. Other self-positions such as ‘self-as-scared’, when faced with life threatening situations

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4 This has affinities with the enactive approach, which proposes strong life-mind continuity. An autopoietic life form participates in generating intrinsic meaning for itself via processes of sense making grounded in interactive engagement between its embodiment and environments. This means that cognition arises *through* the dynamic interaction between the organism and its environment; there is no pre-given mind over and against a pre-given world.
surely emerge synchronically, namely simultaneously with one’s online environmental engagement.

However, I reply that whilst the emergence of ‘self-as-scared’ and the event that cultivates this self-facet may occur at times imperceptible to us, the event nevertheless occurs prior to the dialogical self’s emergence. This argument is logical: firstly, the event would begin happening. At this moment, the being (i.e. self) is not scared. Secondly, the subject would begin processing this event and respond accordingly. Thirdly, the interplay between the world and the being would develop a new self-facet. This would be the emergence of ‘self-as-scared’. Analogously, if someone throws something at one’s face, one’s reflexes do not involuntarily respond and instigate a reaction at the same moment the object begins its trajectory. Watched in slow motion, a small amount of time lapses between the event commencing and one’s reaction. Therefore, the higher-level emergent self-facets are not simultaneously present with worldly lower-level phenomena from which they emerge. Consequently, the dialogical self is not a most basic form of selfhood. Whilst self-facets may (always) emerge through one’s environmental interactions, they are not necessary conditions of one’s initial engagement. They are not the source of subjectivity: a perspectivally owned embodied experiencer is.

Nevertheless, Lysaker and Lysaker (2008: 49) try and stress the irreducible first-person dimension of the multiple self-facets, which, if true, would imply a synchronic emergence. Lysaker and Lysaker suggest dialogical selves are irreducible because ‘self-as-X’ involves the disclosure of worldly events to an experiencer whose life is unfolding in that environment. For example, ‘self-as-barista’ involves the events of making coffees in Starbucks relating to a subject who identifies with those ‘dialogues’ and thus is ‘self-as-barista’. Consequently, Lysaker and Lysaker (2008: 49) suggest that self-positions are inherently reflexive. Thus searching for dialogical selves requires a first-person perspective, third-person modes of knowing are insufficient to find them.

Whilst the dialogical self requires a first-person perspective, this is not reflexive like perspectival ownership: self-positions are not reflexive (and irreducible) as Lysaker and Lysaker suggest (2008: 49), but are reflective; narrating one’s fundamental embodied experience. The dialogical self arises directly from the lived experience of
the embodied subject (Menary, 2008: 76) but it is not itself the experiencer. Therefore a diachronic emergence is appropriate. To have a dialogical self one reflects on one’s personal ownership over one’s experiences, associating oneself with the extended, worldly dialogue, and it is those experiences (namely being an embodied, experiencing thing in the minimal sense) that reflexively point to a minimal perspectival self. A sense of entitlement (Bortolotti and Broome, 2009) must pervade personal ownership, and, as discussed, this originates from the affective framing of one’s desiderative embodiment, reflexively illuminating a perspectival, sensorimotor subjectivity. Therefore, I retain some sense of the transcendental phenomenology of the experience/experienter thesis. However, rather than conceptualising this abstractly as Strawson (2011) and Sass and Parnas (2003) arguably do, I emphasise how this self is transcendentally structured by sensorimotor subjectivity.

3.8 REVISING ‘THE SELF’ – THE SCALED SELF

This final section now categorises my conception of selfhood. The SCALED self has multiple levels, each of which have been distinguished and separated in this chapter, yet build upon one another, enabling the thick, rich texture of human experience. As this chapter has argued, my notion of SCALED selfhood, spelled out below, relies on the minimal self as being dependent upon brain processes and an ecologically embedded body (Gallagher, 2000: 15). Therefore, before moulding the SCALED self’s levels into something compatible with the literature and evidence, I highlight one possible question: is embodiment really a “transcendental condition”, i.e. something that exists prior to our experience in the world? I suggest it is.

I have argued as part of my endorsement of the embodied approach that the body is the centre of orientation; what one experiences is not an empty, homogeneous, mathematical space; but rather lived, oriented space whose directional axes (i.e. left right, above and below, in front and behind) are assessed from one’s own perspectival lived body as the central point from which all objects are relative. Yet, it seems depth perception itself is enacted (and thus dialogically emergent), therefore meaning that this experience of body in relation to objects is not itself transcendental. Held and Hein (1963) performed an experiment in which two kittens circled a carousel. Whilst one had its paws firmly on the ground, and therefore looped the carousel via self-actuated movement, the other was simply suspended
above. As the one kitten walked, both moved in a circle. Despite receiving identical visual stimulation, only the self-moving kitten developed normal depth perception. Noë suggests that from an enactive standpoint, this is because “only through self-movement can one test and so learn the relevant patterns of sensorimotor dependence” (Noë, 2004: 13). This implies some form of emergence of bodily sensation. Despite this, my intuition remains: embodiment is a transcendental, i.e. fundamental, necessary condition of experience. This chapter has argued that the body is always a part of the story; and in this case, I would respond by distinguishing between the emergence of how the subject perceives depth, and the ability to perceive depth itself, which remains transcendental. Such evidence favouring enactivism does not damage my endorsement of Merleau-Ponty (2012) and my claim that perspectival-ownership is spatially located, thus embodied.

The SCALED self’s unity I propose “is anchored in our embodiment” (Menary, 2008: 76). At the heart of human subjectivity “[t]here is a minimal sense of self as a subject of experience and this minimal self is an embodied subject” (Menary, 2008: 76). The diagram below pictures this “minimal self” with the letter ‘C’, short for ‘core’.

![Diagram](image-url)
Level 1, “Embodied Perspectival Ownership”, refers to the self-reference or *perspectival* first-person perspective of Sass and Parnas (2003). It is the core (transcendental) experience-experiencer thesis, but fundamentally, this necessary subject is embodied. “It is with our bodies that we perceive, act, experience and engage with the world and with others” (Mackenzie, 2009). Affective experiences such as pains are not simply ascribed to a body, but rather to lived, experiential bodies that feel like something to experience. Therefore, affective experiences are thus firstly given immediately, non-inferentially to the subjective body (Fuchs, 2010: 549). Tied up with the notion of embodied self-experience, is *how* things are, and *what* is experienced. Affective framing, as I have argued, is an embodied, pre-reflective way of discriminating and selecting salient features of our environment based on our fundamental background patterns of bodily attunement. It is thus a pre-reflective tool with which the subject can engage with the world.

The second level, “Personal Ownership” admittedly is still referring to a very thin conception of selfhood. In the broad spectrum of experiences, which encompass thick dialogical self-facets narrating entire life stories, simply owning an experience personally via immediate reflection remains very ‘basic’. However, as Chapter 4 will illustrate, schizophrenic patients can exhibit a diminution, and even complete loss of personal ownership, and thus the SCALED self must distinguish between reflexive and reflective modes of experience. This is something I remain unsure about Sass and Parnas’ work. They propose schizophrenic patients experience a loss of minimal selfhood, yet with little differentiation between the first-person *perspectival* perspective, self-reference and personal ownership, their meaning can be lost.

The third level of the SCALED self is the “Dialogical Self”. These ‘worldly dialogues’ “arise directly from the lived experience of the embodied subject and these narratives can be embellished and reflected upon if we need to find a meaningful form or structure in that sequence of experiences” (Menary, 2008: 76). Menary’s use of the phrase “reflected upon” illustrates how these ever-changing self-facets require active deliberation and an understanding of the first-person pronoun “I” to emerge, which is grounded in the structural entailments of Level 2. Importantly, I am not saying the dialogical level of the SCALED self is in itself embodied, but rather I am pointing out that its *origin* is body based. Therefore, “[i]t is not narratives that shape
experiences, but, rather [bodily] experiences that shape [the] narratives” (Menary, 2008: 79) that emerge.

Regarding the spectrum of experiences we have, and the varying mental capacities of individuals, I agree with Menary’s (2008: 64) claim that “[w]e shouldn’t expect to find narratives [i.e. dialogical selves] in our more basic bodily engagements with the world”. An infant for example, will only have rudimentary experiences of the self as an actor and may be unable to sustain the reflective requirements to develop a self-facet that accords with its worldly interactions. Importantly, SCALED selfhood develops over time and requires sophisticated cognitive capacities. I propose the developmental trajectory of SCALED selfhood from infancy to adulthood is of rapid, increased expansion.

The notable advantage of the SCALED model of selfhood is it enables one to measure self-experiences according to the requirements for each level. Chapters 4 and 5 will illustrate how the ipseity disturbances of schizophrenia diminish the levels attainable by the patient afflicted with the mental disorder. However, I will argue that both levels 2 and 3 can extend beyond the boundary of the individual, such that their reflective nature can be structurally supported and/or widely realised by artefacts that in part, are external to the body. Nevertheless, this does not mean that the core realiser, the body, is not equally present.

I accept endorsing a position somewhat akin to Menary’s (2008: 63) “embodied narrative account”, where “the [SCALED] self is constituted both by an embodied consciousness whose experiences are available for narration and narratives themselves” has some unwanted implications. Yet I am willing to accept a ‘person’ devoid of sensorimotor subjectivity, proprioception/kinesthesis and minimal experiential whereabouts in the world is consequently no longer a self. Nevertheless, it is debatable (and in my opinion impossible) whether any ‘experience’ could occur in this way; it would not even reflect, or more basically reflexively entail a subject, and so, following the logical thread of the argument presented, could never even be termed ‘an experience’ in virtue of the experience/experiencer thesis.

3.9 CONCLUSIONS
This chapter has taken the transcendental conditions of experience discussed in
Sass and Parnas' phenomenological approach and has then incorporated them within embodied sensorimotor subjectivity, arguing that all experience is reflexively characterised by pre-reflective self-awareness that is present in all experience, without requiring introspection (Fuchs, 2010: 549). These experiences are (normally) personally owned: one commonly appropriates the experience with oneself based on a feeling one has of entitlement, determined and structured by the contextual information (i.e. the environment) in which the organism is embedded. This characterisation of the self accords with Lysaker and Lysaker's (2008: 64) suggestion that each character position reflects a pre-reflectively operatively, determinative way of being-in-the-world. Each organism acts in accordance with its desires and wants via pre-reflective attunement to certain environmental aspects, i.e. affective frames. It is this sort of affective bodily engagement by way of continuous reciprocal interaction with one's environment (a form of worldly dialogue) that enables the diachronic emergence of personally owned, rich, phenomenologically “complete” selves. Whilst the SCALED self appears a thick conception of ‘selfhood’; this is the kind of complexity I propose underwrites our being-in-the-world.

I consider this description accurate, according with developmental psychology, introspection, and human-environmental engagement. Cognition can only be understood with reference to on-going interactions between organisms and their environments. Enactivism explicitly rejects traditional cognitivist notions of internal mental representations and passive computational input-output conceptions of cognitive processing prevalent in cognitive science.

Finally, I reiterate that my conclusions regarding the SCALED self are necessary characterisations of selfhood for this project. To discuss selfhood in the context of extended mind theory, I require a fluid and dynamic model of selfhood, exploring different levels of selfhood and how they may couple together both internally, and with external artefacts, such that they form one cohesive whole: the SCALED self. The following chapter now elaborates on how levels 2-3 are subject to possible extension, namely being partly constituted by ‘artefacts’ external to the self’s Core.
CHAPTER 4 EXTENSION AND DIMINISHED SELF-AFFECTION:
IPSEITY (1)

4.1 IPSEITY
The core abnormality in schizophrenia is a disruption of the sense of self, namely ipseity. ‘Ipseity’ derives from the Latin ‘ipse’ meaning ‘self’ or ‘itself’, and refers to the experiential sense of being a vital and self-identical first-person subject of experience (Sass et al., 2011: 7). In the prodromal phase of schizophrenia, ipseity disturbance happens in two complementary ways. Firstly, there is a weakened sense of existing as a vital and self-coinciding source of awareness and action. This is diminished self-affection. Secondly, aspects of one’s consciousness are experienced as akin to external objects. This exaggerated self-consciousness is ‘hyperreflexivity’ (Sass and Parnas, 2003: 427). This chapter focuses on the former of these two disturbances, arguing that a schizophrenic’s fuller sense of self can be redeemed through interactive engagement with psychotherapy, which *extends* their selfhood.

4.2 DIMINISHED SELF-AFFECTION
Diminished self-affection refers to a reduction in the transparent, lived-through sense of existing as an aware subject or agent of action with which people are normally acquainted. It means that there is a lessening of existing as a first-person perspective on the world (Sass et al., 2013: 431). Patients may complain about profound changes occurring in their subjectivity, for example saying they “…lost [their] feelings, entailing loss of myself, making me another person.” or experience “pervasive feeling of unreality” (Møller and Husby, 2000: 222), yet cannot pinpoint its exact nature as this change is difficult to express in prepositional terms (Sass and Parnas, 2003: 437). Some complaints, like “I am not present in any assortment”, coupled with referring to oneself in the third-person (Berze, 1987: 57), imply the subjectivity one lives through transparently is somehow dwindling; it indicates the patient lacks intimacy with their own experience.

Frank, the schizophrenic discussed at 2.4, presented himself in terms of “emptiness and nothingness” and felt anguish at continually feeling persecuted. Lysaker and Lysaker (2008: 37) suggest Frank considered the person he once was had ‘exploded’, leaving him with mere remnants held together weakly by ‘gravity’ in the
place he had been. This description seems to suggest Frank still experienced from a spatial location, namely there was a perspectival self located at a particular point for whom the experience reflexively was for. However, the predominance of the self-facet ‘self-as-persecuted’ made engaging with him nearly impossible, unless one addressed his persecution. His previous life as a complex self was inaccessible to him: Lysaker and Lysaker (2008: 81) suggest Frank was predominantly a monological self; ‘self-as-persecuted’. Here the internal and worldly dialogues that normally characterise the dialogical self, for Frank are replaced by a singular monologue. His self-world relations are consistently ordered into a singular manner: persecution. This monologue, whilst internally consistent is inflexible, and thus prevents the patient from engaging spontaneously with the world (Lysaker and Lysaker, 2008: 81). Arguably, Frank has lost the fluid interplay of self-facets that emerge through environmental interaction. He admitted to his therapist that if he tried to think of anything outside of the rigid confines of his (monological) dialogical ‘self-as-persecuted’, he felt emptiness and nothingness, concluding that a part of him had been destroyed.

Lysaker and Lysaker (2008: 90) suggest a second model of endangered self-organisation: a barren self, which arguably applies to Frank’s experiences here. This form of disturbed self-experience in schizophrenia follows the distinction I set out in Chapter 3 between perspectival and personal ownership within the SCALED self: perspectival ownership remains but personal ownership, the slightly more sophisticated level of selfhood, is disrupted. The barren self is undeveloped. It has mostly discontinuous self-positions, which lead to a fragmented life-narrative and is populated by few meta-positions, with limited descriptions of worldly interaction. Webern, a schizophrenic, exemplifies this; when asked what he meant when he said ‘I have schizophrenia’, “...would state that he was too old for strenuous activity. When asked for his thoughts he would usually deny having any... Webern could describe events, but he never linked those events to anything he felt, thought or did” (Lysaker and Lysaker, 2008: 83). The statement that Webern never linked any events to anything he experienced suggests a diminishment in his being. He lacks personal ownership.
Robert’s testimony of his schizophrenic experience also exemplifies this. This twenty-one year old high-school graduate had complained for over a year about feeling cut off from the world. Troubled by the surreal and unnerving feeling of not experiencing being fully present in experience or alive, he said, “My first-personal life has been lost and is replaced by a third-person perspective” (Sass and Parnas, 2003: 438). An example Robert gave concerned music: if he heard a melody, he found music lacked its natural fulness “as if something was wrong with the sound itself”. He realised he was somehow “watching” his own receptivity to the music; namely, the way his subjectivity received and registered the tunes (Sass and Parnas, 2003: 438)\(^5\).

Chapter 3 discussed the transparency of the first-person perspective: one cannot attend to it as if an object, whilst concurrently living through it. Robert’s statement above illustrates this truth: in objectivising his first-person subjectivity, he lost the lived dimension. Consequently, Robert periodically experienced his own movements as reflected upon and de-automatised. His thinking processes acquired distressingly acoustic qualities (Parnas, 2000: 124-125). Sass and Parnas (2003: 438) suggest the cause was a loss of the normal tacit, prereflective ‘myness’ of experience that is the condition and medium of spontaneous intentionality. However, this explanation conflicts with my previous endorsement of the transcendental condition of prereflective (reflexive) myness as an experiencer. The word “prereflective” implies that Robert lost his entire self, which if so, suggests he could not experience; as no experiencer existed to experience his third-person experience. I highlight this, not to disagree with Sass and Parnas, but to illustrate the disparity between the language available for this philosophical taxonomy and the rich phenomenological experiences being deciphered.

Applying Albahari’s discussion of perspectival vs. personal ownership to this description of Robert’s experiences, one can say Robert feels his movements do not belong to him because he fails to identify as those movements’ personal owner. Robert does not view his self as possessing a first-personal perspectively lived

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\(^5\) Although this testimony exemplifies a diminishment of immediate personal ownership, Robert’s experiences also highlight the second dimension of ipseity disturbance, hyper-reflexivity. Chapter 5 addresses this, yet I footnote this here to illustrate how these disturbances are somewhat congruent.
through body with respect to his movements. By failing to associate with himself a subjective ownership over the movements and so unable, by not identifying with his actions, to generate experientially felt possessive ownership towards his movements, Robert does not feel his selfhood encompasses his actions. Therefore he does not experience himself as the movement’s personal owner. Equally, when not experiencing his movements as integrated into his implicit embodied selfhood, this means that Robert, as a subject, cannot identify with those bodily movements as an aspect of his selfhood (Albahari, 2006: 61).

4.3 REHABILITATION

Lysaker and Lysaker (2008: 30) claim that rehabilitation literature contains an important observation. A schizophrenic can recover a more empowered sense of selfhood than barren or monological selves by enhancing their narratives regarding their illness and relation to it by continuously engaging and interacting with the world. I suggest this is because the schizophrenic’s process of enactive meaning-making is shaped via on-going interactions with social and institutional contexts (Roe et al., 2006). Therefore, I am adopting an enactive position, in accordance with my discussion of the (embodied) SCALED self.

To reiterate, self-acquaintance is a phenomenological feature of mental states: once we have an experience, we immediately have an ipseity dimension to the experience. We experience it as ‘mine’; given to me non-inferentially. Diminished self-affection picks out cases like Robert’s where this feeling is lessened. So, the question becomes, ‘how can the environment contribute to our experience such that it reflects an experiencer and personal ownership over that experiencer’s experience?’

The answer I suggest is that the self’s personal ownership can extend. Through an analysis of extended selves, we can see how rehabilitative treatments can scaffold and constitute the personal ownership lacking in cases of diminished self-affection. This chapter firstly explores extended mind theory, and discusses its relationship to extended selves, introducing Clark’s (2003) notions of ‘soft selves’ and tool use. Secondly, I argue Clark’s notion of ‘tools’ can encapsulate strategies used in talk therapy, where psychotherapy may serve as a “dialogical prosthesis” (Stanghellini and Lysaker, 2007: 174). Thirdly, I investigate the disparity between my
endorsement of an embodied locus of subjectivity, building on previous concepts of sensorimotor subjectivity, and Clark’s notion of soft selves. This leads me to reject Clark’s (2003: 136) claim that there is no substantive selfhood and highlight an inconsistency with Clark’s later work, *Supersizing the Mind* (2008). This chapter concludes by reflecting on the implications of soft selfhood. We should reconsider the schizophrenic patient and therapist’s relationship during talk therapy. We must acknowledge that the schizophrenic can recover a more empowered sense of self through the construction of narratives about their mental illness and their relation to it, if those self-dialogues are complemented by on-going environmental interactions (Lysaker and Lysaker, 2008: 30), precisely because SCALED selfhood incorporates the external world. The moral is; the schizophrenic’s environment is the schizophrenic, and acknowledging selfhood’s extended nature can lead to improvements in the way we administer, and interpret psychotherapy.

### 4.4 EXTENDED MIND AND EXTENDED SELVES

As humans, we circumvent deficits in our cognition by outsourcing cognitive processing onto the external world. Because environmental artefacts external to the brain play significant roles in realising cognitive processes, human minds and environments can act as coupled systems, which can be conceived as complete cognitive systems in their own right. A thought experiment illustrates: Imagine an accountant, Severus, who performs mathematical equations in his head; this requires the skilful informational processing of numbers. However, imagine Severus suffers a stroke, rendering him unable to calculate mathematical problems intercranially. Therefore, Severus has a chip inserted into his brain, which duplicates the functions his brain can no longer do. The chip’s performance would not only be exactly the same as the part of the brain it is replacing prior to its malfunctioning, but would once again assist Severus in solving mathematical equations in his head. Solving mathematical equations is a function his brain previously performed, and, is something he can once again do; thanks to the inserted chip. One can therefore reasonably consider the chip has as much right to be considered a part of Severus’ brain as the neurons lost during his stroke; the same cognitive processing of numbers occurs with the chip, as did before. The only difference is that the physical realiser (i.e. brain+chip) is different after his illness. Now, if we accept the mathematical equation-solving chip is a part of Severus’ mind, then consider
Severus’ brother, Barnabas. Barnabas has always struggled with mental arithmetic, yet can solve the equations Severus completes in his head both before and after his stroke, with the help of a pocket calculator. (Bray, 2008: 10). So, “How much cognition is present in these cases?” (Clark and Chalmers, 2010: 28). Arguably, all three are similar. Severus’ mentally taxing internal informational processing prior to his stroke appears to be functionally identical to his later internal cognition, which is physically realised by a combination of his biological brain and the neural implant. And Barnabas, with his pocket calculator, displays the same sort of computational structure as Severus, once he has the neural implant, despite Barnabas’ informational processing being distributed across agent and calculator, rather than being internalised within the agent (Clark and Chalmers, 2010: 28). Therefore, it might be best to capture what is occurring in these cases by saying that both the chip and calculator form constitutive parts of Severus’ and Barnabas’ respective minds. This leads to the argument that:

“if an external object is used habitually, and in a dependent fashion, to perform a function that would otherwise be carried out by a part of the brain, why should we not consider that object as a part of the functional apparatus of the mind?” (Bray, 2008: 10).

It is arbitrary to claim mind is contained only within the boundaries of the skull. One cannot simply point to the skin/skull boundary as justification for the internalist position, arguing that Severus’ cognition is realised by his ‘brain’ or his ‘brain+chip’, yet Barnabas’ ‘brain+calculator’ is not the metaphysical basis for his problem solving, since the legitimacy of that arbitrary boundary of skin is precisely what is at issue.

Evidence suggests the human mind does indeed circumvent mentally taxing tasks: when playing Tetris, a game displaying images of various two-dimensional geometric shapes that players must rotate to fit into the shapes below, players have two options: they can mentally rotate the shape in their head, or can physically rotate the images on the screen. Intuitively, one would suppose that some speed advantage accrues to physical rotation rather than mental rotation. Kirsh and Maglio (1994) demonstrated this was correct. They calculated that a shape’s physical rotation through 90° takes about 100 milliseconds, plus an additional 200 milliseconds to select the rotation button. To achieve the same result via mental rotation requires
around 1,000 milliseconds. Kirsh and Maglio argue the physical manipulation of the shape often helps players determine whether the shape and slot are compatible. They therefore label rotating the shape an “epistemic action” (1994: 527), namely an action that alters the world so as to aid and augment the individual’s cognitive processes (Clark and Chalmers, 2010: 28). When performing physical rotation as opposed to internal calculations alone, subjects were between 800-900 milliseconds faster determining whether shapes were compatible with slots. Players were performing extended, *external* calculations; extending their minds by way of the screen, their hands, and the computer’s information processing machinery. This active human-environment interaction supplemented the brain’s cognitive abilities and is known as coupling.

A coupled system is where “…the human organism is linked with an external entity in a two-way interaction, creating a coupled system that can be seen as a cognitive system in its own right” (Clark and Chalmers, 2010: 29). Clark and Chalmers (2010) suggest a criterion for the constitutive thesis. For an organism’s cognitive processes at times to literally be *constituted* by both the organism and material features of its environment the following must be true:

1. All components of the system must play an active role.
2. All components of the system must jointly govern the organism’s behaviour in similar ways internal cognition normally does.
3. If we remove external components of that system, the organism’s cognitive competency will drop, just as one would expect if one removed a portion of their brain.

Based on 1-3, coupled extended processes count as equally as cognitive processes as internal *biological or neuronal* processing.

There are two interpretations of causal coupling. Firstly, asymmetric influence describes cases where environmental features have causal influence over one’s internal cognitive processes. This means one can change the external environment in ways that enhance the individual’s cognitive competence. For example, notes might remind oneself of a chore. If removed, one forgets. Therefore, the environment can *prompt* certain cognitive acts, like remembering. However, no further explanation
is necessary; just because notes inspire remembering, this is insufficient to motivate claims that it is a part of one’s memory. However, the second interpretation of causal coupling describes stronger cases where internal cognition and external artefacts have mutually constraining causal influence over one another that emerges over time. Such artefacts, unlike notes do not simply prompt cognition; rather the external artefact and the internal cognition coalesce as ‘extended cognition’, jointly governing one’s behaviour. Menary (2007) refers to this as “cognitive integration”, whereby there is continuous, reciprocal causation between constitutive parts, linking the brain, body and world (Clark, 1997: 163). Although we can identify the relevant components, categorising them as ‘internal’ or ‘external’, the nature of reciprocal coupling makes it difficult to study the components as separate systems, as they continuously influence and respond to one another. Yet, still we remain unable to distinguish between coupled cognitive systems, and coupled non-cognitive systems. Clark and Chalmers invoke the parity principle to help make such judgements.

The parity principle makes us reconsider our Cartesian prejudice; just because a process is external should not be the defining feature that determines it as non-cognitive. Parity introduces functionalist credentials into the extended mind hypothesis; placing the importance on the cognitive function of the process, not where the cognition is located (Menary, 2010: 6). Clark and Chalmers make this clear in their discussion of Inga and Otto. They imagine a fictional Alzheimer’s patient, Otto, who always carries a written notebook containing his dispositional (i.e. non-occurrent) beliefs. The notebook is functionally poised to play the role usually played by biological memory. Otto’s notebook is like Inga’s memory, it just happens Otto’s non-occurrent beliefs lie beyond his skin. Clark and Chalmers’ argument is as follows:

1. Otto’s notebook of dispositional beliefs is functionally identical to Inga’s memory.
2. “There is nothing sacred about skull and skin” (Clark and Chalmers, 2010: 29).
3. If the causal dynamics between internal and external “cognition” are identical, (following the parity principle) then mind is extended.

Based on 1-3
4. Otto’s mind is extended.

Clark and Chalmers (2010: 34) argue the alternative internalist explanation is pointlessly complex. Insofar as beliefs and desires are characterised by their explanatory roles, Otto’s and Inga’s are equivalent. One is happy to explain Inga’s actions (heading to the Museum of Modern Art) in terms of her desire to visit the museum and her standing belief that it is at 53rd Street. Plausibly Otto’s actions have a similar story. If not, the alternative is to explain Otto’s similar actions (heading to the MoMA) firstly in terms of his occurrent desire to visit the MoMA, secondly his standing belief that the MoMA is where the notebook describes, and thirdly the accessibility of knowing the MoMA’s location. This substantially complicates a simple cognitive process, and is “pointlessly complex”, similarly to how overly complex an explanation of Inga’s cognitive process would be if it explained her actions in terms of beliefs about her memory. Clark and Chalmers (2010: 34) therefore say, “[t]he notebook is a constant for Otto, in the same way that memory is a constant for Inga; to try and point to it in every belief/desire explanation would be redundant. In an explanation, simplicity is power.” The underlying point is that an agent’s coupling to an environmental artefact is transformational in nature. Clark (2003: 142) thinks that, as humans, we are naturally prone to be subjects of repeated transformations. We manipulate our abilities and transform ourselves into beings-that-can-do-X.

Now, if the mind can extend beyond a person’s biological boundary, then arguably, selfhood too, is similarly extended (Krueger, 2010: 569). It is commonly accepted that the self outstrips the boundaries of consciousness. One’s dispositional beliefs for example constitute in some deep sense a part of one’s self-identity, yet are not about things presently being consciously endorsed; rather, they are things people are prone to believe, under certain circumstances. Despite normally these dispositional beliefs being beyond immediate consciousness, we still consider them central to selfhood. And as the above discussion argues, one’s dispositional beliefs may fall beyond that organism’s physical boundaries; Otto’s notebook for example, is central to his identity as a cognitive agent. Consequently, both Otto and Severus may best be regarded as extended systems, constituted via a coupling of their biological organism to an external resource. External artefacts can thus constitute a part of a person’s self-facet by enabling certain behaviours that develop narratives.
Consistently resisting this conclusion would require shrinking selfhood to a mere bundle of occurrent states, severely threatening its deep psychological continuity. Clark and Chalmers (2010: 39) therefore suggest a broader view is better, understanding agents themselves to be extended selves, blurring the divide between the internal and external, and spreading out into the world. We can think of many artefacts, whether cultural narratives, other people or institutions, which house dispositional beliefs we consider essential to selfhood. By accepting this, I suggest no fixed thing or substance constitutes the higher levels of a SCALED selfhood, after the minimal, self-reflexive “I”. It would make a difference to the personally owned narratives/dialogues, namely the thick conception of “I”, to find itself moving, thinking and acting in a more highly biotechnologically integrated world. Clark suggests we are ‘soft selves’, prone to assimilate other things into ourselves. Selfhood thus has plasticity: our boundaries are malleable, and changeable.

Clark considers the self’s extension in two ways. Firstly, the self is comprised of things that one directly controls. This includes one’s body and thoughts, but also parts of the external world. Control is an important feature of our self-experience; it differentiates us from other inanimate things as we exhibit both organisational coherence and intentionality. Dennett (1984: 82) suggests control is the ultimate criterion of selfhood: “I am the sum total of the parts I control directly.” The notion of “direct control” therefore intends to rule out cases where we first control our bodies, and, manipulating them accordingly, control something else (Clark, 2003: 131), as in these cases, first-order, direct control remains confined to the biological boundaries of the individual. Examples of extended, direct control are perhaps most clear in people who incorporate prosthetic limbs into their body schema. Stelarc, a performance artist for instance, incorporated a third hand into his body schema. Slowly, Stelarc learned to control its fingers and movements in very fine-grained ways with his abdominal movements; reporting that he experienced the hand as a part of himself. This accords with the sense of personal ownership discussed in Chapter 3: Stelarc experienced from the first-person perspective as the thing that owns, controls and manipulates the hand; appropriating himself with this external prosthesis. He acquired a conscious sense of control over the hand, and so according to this first criterion of Clark, the hand became a part of himself. Clark (2003: 131-132) thus says, “[t]he most basic notion of the self, on this model, is
simply the plastic, multiply negotiable sense we have of our own physical presence in the world. This sense is determined by our experience of direct control”.

However, conceptualising the extended self via the notion of control does not enable schizophrenic patients to extend their selfhoods. This is because what is often absent in their experience is precisely this tacit first-person governance over their experience, exhibited in diminished self-affection. Therefore, explaining how the environment can play a part in a schizophrenic’s experience such that it enhances the self-affection that is experienced as lacking, I turn to Clark’s second notion of extended selfhood. Clark suggests the self is a bundle of on-going goals, projects and commitments, referring to the narrativity of selfhood. We are partly constituted by the things we, and others, say about us, integrating our life experiences into an internalised, evolving story of our individualised selfhood. Clark suggests the notion of self-narrativity opens the door to a radical possibility: the narrative self is a biotechnological hybrid. This is because one’s on-going projects, goals, and the very way one defines oneself, would differ in a world where one has smooth, immediate access to enhanced capabilities via some technological device. If an individual had a different sense of what they could do, then the self-descriptions personally owned by that first-person subjectivity would differ, and consequently, that self will have different aims and projects. Clark’s proposal that how we act in the world is a hybrid process involving the brain, body and environmental tools, is compatible with Chapter 3’s endorsement of the dialogical self.

4.5 PSYCHOTHERAPY AND TOOLS
I now apply Clark’s analysis of ‘tools’ and extended selves to talk therapy, arguing it is an external scaffold that can be ‘used’ analogously to Clark’s technological devices. Talk therapy is a form of psychotherapy, and includes multiple psychotherapeutic practices that use verbal communication to alleviate symptoms of mental disorder, rather than strategies that require drugs or physical exercise. “[B]y definition it is a conversation between two or more people, and often seeks the explicit goal of enriching the client’s personal narratives” (Lysaker and Lysaker, 2008: 136). Evoking the so-called ‘talking cure’ is widely practiced in psychotherapy and opens the door for the schizophrenic to discuss their issues, feelings and life events. By articulating their problems and sharing their perspective with the
therapist, it is hoped that the client will gain a deeper insight into their experiences and find relief (Maiese, 2016: 235). The therapist establishes a professional relationship with the patient, aiming to firstly mitigate or reshape the client’s existing symptoms, secondly mediate their disorganised patterns of behaviour and thoughts, and ultimately further positive psychological growth and improvement (Wolberg, 2013: 29). This is accomplished via a thorough scrutiny of the client’s life history, involving an analysis of the patient’s current relationships and life situation. The therapist attempts to understand the “historical roots and current ramifications of maladaptive interpersonal patterns as reflected in the doctor-patient relationship and in daily life” (Gabbard, 2007: 346). The expectation is that this will result in modification to the patient’s maladaptive interpersonal patterns and personality development.

I argue that conversing with the therapist is a kind of tool the schizophrenic can capitalise on. Talk therapy enables the schizophrenic to rekindle interpersonal dialogues and strengthen compromised dialogical capacities (Lysaker and Lysaker, 2008: 136). I propose the client can use the therapy session, and therefore change him/herself, by developing a different sense of what they can do (i.e. acknowledging their personal ownership as opposed to experiencing diminished self-affection). This will enable them to develop enhanced self-descriptions, namely using the first-person pronoun “I”, and thus they will cultivate different aims and projects.

Whilst I cannot maintain this position by exploring the schizophrenic’s control over the therapy session analogously to Stelarc’s control over his ‘third hand’, as the patient by no means controls the discussion (arguably the therapist does this), Clark makes a second conceptual point. He says that because external technologies become more reliable as one uses them, they change the extended individual in terms of their tacit, implicit sense of their capabilities. This in turn changes the ways that one describes oneself, posits goals, and develops projects. I suggest this premise is applicable to talk therapy sessions. Clark (2003) supposes that one does not need to ‘feel’ all the biological and technological processes for them to be constitutive parts of a self in the process of performing some task. For Clark, they are all part of you-in-the-process-of-achieving-X. Likewise, I suggest the
psychotherapy sessions are part of patients-in-the-process-of-enhancing-their-personal-ownerships.

Before detailing how psychotherapy can extend a schizophrenic’s selfhood, I make some preliminary clarifications. Firstly, the psychotherapy is not an unconscious process in the way that Clark conceptualises inanimate tools. Therefore, my analysis does not make a similar stark contrast between conscious and unconscious parts that constitute the schizophrenic’s selfhood. Rather, the relationship is more that the schizophrenic is affected by the therapist’s words, and what the therapist tells them, they have no power over.

I claim patients use the conversations in therapy as a tool to retard their existing diminished self-affection. However, my rebuttal of the first concern leads to second clarification. Initially, it appears strange to say patients use the therapy, because, as stated, they cannot predict exactly how the therapist will approach their treatment. The possible criticism here is grounded in a narrow understanding of ‘use’: one can accept ‘using’ inanimate objects because specific goals are sort after. Scissors for example are used to cut, and we know the exact sequence of events required to actualise this result. Likewise, Stelarc employs the necessary steps to use his third hand to write. This worry is therefore summarised in the question ‘whilst we might say the therapist broadly helps patients, can we legitimately say patients use the therapist?’

Arguably, yes. Patients still expect therapists to do specific things. Glass for instance, a schizophrenic patient Lysaker and Lysaker (2008) describe who suffers from diminished self-affection, often wanted his therapist to explain events in his life. “[H]e repeatedly asked his therapist for an account of his own, i.e. Glass’s, problems” (Lysaker and Lysaker, 2008: 143). This request demonstrates Glass explicitly wants a resource beyond his physical body (i.e. the therapist/therapy) “to do the work” (p. 143) of presenting and synthesising his life. It is irrelevant that Glass does not know ‘how’ this request may be actualised; rather one must acknowledge that this is his desire, and he hopes this therapy is a means to restoring his personal ownership. A parallel may be drawn with medicine: people commonly use medicines to restore their health without knowing ‘how’ this occurs, or the exact outcome; rather they simply aim to feel better. The only difference between these cases and the case of
using scissors, is how narrow and guaranteed the outcome of the tool-use is. Therefore, a broad desire to regain personal ownership is not reason to question the patient’s intentional use of the therapy.

Finally, I suggest the word “tool” itself may elicit possible misunderstandings. Clarifying this has made me tighten the scope of my analysis of an extended self that is partly constituted by psychotherapeutic practices. Admittedly, my above clarification, whilst expressing my position, will nevertheless still arouse the question ‘is the client really using the therapist?’ I think this question persists because ‘tool’ seems to objectify the other, denying the therapist’s autonomy. This is hard because the technologies Clark (2003) discusses are unconscious. We rarely (if ever), conceptualise tools as possessing independent consciousness. It would be confused to say for example Stelarc’s third hand has autonomy. Whilst Stelarc may not control its every process; it may make internal movements that Stelarc does not determine, the hand nevertheless remains unconscious; it is robotic. Yet, once you consider people, it becomes harder to talk about soft selves. Criticism may be levied saying that this ‘using’ is more akin to an intersubjective relationship between therapist and client6.

However, Clark and Chalmers (2010: 38) nevertheless say that in unusually interdependent couples, “it is entirely possible that one partner’s beliefs will play the same sort of role for the other as the notebook plays for Otto”. The argument’s functionalist grounding gives it credibility. A person can play a functionally equivalent role to an inanimate object and thus fulfil the criteria to be an enabling condition for another subject to achieve X, thus making that person a part of the subject-in-the-process-of-achieving-X. Whilst true that “[i]n other social relationships these criteria may not be so clearly fulfilled... they might nevertheless be fulfilled in specific domains”, for example one’s dispositional beliefs might be embodied in one’s secretary, one’s collaborator (Clark and Chalmers, 2010: 38), or even in one’s therapist.

6 Whilst I do make this argument in 4.4, focusing on one’s fundamental embodiment, this will compliment rather than contradict my more clinical characterisation of psychotherapy here.
I think arguments that imply therapists can become constitutive parts of their clients’ extended selves have plausibility. However, as discussed, it remains controversial, and requires rethinking the nature of ‘tool’, ‘use’, and autonomy\(^7\). Therefore, discussing therapists themselves is now side-lined, whilst I conduct my analysis of talk therapy and ‘tools’. My specific focus is on the linguistic structures at play within psychotherapy. The majority of cognition taking place within the therapy, and the *using* of the therapy by the schizophrenic patient, I argue, is carried out within the therapy’s linguistic niche. Without language, we might be much more akin to an internalist, Cartesian view, in which complex cognition relies largely on intracranial information processing. However, the advent of language enables us to spread this burden into the world, complementing our inner states. Clark and Chalmers (2010: 39) suggest language “serves as a tool whose role is to extend cognition in ways that on-board devices cannot”. The line of argument I therefore develop below is that in talk therapy, the client, however intentionally or unintentionally, exploits the transformative power of language (Colombetti, 2009: 13) to enhance their personal ownership. Because this external prosthesis changes the client’s abilities, and thus their self-descriptions and self-facets, the language structures used in talk therapy can be seen as a constitutive part of the client’s selfhood; re-establishing their lost personal ownership.

Lysaker and Lysaker (2008) do not think the therapist’s role is to remain silent. Rather, they are to explicitly and repeatedly notice the perceptions Glass offers in the session, no matter how minimal they are, and illustrate that Glass himself experienced these perceptions. The aim of this therapeutic process is to help Glass establish the “intentional arc” that connects his selfhood to the present context

\(^7\) Bray, (2008: 11) also highlights possible issues arising from reliance on other people. She suggests that dementia sufferers like Otto can make fairly free use of a notebook or other inanimate objects to supplement their memory. The objects will not refuse help, grow bored or find another person to help that they prefer. People, however, are subject to all of these disadvantages, and make notoriously unreliable tools. “Once other social actors are recognized as (at least) potentially deceitful, extending one’s mind into another’s brain becomes an extremely risky business…” (p. 11). It is possible to criticise this argument by reminding the critic of the rules and regulations surrounding psychotherapy, meaning that the therapist is a reliable and trusted person. However, it remains possible bad tempers, tiredness or illness on behalf of the therapist nevertheless render them more susceptible to problems, and thus less reliable than inanimate, unconscious notebooks.
(Stanghellini and Lysaker, 2007: 174). This arc, described by Merleau-Ponty (1945), cements the self within its current context and bridges the gap between intentional objects of perception, namely the external artefacts one experiences, with the background proprioceptive sensations of one’s body. In healthy individuals, one’s desiderative bodily feelings keep the person continuously aware that they personally own the experience of the intentional object (Stanghellini and Lysaker, 2007: 174). This arc can be restored via the linguistic structures employed during talk therapy.

To accomplish this, the therapist may exemplify the second-person dimensions of the therapeutic address. For example, in one therapy session, Glass says he watched television, leading the therapist to stress the ‘you’ in questions like, ‘What did you watch?’ or ‘Did you like what you watched?’ (Lysaker and Lysaker, 2008: 144). Stressing the second-person in psychotherapy sessions inherently treats clients as participants in their own lives, implying that they are the narrator of their experiences. The second-person grants them as something more than simply passive players. The therapist means to allude that Glass is not simply perspectively witnessing these experiences, but rather he personally owns them. Furthermore, questioning Glass in the second-person calls upon him to participate more robustly in his own life. By spotlighting ‘you’, Glass is made to try and recall the experiences he has undergone. This linguistic structure also reaffirms the expectation implicit in all communication, that Glass should be able to articulate to himself and others a narrative about what he has experienced in which he is the central player. Therefore Lysaker and Lysaker (2008: 144) suggest that using the second-person may also “serve as an enabling condition for the generation of meta-positions and large-scale life narratives”. It is even plausible that personal ownership of the first-person perspective can be restored because the schizophrenic finds their “I” in the structural entailments of the second-person “you” to which they respond: if the client is responding to questions about their experiences as that person (i.e. by correctly using the first-person), then acknowledging that they own the experiences seems possible, and even likely.

One’s understanding of oneself as the protagonist on one’s on-going narrative is conditioned by one’s understanding of one’s capacities and potentials (Clark, 2003: 142). In the case above, this understanding is impacted in a deep way by the
linguistic niche in which Glass’ experiences and perspective are “conceived, incubated and matured” (Clark, 2003: 142). However, rather than this being a “technological cocoon” as Clark (2003) envisages, it is a linguistic scaffold. The language, the conversation itself, is the key cognitive tool through which Glass can objectify, intentionally consider and therefore consciously engage with his capacities of thought, reason and self-understanding (Clark, 2005: 265).

An example helps illustrate my argument. During Glass’ therapy, Glass explains that whilst at work, a colleague tried making small talk to him whilst he was occupied, and he was unsure how to respond, or even recognise how he felt. Lysaker and Lysaker (2008: 146) suggest Glass was ‘empty’ at that moment, unable to consider what he should have done. The therapist’s response is to ask, if he, the therapist, was in that position what would he have felt and done. Glass can comprehend these questions and form clear answers, enabling Glass to consider how he felt and how he could have handled the situation differently. In responding to the therapist’s question, Glass would articulate his thoughts using the second-person pronoun, saying, “you would feel”, and by imagining the therapist possessing those attributes and intentions, Glass could further apply them to himself, generating his individual sense of selfhood by way of contrast (Lysaker and Lysaker, 2008: 146). Framed in object relation terms, Glass firstly needed to experience his mental life located within a mental representation of the therapist’s mind by considering how the therapist would socially engage, before he could secondly experience his mental life within himself.

Language works as a tool that enables us to consider our own thinking. Therefore, Clark (2005: 265) thinks that we can “devise cognitive strategies aimed at modifying, altering or controlling pretty much any aspect of our inner life”. To perform well in strategic and skill based actions, as cognitive agents, we can capitalise on language’s ability to scaffold our thoughts. When playing the piano for instance, one may notice that, when playing one’s favourite well-known section the tempo incorrectly increases. Therefore, the player will believe that they are prone to playing the section too fast and thus, whenever approaching this part, the sentence ‘DON’T speed up’ will flash through their mind. This sentential prop scaffolds the pianist’s awareness and subsequent behaviour. In such cases, Clark suggests that with sufficient practice the person may learn sets of strategies whose emergent outcome
is that the piece maintains a consistent tempo. Likewise, following the talk therapy, sentential props will enhance the schizophrenic's personal ownership. They may internally narrate their actions to emphasise their agency over their actions saying, “I'm doing this”, “I'm thinking this”. In this way it becomes even more natural to acknowledge language as a tool once the patient is independently using it. Whilst this final point may backtrack on my claims, as this tool is internally mediating the schizophrenic's experience\(^8\), its linguistic structure and pattern of thinking is found externally in worldly dialogue and collectively endorsed grammatical rules.

The process of making explicit what were previously un-owned experiences for the schizophrenic is far more than just cheats for patients suffering from diminished self-affection. Rather, the linguistic structure that externally scaffolds the patient’s self-reflection is central to what matters most about the human mind and about one’s unique capacity to hold oneself accountable for one’s actions. This only makes sense in the presence of some degree of possible-control, and, as this control is externally scaffolded via linguistic structures, it seems natural to extend Glass’ selfhood, to encompass this external tool. The language therapy is an extended source of selfhood that unlocks self-aware personal ownership. The linguistic niche gives Glass the capacity to comprehend himself as a subject moving within the world.

Consequently, I think Clark (2005: 262) is correct in claiming, “[l]anguage… may thus act as a kind of affect-dampening layer of insulation, enabling us to pursue our goal”. Selfhood comprises our on-going goals and commitment; and Glass’ on-going projects, commitments, and the very way he defines himself is different in a world where he is able, through the linguistic devices employed by the therapist, to access his personally-owned self. The linguistic niche is the enabling condition for this change, and following the counterfactual conditional, as the behavioural competency of these self-facets will decrease without these linguistic tools, then Glass’ selfhood must include these external resources, thus extending. I use the counterfactual in the following way: without the linguistic scaffolding (P), Glass cannot achieve self-reflective competence (Q).

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\(^8\) It has only been highlighted as further directions this approach could take.
However, if the criterion for linguistic structures and patterns to partly constitute Glass’ selfhood is simply that without P, we cannot have Q, one can ask why in psychotherapy is P so important, yet other circumstances are not? My answer returns to the nature of therapy; psychotherapy may serve as ‘dialogical prosthesis’ because the patient can become coupled to the linguistic structures, generating feedback loops between the patient’s thoughts, how they intuit and express them propositionally, and the deeper reflection and appreciation for their selfhood the first-person and second-person syntaxes can elicit. Other circumstances, like the ceiling colour or position of the door do not enable these rich couplings. As Stanghellini and Lysaker (2007: 174) suggest, psychotherapy may re-establish the lost intimacy between a patient’s bodily feelings, their emotions, and interpersonal situations, and it is the specific coupling of the patient capitalising on the linguistic structure that enables these feedback loops and enriches their personal ownership.

The notion carried forward from this discussion is that phenomenologically informed psychotherapy takes place in the public space between the therapist and the patient. It is not purely internal (Perez-Alvarez et al., 2011: 191). The goal of patients engaged in psychotherapy is to enhance their selfhood, achieved by enabling them to acknowledge their subjective presence within their experiences and take an intentional stance towards them (Stanghellini and Lysaker, 2007: 175). Patients like Glass want to attain personal ownership, and so use the therapy as a means to an end, treating the therapy as a tool.

4.6 BRINGING THE BODY BACK INTO THE STORY: ENACTIVISM

Using talk therapy as a “dialogical prosthesis” (Stanghellini and Lysaker, 2007: 174) is enactive in nature. I have argued the therapy is a tool, but this does not mean I do

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9 I remain wary of this claim however, as it is possible a schizophrenic’s delusions of persecution do arise from such circumstances we normally take for granted and thus a patient may be more attuned to benign environmental artefacts. For example, a ceiling colour may convey some ‘hidden message’ for the patient. Yet it remains unclear how a coupled relationship could emerge; rather I would be inclined to suggest an internalist understanding of this: the ceiling colour elicits thoughts internal to the patient, which they then believe and perhaps act upon.
not acknowledge its intersubjectivity. Intersubjectivity is the meaningful engagement between subjects; it is how we collaborate to make sense of the world and one another (De Jaegher, 2015: 113). The public space between the therapist and the patient that evokes feelings of the ‘you-and-I relationship’ via the syntactical structures used, necessarily involves feelings of “being there” as a bodily presence, and acknowledging the bodily presence of the other (Perez-Alvarez et al., 2011: 191). The schizophrenic must recognise that both they themselves and the therapist are embodied entities in the world that can do things. Acknowledging this is a necessary requirement for re-establishing the first-person perspective that is absent in cases of diminished self-affection.

The therapist and patient engage in participatory sense-making, namely the sense-making of the two autonomous agents is “mutually modulated” as they engage in this interactive encounter (Cuffari et al., 2015: 1099). New understandings emerge; patients may comprehend themselves as personal owners over their experiences, and therapists may learn more about the nature of their patients’ conditions. These understandings emerge through the actual process of “second-person interaction” (Maiese, 2016: 237), and importantly, happen literally between the individuals: the schizophrenic’s appreciation of their personal ownership over experiences happens in the joint space between the two people, and is mutually constructed (Fuchs and De Jaegher, 2009: 466). Such interpersonal engagement is enactive because the individuals participate in generating meaning for things that matter to them (De Jaegher and Di Paolo, 2007: 488). I suggest that both parties do this during their active engagement in conversation, achieved through a number of embodied actions including: coordinating, synchronising and mimicking the gestures, facial expressions, and postures of the other.

To elaborate, I turn to an example explored by De Jaegher and Di Paolo (2007: 500-501). In social engagement, commonly the sense-making activity of one person orients the attention of another. In charades for instance, when miming a word, the intention is to orient one’s teammates, and so generate meaning from one’s embodied actions. De Jaegher and Di Paolo (2007: 501) explain how, as the interaction unfolds, what begins as orientation becomes more symmetrical as one’s team-mates alter their sense-making so as to correctly interpret meaning that
conforms with the gestures being offered. For example, when words are suggested that rhyme with what one is performing, one might rotate one’s hands to signify they are close. It is apparent how the new meaning of the gestures is jointly constructed during the interactions between the one miming and the guessers, so that the mimes offered, such as spinning one’s hands to signify the guesses offered are nearly right, follow from the suggestions. Once guessed correctly, it is apparent that the new meaning of the gestures has been jointly constructed during interaction and evolved through patterns of orientation, coordination and breakdowns. The mimes become jointly understood, and can be further used within the game or transformed into something similar.

Maiese (2016: 238) thinks that such “participatory sense-making” is explicit in the transformative process of effective talk therapy. Whilst the therapy comprises a dialogue, this interaction nevertheless includes synchronisation, mirroring, anticipation and imitation of bodily expression. The way both party members understand the situation is mediated by the sense-making activities of the other. She proposes that during “face-to-face second person encounters, our whole bodies, not just our brains resonate with the other person…” enabling the generation of joint meaning and modification of others’ understandings. I suspect within the therapy, the therapist’s gestures may participate in generating the meaning of sentences for the schizophrenic. When Glass is reminded ‘you watched television’, and asked ‘do you remember something about that?’ (Lysaker and Lysaker, 2008: 144), deictic gestures may accompany these comments. Deictic gestures connect aspects of speech to other ideas, objects, locations or actions (Kelly et al., 2008: 2). When rock-climbing for example, the comment ‘watch that loose stone’ may be accompanied by gesturing to it. Equally, in Glass’ talk therapy, the therapist may point to Glass and spatially locate him, thus reaffirming for Glass the therapist’s understanding of him as a person with a narrative. This explicit deictic gesture evokes participatory sense-making; new domains of social sense-making are generated that were unavailable to each person individually. This explanation particularly applies to Glass, who alone, cannot make sense of his experience. Yet, one should not dismiss this as the therapist simply telling Glass his observations; it is intersubjective in nature as, depending on how Glass responds to these statements, the therapist will continue in different ways. Glass’ verbal and bodily responses help the therapist understand how
the statement “you watched television” resonates with his patient. In this way, the individual’s sense-making is mutually modulated as they engage in interactive therapy.

Expression, communication and relatedness all feature in talk therapy, and all are rooted in the body. This is because the dynamics of intersubjective influence in conversation are at least somewhat grounded in our bodily responsiveness and affective awareness of another’s gestures and expressions. Maiese (2016: 238) suggests that “[b]odily responsiveness and the establishment of a communicative base can be understood as a matter of deep bodily attunement and the entrainment of interactors’ affective framing patterns”. Most explicit in face-to-face social encounters such as psychotherapy, subjects undergo noticeable affective re-orientation that changes how they understand and interpret their surroundings, and their location within it. In the rock-climbing example, arguably the instructor pointing to the loose rock is trying to make the novice adjust his affective framing patterns. Suppose both instructor and novice are aiding a cliff rescue, so need to be attuned to one another’s actions and intentions: the instructor may tap the loose rock, adjusting what become salient features of the novice’s environment. The communicative base, namely: this rock is loose, is established “through their direct, face-to-face bodily engagement” (Maiese, 2016: 238).

Likewise, during psychotherapy, the schizophrenic’s affective framing patterns change, their perspective and patterns of attention shift, and they begin to interpret and understand their experiences in new ways. Glass’ attunement to the therapist conceivably helps to ground his first-person perspective, and the overall to-and-fro of the conversation serves as an enabler for participatory sense-making. I propose Glass’ patterns of focus and attention will recalibrate as a direct affect of the therapist’s bodily gestures, such as possible deictic pointing and ‘interested’ body language, which supplement the overall grammaticality of the conversation. Maiese (2016: 239) nevertheless highlights that, whilst the therapy aims to rehabilitate the schizophrenic, to the extent that empathetic attunement involves “feeling with” the patient, the therapist’s perspective is equally reshaped during the discussion.

Therefore, I am justified in supposing once the interactors’ gestures, facial expressions and emotions align with one another, the subsequent affective framing
patterns become entrained so that each individual’s bodily movements modulate the behaviours of the others. There is an interpersonal looping; literally interpersonal in the sense that a part of the understanding process is constituted by processes that happen *between* people. Importantly, Maiese (2016: 239) suggests, “the reason why social interactions such as talk therapy can be so transparent and direct, and also potentially transformative, is that they engage the subjects at a basic bodily level”. She is claiming that the bodily attunement that occurs during these interpersonal couplings can involve “motor resonance”, namely physical bodily changes that alter the way the subject experiences, such as an increased heart rate, fluctuations in blood pressure or hormone variations.

Thus, the enhancement of the schizophrenic’s personal ownership over their experiences via their ‘using’ the therapy as an ‘external prosthesis’ or tool does not take place in isolation from the living body. It is misconceived to see talk therapy simply as a way to enhance the mind or intellect. One must remember the fundamental argument from Chapter 3: the self is an embodied self. Therefore, whilst the schizophrenic’s enhanced narratives help to unite the experience of subjects such as Glass, all their “perceptions, emotions, beliefs, and experiences take place against the backdrop of a subject’s affective framing patterns” (Maiese, 2016: 239).

In this chapter thus far, I have provided a detailed analysis of the relationship between the therapist and the schizophrenic patient during psychotherapy. I have argued that the therapy can be seen as a tool ‘used’ (broadly speaking) by the patient, who capitalises, however intentionally, on the structure of the I-You perspective within this dialogue. Thus, the dialogue is an external prosthesis, and is the “wide realization” (Wilson, 2004) of the schizophrenic’s personally owned selfhood. In the latter part (4.4), I have introduced the notion of embodied intersubjectivity, arguing that the client’s ability to capitalise on this external prosthesis is grounded in their embodiment. The following section offers a potential counterargument to my position, namely that the linguistic structure of talk therapy extends the embodied subjectivity of the patient, by following Clark’s (2003) criticism of “a kind of privileged user” (p. 136). I overcome this position.
4.7 THE EXTENDED SELF, RECONSIDERED

Clark (2003) raises a plausible objection to the consideration that the tools one uses constitute a part of an extended self. Criticism may be levied that although the incorporation of external props, such as the grammaticality employed during talk therapy, constitute a part of the schizophrenic’s personally owned self, it is nevertheless the brain that controls and chooses the actions. The brain alone capitalises on the I-You relation in the therapy. This is a typical internalist objection and is endorsed by the likes of Rupert (2004) and Adams and Aizawa (2001).

Clark (2003: 136) replies by noting that if you think the self is constituted by what is ‘controlling’, this shrinks the self drastically. Selfhood is not just the brain, as the brain does many different things, and not all of them are involved in controlling and decision-making. Neuroscientists now consider the prefrontal cortex the seat of “executive functions” (Kane and Engle, 2002), governing one’s decisions and thoughts. These are higher cognitive functions, and so it is questionable:

“Do we now conclude that the real ‘me’ is to be identified only with those select elements of the neural machinery involved in ultimate decision making? Suppose only my frontal lobes have the final say – does that shrink the physical machinery of mind and self to just the frontal lobes?” (Clark, 2003: 136)

Clark disagrees; this reduction is absurd. If one raises the brain objection, arguing that someone uses the tools, but the brain is the seat of the self controlling which tools one uses, this controller itself is reducible to its constitutive parts: the prefrontal cortex. This too then also becomes suspect, and possibly further reduced. Therefore, to avoid this criticism Clark (2003: 136) suggests “[w]hat we really need to reject… is the seductive idea that all these various neural and nonneural parts need a kind of privileged user. Instead, it is just tools all the way down”. The brain is a tool; just as one’s body parts and the world are tools. The brain, body and world are intertwined, the complementary parts enabling people to achieve goals, such as Otto’s successful navigation, Severus’ accountancy duties, or Glass’ retention of his personal ownership. Apart from giving rise to our sensitivities, our incorporation of language is noticeable in how we, as humans, structure our actions, manage our memory and plan or make decisions. The total enmeshing of language and cognitive
abilities is a reason why it is so challenging to demarcate where language begins and ends (Cuffari et al., 2015: 1117). It is a tool, incorporated into our natural, human selves. Cuffari et al. (2015: 1116) suggest we most noticeably incorporate a linguistic style of being. “Our biological being co-evolves with our linguistic and existential being”. Clark does not deny that some elements play more important roles than others in our sense of self. Likewise, within the brain, neural circuits contribute in different ways to the sense of self, some, like the prefrontal cortex playing crucial functions whilst others are expendable. This means that whilst the brain provides some vital features, it is human nature to incorporate external non-biological elements into our bodies that provide our further capacities. These “tools” enhance us in various ways, yet all remain parts of our “nonlocalized” (Krueger, 2010: 569) selfhood. Clark’s view is epitomised in his claim that “[n]o single tool among this complex kit is intrinsically thoughtful, ultimately in control, or the “seat of the self”” (Clark, 2003: 137). He uses the term “soft-selves” to refer to our ever-changing amalgamation of tools. We continuously absorb new tools into our psyche and are driven to leak through the arbitrary ‘skin’ boundary drawn by internalists, incorporating evermore “nonbiological elements as aspects of the machinery of mind itself” (Clark, 2003: 137). Consequently, there is no Lockean self (1984). Strawson (1999) endorses a Cartesian understanding of selfhood, postulating a central cognitive essence that is my personal identity. However, all there really is, is “a rough-and-tumble, control-sharing coalition of processes—some neural, some bodily, some technological—and an ongoing drive to tell a story, to paint a picture in which “I” am the central player” (Clark, 2003: 138).

4.8 HYPOTHESIS OF “ORGANISM CENTERED” COGNITION: IT IS NOT “JUST TOOLS ALL THE WAY DOWN”

Clark (2003) rejects the idea that an ‘essence’ underlies the self-facets that emerge through couplings of organisms to environmental tools. To explain this, he imagines pouring sand onto the ground, such that it forms a stable pile of particles. If the pile somehow developed self-awareness, he suggests it may falsely intuit an inner essence that has governance over and organises the constitutive parts, so that the stable arrangement is achieved. However, this would be mistaken; the grains rather simply self-organise. Likewise, when pouring water into a container, the H₂O molecules fill the container’s total available space. The liquid’s bonds are strong
enough to keep the particles together, but weak enough to allow them to flow past one another easily, meaning the water’s surface remains flat. These apparent patterns are not intended, but rather simply self-organised. No essence underpins them.\(^{10}\)

However, Clark seems to disregard the spatial location of the individual. This is understandable, given his endorsement of EMT and thus subsequent dismissal of any arbitrary skin boundary. Yet, in doing so, he seems to remove the inherent embodied experience we have of ourselves as an entity which capitalises on our ability to use tools. Strawson (1999: 4-5) employs a phenomenological constraint, suggesting investigations of selfhood must begin by addressing how the self is experienced. Only then, can we answer the metaphysical question, what is it? And it seems that answering this question by suggesting it is ‘nothing’ as Clark does, does not accord with evidence or with one’s individual embodied experience.

Lysaker and Lysaker (2008: 37) say Frank’s diminished self-affection made him believe and feel that the person he once was had “exploded”: he was left with the mere remnants that were held weakly in the vicinity of one another by “gravity”. To refer to Chapter 3’s argument, Frank’s experiences nevertheless remain spatially located; the experiencer (a perspectival self), i.e. the minimal self (Zahavi, 2005) that enables Frank to experience at all, remains localised. Therefore, whilst I accept the basic premise of Clark, namely that the narrative dialogical self can be constituted by parts external to the subject, such as the talk therapy, Clark has set up an irresolvable conflict: he endorses the narrative self, which requires an “I”, and thus

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\(^{10}\) Examples of self-organisation are frequent in nature. Ant colonies are capable of achieving complex patterns of behaviour, including finding new food sources, exploiting them efficiently and reacting swiftly when they are depleted. Without a central controller, the apparent organisation is achieved by the ants sharing information using their acute sense of smell: when ants go foraging they leave pheromone trails behind them that others can follow. If they find food, they lay more pheromone on their return, strengthening the trail. Consequently, the ants self-organise; following the pheromone trails without a central commander. Each ant deals with simple rules, but collectively intelligent behaviour emerges. Dennett (2005) asks; “what is it like to be an ant colony?” The answer suggested is that it feels like nothing, even if it feels like something to be an individual ant. This is because no organised subject exists as the enjoyer or sufferer, owning the experience. The candidate subject is disunited (Schmid, 2014: 6). Ants, like human cells, have different functions within the nest, yet operate together as an ordered whole without an underlying essence.
personal ownership, yet rejects a perspectival experincer that underpins this (slightly) higher level of minimal selfhood\textsuperscript{11}.

This price is too high to pay, and thus an alternative hypothesis, namely “organism centered” cognition (HOC) better accords with my analysis. HOC suggests human cognitive processing can literally extend into the organism’s environmental surroundings, yet the organism, or more specifically the brain within the organism, remains the core and most active element of this extended system. “Cognition is [therefore] organism centered even when it is not organism bound” (Clark, 2008: 139). Clark (2008: 123) suggests under this alternative view, it is the biological human organism that orchestrates the webs of cognitive scaffolding to which it becomes coupled. The therapy’s grammaticality can thus be a part of the extended machinery of Glass’ thoughts and reasoning, and whilst Glass’ cognition extends beyond the skin and skull boundary, it nevertheless remains “organism centered”. We can imagine this like a spider and a web; whilst the web extends the spider’s capabilities this fly catching system still has a central operator, which is very much the organism and its possibilities as an embodied thing\textsuperscript{12}. My previous discussion of embodied intersubjectivity (4.4) exemplifies this: extended systems still retain bodily cores, which enact and thus shape the meaning of the entire extended operation, namely how it is used, works and aids the subject. Furthermore, Clark (2008: 117) says that the “most important thing to notice is that there is no incompatibility whatsoever between EXTENDED and the notion of a persisting common biological core”.

Consequently, I am inclined to accept a coarse grained approach to understanding the term “use”, rather than reducing this “user” to parts of the brain as Clark (2003)

\textsuperscript{11} This slightly odd grammar which seems almost contradictory, is referring to the SCALED self’s distinction between what commonly is just referred to as ‘minimal selfhood’, namely within Sass and Parnas’ (2003) work. The SCALED self splits this into perspectival and personal ownership, the second of which, although still very thin, sits at a different level to embodied reflexive subjectivity.

\textsuperscript{12} HOC is therefore a different formulation of extended selves to cases where there is no centre initially, such as an ant colony. This is a natural phenomenon where a nonlocalised entity achieves self-organisation, a function entirely performed by non-bounded entities. There is no core. Clark (2008: 118) notices that we do not find or individuate human beings by firstly finding their cognitive mechanisms. Instead, we conceptualise an agent based on our identification of a reliable, “easily identifiable physical nexus of perception and action, apparently driven by a persisting and modestly integrated body of goals and knowledge”.
imagines. We should accept that the embodied organism is the centre of the extended cognitive activity. There is an embodied perspectival self to which an extended dialogue can be attributed. I endorse this position because in Chapter 3, I equated the perspectival self with the embodied entity, which has a spatial location, and that is the core “I”. A coarse grained approach to understanding this perspectival location therefore means that a localised centre remains, and it is not just tools all the way down. This is a tenable position, compatible with my notion of the SCALED self, and Clark himself seems to have a conception of the organism, evidenced in his (2008) notion of “organism bound”.

4.9 WHY INTERPERSONAL INTERACTIONS AND ENVIRONMENTAL ENGAGEMENTS ENHANCE REHABILITATION

Taking the soft-self hypothesis seriously invites us to reconsider our understandings and prejudices concerning cognitive rehabilitation strategies and how cognitive impairment is environmentally overcome (Clark, 2003: 140). Schizophrenics can recover more empowered sense of their selves by constructing narratives regarding their mental illnesses and their relations to it if those constructions are enhanced by the on-going interactions with the environment precisely because personal ownership incorporates the external world. Psychotherapy can be seen as an external prosthesis of the schizophrenic’s selfhood. As embodied entities, patients can capitalise on the therapy sessions’ structures, furthered by interpersonal engagement, using the second-person’s grammaticality to structure their diminished personal ownership over their experience.

I acknowledge criticism surrounds claims of extended minds, e.g. Sterelny (2004, 2010), and Rupert (2004). It is questionable whether the therapy’s linguistic niche, in supporting and scaffolding the cognition of Glass and other patients, really is a constitutive feature of the schizophrenic’s enhanced selfhood. Yet, I suggest what is important is the complexity of these integrated systems: we should focus on the different properties or qualities these elements elicit when combined, rather than quarrelling about whether they are extended or embedded. The more general project of ‘external cognition’ aims to synthesise the complex and often unobvious relationships between internal and external forms of representation (Wilson and Clark, 2008: 66). Therefore, the moral of this chapter is that certain environmental
harm are simultaneously harms to ourselves. Glass’ cognitive relation to his own words and the therapist’s languaging defies simple categorisation of inner vs. outer. The linguistic niche reconfigures his personal ownership, and restores wholeness to his experience via interactive feedback loops. Consequently, I endorse Clark’s (2003: 141) claim, “our worlds, ourselves”.
5.1 INTRODUCTION
This chapter explores the compensatory strategy (Mishara, 2005: 147) the schizophrenic may adopt when they feel a decline or compression in their experienced self-affection: they become hyper-reflexive, namely hyper-aware of aspects of their bodily consciousness. Firstly, I reiterate the tacit embodiment of our perspectival subjectivity, exploring the concepts of ‘transparency’ and ‘body schema’; secondly describing how hyper-reflexivity is fundamentally a disruption of embodied consciousness. Referring to body-as-object and body-as-subject, I question whether this implies a disembodiment of the SCALED self’s core, and consequently whether the embodied viewpoint I hold, holds. It does: I provide reasons why the hyper-reflexive subject is still necessarily embodied, despite appearances. Thirdly, I explore how body-orientated therapies may recalibrate the schizophrenic’s embodiment, referring specifically to yoga’s therapeutic properties.

The final section then applies Wilson’s (2004) notion of “wide realization” to the SCALED self, making a critical distinction between the relationship of therapies that target the second tier personal ownership, and those targeting perspectival ownership. My analysis can be summarised by asking, ‘Do both tiers of the SCALE have equal possibility of extension?’ I argue they do not: body-based treatments for hyper-reflexivity cannot extend the core level of selfhood similarly to psychotherapy’s constitutive role in generating personal-ownership. I point to the levels’ important differences in cognition, and the core self’s inability to become coupled to external resources, concluding that bodily-orientated treatments for hyper-reflexivity may be best characterised under the hypothesis of embedded cognition (HEMC) (Rupert, 2004), whilst psychotherapy implies an extended view of cognition (HEC). This conclusion provokes my final chapter’s topic: a detailed exploration of how avatar therapy can become a constitutive part of a schizophrenic’s mind.

5.2 THE SCALED SELF: TACIT EMBODIED PERSPECTIVAL OWNERSHIP
Chapter 3 argued the SCALED self originates from an embodied core. This embodied subjectivity has a mass, which is transparent to one’s subjectivity. Micali, (2013: 210) says “…the transparency of the lived body is a necessary condition for
this specific experience of one’s own body”. Mind is integrated within the living processes of the body, which are transparently lived through by our consciousness. Our bodily processes “render themselves transparent to the world” (Fuchs, 2005: 95). In this way, we experience “body-as-subject”. Our lived immediacy to our bodies renders it impossible to perceive our seeing, or experience our experiencing via sense modalities. Rather we live through our senses, and they cannot be taken as objects of reflection. Fuchs (2005: 95) notes that we neither see the biochemical alterations in our retinas, nor how our brain deals with the sensory data. Rather, through seeing itself, the subject embodies and enacts these processes: “Their invisibility precisely means their transparency” (Fuchs, 2005: 95). Such processes are implicitly present in every instance of seeing. This is similar to how we hear music; we focus on the melody that emerges from an orchestra’s performance, and whilst each individual instrument’s note is implicitly present in the ensemble, we are unaware of them.

Our body’s transparency is enacted through our practical worldly engagement. We have bodily know-how (Siewert, 2005), namely practical knowledge of how to act with our body using our sensory modalities. Merleau-Ponty (1945: 137) describes this as the body consisting in a sense of “I can” (de Vignemont, 2016). This tacit bodily knowledge is taken for granted, and primarily based on one’s neuronal couplings of single sensorimotor units that emerge by repeated perceptions and/or actions (Fuchs, 2001: 324). Paradigmatic of such muscle-memory motor skills of performance are things like writing, playing instruments and skilful actions in sport. These motor skills are sensorimotor because they involve the ‘performer’ coordinating their sensory perception with their movements of action (Shusterman, 2011: 4). Our bodies hold implicit memory of how to perform actions; previous experiences aid our performance of bodily tasks without conscious awareness. A pianist’s body schema for example incorporates “the instrument, so that he lives in it like a limb and inhabits the expressive musical space it opens, without paying attention to his or her single movements.” (Fuchs, 2005: 97). Skilful bodily-knowledge is learnt and forgotten simultaneously and enables us to act smoothly in the world.

However, one can alternatively attend to each individual bodily movement commonly
taken for granted in one’s implicit performance, fragmenting the usually connected events (Fuchs, 2001: 324). For example, as a pianist I know that when relying on my implicit muscle-memory to perform, if I stumble over a note, suddenly attending explicitly to how each individual finger is moving over the keys makes the performance very hard. I seize up and the movements lose fluidity. “Explication [i.e. making the tacit clear] thus disturbs the former familiarity and leads to an alienation or disintegration” (Fuchs, 2001: 324).

5.3 HYPER-REFLEXIVITY AND THE SCALED SELF’S EMBODIMENT

Hyper-reflexivity specifically refers to a pathologic explication of the implicit or transparent sensorimotor modalities with which we are normally tacitly acquainted. ‘Reflexive’ refers to situations in which a self takes itself, or an aspect of itself, as its own object of awareness (Sass, 2003: 246), and so the exaggerated way that this occurs frequently in schizophrenic consciousness can be termed a hyper-reflexive disposition. The relationship between hyper-reflexivity and diminished self-affection is of the most intimate kind, “involving something more like mutual phenomenological implication than causal interaction; they are, in a sense, different aspects of the very same phenomenon, but described from two different standpoints” (Sass, 2000: 152).

For example, the writer Antonin Artaud (1976) who suffered from schizophrenia, describes simultaneously “losing contact with” his self, thus displaying negative symptoms, whilst also becoming deeply aware of “all those first assumptions which are at the foundation of thought” (1976: 290). The diminishment in the intentional arcs of self-experience implicate or, as Stanghellini (2004: 152) puts it, “induce” a hyper-reflexive pathologic strategy to retain one’s experiential existence, which results in the schizophrenic adopting an objectified, third-person stance over their subjectivity and can cause feeling bodily alienation.

In cases of hyper-reflexivity, one’s intuitive bodily connections between different actions are deconstructed. Therefore a patient instead takes each self-movement itself as a direct object of attention. The schizophrenic must consciously compensate for losing their immediacy to their actions by being aware of each movement and the steps involved: they must prepare each action and actuate it deliberately (Fuchs, 2001: 325). Those affected may, for example, have to concentrate on calibrating their grip and moving into the right position when putting books on bookshelves.
Therefore, Fuchs (2001: 325) thinks it is natural that those afflicted with hyper-reflexivity complain of a split between their mind and body, or feel hollowed out and robotic. One's lived actions become unfamiliar and object-like. Therefore hyper-reflexivity may be best understood as hyper-objectification or self-objectification (Irarrázaval, 2013: 14). Now, Toombs (2001: 87) says that the objectification of the body results in the loss of embodiment. This hyper-objectification comes in the form of uncomfortable self-consciousness and is akin to a third-person perspective, namely looking at one's own body as if it is an external object. Thus, the body can become an object of thematic attention (Krueger and Henriksen, forthcoming).

Instead of living through one’s body from one’s first-person perspective, hyper-reflexive patients objectify their bodies (Krueger and Henriksen, forthcoming), similarly to how someone may objectify their body when judging their physique.

One schizophrenic testimony exemplifies this objectification of the body saying: “None of my movements come automatically to me now. I’ve been thinking too much about them, even walking properly, talking properly and smoking - doing anything. Before, they would be able to come automatically” (Badcock, 2009: 113). In hyper-reflexive cases, patients “become abruptly aware of [their] body as a thing impeding [their] action” (Krueger and Henriksen, forthcoming). Rather than the body enabling our action, it becomes an obstacle. “[W]hen the implicit body-as-subject becomes explicit (i.e., a thematic object), the usually inhabited or automated bodily processes characterizing the transparent functioning of the body-as-subject become disturbed” (Krueger and Henriksen, forthcoming).

I prefer this characterisation of hyper-reflexivity as a ‘disturbance’ or ‘diminishment’ in one’s subjective embodiment, rather than Toombs’ (2001: 87) crude notion of “disembodiment”. Hyper-reflexivity is not precisely a loss of embodiment, but rather the relationships schizophrenic subjects assume with respect to their bodies change. One’s tacit experience of ‘I feel myself’ morphs into a third-person perception of oneself, namely ‘I perceive myself’; one’s immediate ‘I think’ experience becomes unconcealed, becoming ‘I dialogue with myself’; and feeling bodily-immersed in one’s actions becomes explicit to one’s awareness, making one a spectator of one’s own actions. (Stanghellini, 2004: 151). There are two connected reasons to be more specific than asserting hyper-reflexivity is a loss of one’s core embodied selfhood, as
Toombs (2001) suggests. Firstly, the body remains present in these experiences, the schizophrenic is aware they have lost their lived immediacy to their bodies, complaining for example “When I walk sometimes I become aware of every single step” (Stanghellini, 2004: 152). There is a decoupling of the self and oneself, but this does not mean oneself (i.e. the body) vanishes, only that an internal distance appears, whereby the self is not inhabiting itself properly. Secondly, taking this hyper-objectified stance towards the body does not disembodied the self but, as the walking example illustrates, assumes a different relationship to it: “the lid has been taken off my head and I see my brain’s silver filaments” (Stanghellini, 2004: 152). These are both sides of the same coin: the phenomenologically felt body does not disappear from one’s perspectival ownership, rather the SCALED subject’s grounding in an embodied core shifts. The perceptive angle is from the third-person, observing it thematically.

Consequently, whilst the SCALED self may suffer a disruption of its core, there remains a loose coherence. A hyper-reflexive experience is not a disembodied, empty experience, such as those found in Zen Buddhism, where “to forget the self is to be actualized by myriad things. When actualized by myriad things, your body and mind... drop away... No trace of realization remains” (Dōgen, 1995: 69-70). Unlike Zen, where one must cast off the body and mind altogether and experience a dis-identification (Mathers et al., 2009: 11) and even more minimally, a dis-association of the body, hyper-reflexivity retains perspectival ownership. It is just there is an “unplugging” (Stanghellini, 2004: 152) of the intimacy between subjective experience and bodily feeling. Therefore, cases of hyper-reflexivity do not compromise my model of the SCALED self, which accommodates this pathology of schizophrenic selfhood. Furthermore, this reaffirms my conclusions of Chapter 4: the self’s fundamental core is embodied, making Clark (2003: 136) wrong to assert, “it is just tools all the way down”.

Yet, as discussed, this core can be disrupted. Therefore, the remainder of this chapter answers the following two questions:

1. What innovative treatments are available for hyper-reflexivity?
2. How might these treatments feature in the organisation of the core self?
5.4 BODILY ORIENTATED THERAPIES FOR HYPER-REFLEXIVITY

Hyper-reflexive monitoring of normally ‘inhabited’ bodily movements cause elements of self-experience to become alien. What is thus required is the re-coupling and ‘gluing’ of the subject within the body so that the subject achieves a “fluid, automatic, and context-sensitive preunderstanding of everyday situations” (Fuchs and Schlimme, 2009: 572). Reforming this tacit bond may be achieved through the immersion and absorption in body-orientated therapies that give the subject the sense of seeing/living out through the body, rather than down, onto it, from an objectified viewpoint. By engaging in mind-body orientated practices, the patient becomes immersed in “a process that leads to embodiment and integration” (Mehling et al., 2011: 7), minimising these hyper-reflexive processes.

Body-based therapies can enhance one’s lived experience as body-as-subject including yoga, music, dance, and movement therapy. The American Dance Therapy Association (1974) defines dance or movement therapy as “the psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual” (Pallaro and Fischlien-Rupp, 2002: 19). As these therapies redirect the patient’s awareness and attention to their body and its boundedness with their selfhood, they intervene at the core of the schizophrenic’s pathological self. Such bodily-orientated therapies “involve attentional focus on and awareness of internal body sensations” (Mehling et al., 2011: 2), and thus are key interventions in treating misled subjective experiences of one’s body (Röhricht, 2009: 140). This is because a central skill the patients develop through training and repetition of bodily movements within these therapies is the ability to notice “sensations, thoughts and feelings as they occur in their actual immediacy” (Mehling et al., 2011: 6).

Franziska Boas’ work illustrates this idea. A teacher of ‘creative’ and improvisational dance, she volunteered at Bellevue Hospital (New York) between 1939 and 1943, and, working in collaboration with Dr. Lauretta Bender to pioneer dance therapy, explored how dance could facilitate mental therapy. Boas gives the example of a schizophrenic boy who wanted to complete a backward somersault, yet each time he tried he stopped, for fear of dying or losing himself. This illustrates how a disrupted, unnatural acquaintance with one’s body-schema inhibits the possibilities of bodily action. Boas thus suggested that just as body-image affects the repertoire of actions
afforded, deliberate changes within this repertoire will affect the body-image. Consequently, she encouraged patients to engage in new movement experiences, for example subjecting them to different postures and exploration of movements that brought the body into close contact with the floor (Levy, 1988: 110). I suggest such movements will have helped patients become acquainted with their embodiment, and the absorption in new movements in close proximity to the floor will have encouraged an instinctual coordination of their self and themselves, as they will have experienced their bodies in a spatial relation to a solid object, and thus located their perspectival vantage point onto the world.

However, there remains a dialectical tension within these bodily-orientated therapies: whilst they try to alleviate the hyper-reflexive stance of patients by getting them moving spontaneously, they themselves are simultaneously modes of structured hyper-reflexivity. These therapies aim to get patients thinking and attending to different bodily movements, enhancing their tacit awareness of their lived immediacy to the actions performed. The therapies do not demand a total abandonment of the pathological, hyper-reflexive stance, but rather facilitate a softening and controlled application of bodily awareness. Yoga therapy epitomises this.

5.4.1 YOGA
Daubenmier (2005: 208) states that the underlying goal of yoga is “… to unify the mind and body, in part, by immersing oneself in subtle sensations of the body”. Executing sequences of yoga movements strikes a chord with the subject's bodily feelings and importantly such immersion in bodily activity is “…a potential reprieve from hyper-reflexivity” (Maiese, 2016: 241). “[T]hrough a direct experience of the body, physical activity may counteract self-objectification” (Daubenmier, 2005: 208). By repeating actions and poses, as well as an enhanced sensory self-awareness, patients begin to feel more at home in their bodies, forging a felt connection between their subjectivity and their body that does not simply objectify their movements. It unifies the body and mind (Maiese, 2016: 241). Yoga enables hyper-reflexive patients to feel comfortable in their own skin and expertly perform their movements, as their actions are self-originating and immediate. In yoga, one is acquainted with one’s body in such a way that one can skilfully move it accordingly; in the same way that someone is fluent with a language. Therefore, I suggest yoga achieves a ’bodily
fluency’. This is how I interpret Maiese’s (2016: 242) claim that, “what is needed is a “cultivated immediacy”: a relationship to the body that is characterised by sensitivity, attunement and acceptance”.

A large part of the skill in yoga comes from sensing how far to go with a pose. If one does not move far enough, then the muscles are not challenged, but pushing too far can result in pain/injury. Therefore, yoga practitioners “may increasingly value autonomic processes and physical abilities, thereby diminishing the importance of physical appearance to one’s physical self-concept and overall sense of self” (Daubenmier, 2005: 208). This explanation points to a spontaneity and tacit understanding of one’s bodily abilities, suggesting an intuitive ‘know-how’ of the pose, whereby the practitioner is attuned to the bodily sensitivity of their muscles, without objectifying themselves hyper-reflexively. Yet, this simultaneously implies an attunement of the subject to a reflexive dimension of bodily experience, namely being subconsciously aware of bodily feedback from the muscles. Therefore, as stated, I think the goal of therapists who engage schizophrenic patients in yoga therapy should be to ‘reset’, rather than remove their client’s capacity for reflexive objectification.

Movement within the sessions should be fluid and poses should not be held statically, as this allows the participants’ minds opportunities to return to familiar, disordered thought patterns (Visceglia, 2007: 99) and self-objectified positions. Visceglia, who practices yoga therapy with schizophrenics, regularly begins the movement section of class by focusing on opening and grounding the feet. She prompts the schizophrenics to “inhale and lift up to stand on tiptoes, exhale the entire foot to rest on the floor, inhale and pull the toes back toward the shins, and exhale return to full standing”. This movement enables clients to proprioceptively feel the length and width of their feet, and prepare them for following poses (2007: 99). Importantly, the leader must attend to the bodily desires and needs of participants, and so Visceglia may follow the lead of a client who begins their own sequence of stretches. This facilitates an environment in which participants can “listen to and trust the messages they are receiving from their bodies” (Visceglia, 2007: 100), thus illustrating that yoga-therapy can cultivate a natural unity between one’s self and body.
Maiese’s (2016: 241) claim that yoga enables subjects to feel more “at home” in their bodies is demonstrated in the testimonies of schizophrenic participants. One 43-year-old woman who suffered from chronic stiffness throughout her body, after yoga, realized “…the pain I had not only in my mind, but in my body too. Then I can try to fix it” (Visceglia, 2007: 100). Now, whilst not demonstrating a direct reduction in this client’s hyper-reflexivity, it does illustrate a direct appropriation of bodily experience to subjective, embodied experience. Therefore, Visceglia’s (2007: 101) claim that yoga practice frequently permits clients to feel their actual body suggests the possible fruitful application of yoga therapy to treating hyper-objectification. Other cases of enhanced bodily attunement support this hypothesis; one 57-year-old man reported after trying breathing retention exercises for the first time, “Now when I breathe, I can feel the relaxation move all the way into my toes” (Visceglia, 2007: 101). This implies his immediacy to his ‘lived dimension’, such that he is subjectively attentive, yet one-with his bodily experience. This feeling was achieved through exercises that began by consciously noticing one’s breath entering and exiting the body.

Therefore, I think these studies suggest yoga therapy provides a viable alternative way for subjects to re-inhabit their bodies and restore bodily attunement, so that their sense of prereflective embodied ownership and bodily unity begin to be reinstated. Yoga therapy can forge a more tacitly felt connection with one’s bodies and achieve what many yoga practitioners describe as “mind–body unity” (Maiese, 2016: 241).

5.5 “ENTITY-BOUND REALIZATION”, “WIDE REALIZATION”, AND THE SCALED SELF

The following section now applies Wilson’s (2004) notion of “wide realization” to the SCALED self, in order to distinguish between the relationship of talk-therapies that target personal ownership, (tier two of SCALED selfhood), and bodily-orientated therapies that seek to reconfigure the self’s core perspectival, embodied ownership. I propose yoga features differently in ‘treating’ this embodied core, compared with psychotherapy’s constitutive role in reinstating personal ownership. This is because there is a fundamental distinction between these two levels of the SCALED self.

To make this argument, I first clarify the foundations of the SCALED self. This core, as described in 3.8, is perspectival embodied ownership. Most fundamentally, this
core has properties as an experiencing thing, it has phenomenological ‘what it feels like’ proprioceptive experiences, demonstrated for example in studies of the rooting response (Rochat and Hespos, 1997). Myowa-Yamakoshi and Takeshita’s (2006) evidence that between nineteen and thirty-five weeks of gestation over half of the foetus’ arm movements result in the hand touching the mouth, as well as the foetus opening its mouth prior to contact further suggest embodied perspectival ownership is developmentally basic. Infants, and even foetuses seemingly explore themselves from a phenomenologically felt, “my perspective” (Albahari, 2006: 54). This is because it feels like something to be an embodied subject. This pre-developmental “tacit acquaintance” is an experiential property of the core self.

Wilson (2004) argues against the physical constitutivity thesis, which says that the realizers of states and properties are exhaustively physically constituted by the intrinsic, physical states of the individual to whom those states and properties belong. He distinguishes between ‘core realizers’, namely a state or specific part of the system that is most readily identifiable as playing a critical causal role in bringing about, producing, or sustaining a property; and ‘total realizers’. This is the state of the whole system that contains the core realizer, which all together, is metaphysically sufficient for generating a new property. We can apply this notion to the core self: the core realizer of kinaesthetic, embodied experience is the sensorimotor system. This is the neuromuscular makeup of our body. The total realizer is the entirety of our body that houses our sensorimotor system. When applying this concept to the SCALED self’s foundational level, there is little distinction between the core realizer and the total realizer, because the realized property, i.e. the perspectival, bodily subjectivity is embodied, and so distinctions between core and total realizers are difficult to come by. However, whilst one might point to our neuromuscular makeup and sensorimotor system precisely as the core realizer of embodied subjectivity, the total realizer may encompass a hair or a nail that we do not proprioceptively feel, but nevertheless is a part of our entire embodiment. Our embodiment is therefore metaphysically sufficient for the property of “the embodied perspectival subject”. This is a case of entity bound realization, as the neuromuscular sensorimotor system is the physical realizer of perspectival subjectivity. The entirety of this system is contained within the bearer of this subjectivity. Crudely put, all of this subjectivity’s
perspectival ownership exists within the individual: the system that realizes this state of self-acquaintance is completely within its body.

However, there are times when the physical realizer(s) of properties, namely the system from which the property arises, are not exhausted by the internal physicality of the individual bearer of that state. In these cases of wide realization, the system includes the bearer of said property, but it also includes parts of things external to this individual’s embodiment. My discussion of psychotherapy at 4.3 is illustrative of wide realization: to realize the property “personal ownership”, this includes the embodiment of the schizophrenic, evidenced in my discussion of intersubjective facial expressions and interpersonal couplings (4.4), but it also includes the linguistic niche. Therefore the system that realizes ‘personal ownership’ includes something beyond the individual. To make this clear, let us recap an example from Glass’ therapy sessions. In one session, the therapist asks, “What did you watch [on TV]” (Lysaker and Lysaker, 2008: 144). I argued that the grammaticality of the second-person constituted an external part of Glass’ extended personal ownership. Therefore, applying this to Wilson’s notion of wide realization, I suggest that ‘appropriated excitement’ i.e. Glass’ personally owned mental state of excitement towards the programme, is partly realized by this external prosthesis. Therefore, part of the physical realizer of ‘appropriated excitement’ is external to Glass, and thus his mental property is widely realized.

Yet, one may question this, asking, ‘why is ‘appropriated excitement’ widely realized and not entity bound?’ After all, the mental state of ‘being scared’ seems entity bound realization, on the grounds that ‘being scared’ is something that happens through the body, if endorsing my embodied approach. Consequently, the total realization of ‘being scared’ is entity bound: the core and total realizers are internal; affective phenomenon like fear is determined by circulatory functioning, and the heartbeat influences how and when fear inducing stimuli are produced (Gallagher, 2014: 16). However, the mental state of ‘being scared of X’ is arguably widely realized. Imagine being scared by wolves. If this situation occurs in real-time, one may experience a mental state of ‘fear of wolves’. This discrete emotional state emerges from the interplay between sensory information from the world (seeing wolves), internal bodily sensations, (e.g. a racing heart, tensing of muscles and
dilating of pupils), and conceptual representations linked to previous experiences that are relevant to the situational context (Oosterwijk and Barrett, 2014: 250). Parts of the physical total realizers of this state are external to the individual. Likewise, I suggest mental states that possess an “I own” qualia are not purely internal phenomena. They are not solely realized within the entity simply because one has to own something, and the things that one owns are contingent on an external environment and one’s interactions with it, just like fearing external stimuli.\(^{13}\)

Furthermore, one’s experience of personal ownership is contingent on an external environment because, as Chapter 3 argued, mental states develop a qualitative personal ownership when those mental states are causally integrated into the contextual information. This contextual information is external to the individual, and in the case of diminished self-affection, it is the external linguistic niche that provides this contextual background, and thus is the total wide realization of ‘I personally own X’. In the exemplar case of Glass, one cannot tell whether he experiences personal ownership unless you look precisely at his interaction with the therapist, namely whether he is responding positively and coherently to the grammaticality of the I-you syntactical structure. I propose SCALED selfhood’s personal ownership is a relational property, and thus widely realized.

However, Wilson (2004) argues subjects cannot extend, saying that in this world, with our biological make-up, we have grounds for marking “individuals as the subjects or ‘owners’ of the corresponding mental properties… Individuals are ‘spatio-temporally bounded, relatively cohesive, unified entities that are continuous across space and time’ (2004: 142). This seems a natural intuition, and I am inclined to agree; having endorsed an embodied core to one’s self that underlies the SCALED tier of one’s experiential qualia. This embodied core has a perspectival spatial-temporal location in the world. Yet, I have also endorsed the possibility of an extended (or widely realized, to follow Wilson’s (2004) terminology) second tier of selfhood: personal ownership. So, the question becomes: how can I coherently endorse both claims? For clarity, they are:

1. The core selfhood of individuals is entity bound by that individual.

\(^{13}\) Admittedly, line of argument rejects the brain in a vat’s (Putnam, 1981) ability to have ‘experiences of’.
2. The personal ownership of that individual’s SCALED selfhood can be widely realized.

My interpretation of Wilson here is very specific, making the same distinction I made with Sass and Parnas’ (2003) conception of selfhood. When Wilson (2004: 142) says, “…individuals are the subjects or ‘owners’ of the corresponding mental properties”, I interpret this as referring to perspectival ownership. The subjective experiencer is not able to extend. This is because the perspectival self is fundamental, by nature embodied, and the total realizers internal to that individual necessarily constitute an embodied perspectival ownership. This means the core of the SCALED self is fundamentally bounded. Therefore, following this logic, bodily-orientated therapies may supplement and scaffold the core self, recalibrating its tacit phenomenology such that the subject no longer takes oneself or a part of oneself as objects of intense reflection (Perez-Alvarez et al., 2011: 189), but these therapies cannot constitute this bodily awareness. The constitution claim, as made in the previous chapter, can only be endorsed with regards levels two and three of SCALED selfhood.

Consequently, HEMC is a more appropriate characterisation of the schizophrenic’s interaction with bodily-orientated therapies that seek to treat disturbances in perspectival embodiment. HEMC suggests that intimate interactions between organisms and their environments, for example yoga movements and interaction with the mat and instructor, supports what we would normally take to be the cognitive and mental capacities of the individual clearly in possession of them (Rupert, 2004: 428). Therefore, I suggest we can characterise the schizophrenic’s recalibrating of their hyper-reflexive cognitive processes by only taking into account how the agent exploits bodily-orientated therapies to carry out its cognitive work. In contrast, within psychotherapy, I think the unit of analysis should be the patient and certain aspects of the linguistic niche, treated together as a single system, unifying internal and external domains.

My reasoning for this distinction is because patients do not become coupled to the yoga or other forms of bodily-orientated therapy as their body, despite possibly experienced from a third-person perspective, is bounded: perspectival subjectivity is necessarily embodied. One’s tacit experience of body-as-subject is not something
that requires conscious reflection. It is wholly transparent and therefore the core of the SCALED self. However, personal ownership requires some sort of conscious endorsement. Therefore, in psychotherapy, this newfound cognitive state can literally comprise, as wholes do their proper parts, elements of the therapy. As discussed, you become coupled to the linguistic niche and there is a to-and-fro interaction between the grammaticality expressed in the session, and how the patient interprets, applies to oneself, and responds. Personal ownership can thus be widely realized, namely extended (HEC).

However, bodily-orientated therapies cannot extend the schizophrenic’s core perspectival ownership as they focus on recalibrating one’s embodied feelings. Within yoga sessions, grounding one’s breathing and body let the mind follow the body’s movements, and practicing moving meditation creates bodily peace and control. These are internal feelings, and whilst one’s conscious movement may become smoother and more orderly, there is no external stimulus, no extended feedback loop, that constitutes a part of the orderly perspectival self. Therefore, whilst I endorse HEC when considering psychotherapy’s treatment of personal ownership, I only endorse HEMC when considering bodily-orientated therapies that treat hyper-reflexivity. The core of the SCALED self remains entity bound.

5.6 CONCLUSION

This chapter explored the hyper-reflexive stance schizophrenic patients may take regarding their bodies. Schizophrenics may experience an attention disturbance of one’s cognitive unconsciousness, such that they becomes self-aware of features of cognitive processing that normally are presupposed (Frith, 1979). However, it is important to note my analysis is niche. Although not discussed in this chapter, hyper-reflexivity may also make one’s thinking processes lose their sense of subjective mastery and control over what is thought. Like bodily alienation, the thinking process too may be experienced as increasingly objectified (Parnas, 2003: 230). Parnas (2003: 229) gives the example of one man who found that if a thought passed through his brain without his direct awareness, he was forced to re-direct his attention back to it, scrutinising his mind to explicitly know what he had been thinking. Such attentiveness to thoughts again reaffirms the idea the schizophrenic’s perspective becomes decoupled from the fluency of perspectival ownership.
I argued via bodily self-exploration in body-oriented therapies, subjects can forge more noticeable felt connections with their bodies and minds, enhancing their sensory self-awareness, thus reinstating the tacit dimension of perspectival ownership: body-as-subject. These therapies scaffold the subject’s bodily attention, yet cannot extend organism-bounded feeling of the individual’s body. Whilst one’s bodily attunement may be embedded within the yoga practice, these therapies do not constitute one’s experiential body-as-subject. However, building on Chapter 4, I argued personal ownership can be widely realized.

Critics of the SCALED self may ask, but why endorse HEC at all? HEMC still seems to explain these phenomena, exemplified in cases of yoga therapy. Arguably the processes I described where personal-ownership was partly constituted via external linguistic vehicles equally does not exemplify extension but rather illustrates niche construction, where organisms engineer environments to support their activities. My integrationist approach, depicting the organism and environment as forming a “hybrid system” that gives rise to mental processes the organism alone, “de-coupled from the relevant environmental structure, would be incapable of instantiating” (Slaby, 2014: 37) is arguably “explanatorily equivalent” (Sterenly, 2010: 472) to niche constructivism. Patient-environment relationships can be interpreted either under niche construction, scaffolding levels of the SCALED self, or as extended systems. Why make the further extension claim?

But such objections beg the question, for it is far from certain human-environment interactions are reducible to scaffolding alone, as the feedback loops I described between personal ownership and external grammaticality were self-stimulating and self-generated (Clark. 2008: 131). Glass’ referring to the therapist as “you”, stimulated his own feelings of “I”, thus making him the instigator and enabler of the discussion. Languaging, unlike movements designed to attune oneself to the body, is an effortlessly maintained structure in our internal and external environment. Consequently, Glass’ cognitive relation to his words and languaging defies simple demarcations between inner and outer (Clark, 2005: 265). There is reason to consider the degree of cognitive co-activity among patients and elements in their psychotherapy to create an interactive system that might more fruitfully be discussed and interpreted as a single, unified system (Rupert, 2004: 394).
Ultimately, I think my distinction between bodily-orientated therapies (HEMC) and psychotherapy (HEC) depends upon the cognition they elicit. For therapies to extend the schizophrenic’s SCALED self, explicit cognitive elements must exist, i.e. *reflective* components in which the client consciously engages with some aspect of the therapeutic device. This happens in psychotherapy, where cognition is explicit, but not in bodily-orientated therapies where cognition is implicit. To explore this, my final chapter returns to fundamental arguments of extended mind, arguing that higher levels of SCALED selfhood may extend when treating auditory hallucinations. I suggest that in avatar therapy, the schizophrenic’s cognitive processes required to overcome their hallucinatory voice extend into the environment, and thereby are constituted (in part) by external resources outside the individual’s embodiment.
6.1 OVERVIEW: WHAT IS AVATAR THERAPY?

Avatar therapy is a new treatment for people suffering from hearing phantom voices. The project was developed and is being led by Professor Julian Leff at UCL Mental Health Sciences. Presently, between 25% (UCL, 2013) and 30% (Williams, 2013) of schizophrenics continue to suffer with persecutory auditory hallucinations despite antipsychotic medication. Williams (2013: 1) suggests the worst aspect about hearing persecutory voices for many patients is the feeling of helplessness it induces. Adapting “voices dialogue” therapy, where patients are encouraged to enter into dialogues with their voices yielded positive results (Romme et al., 2009) and informed the development of avatar therapy. If dialogue can be sustained with the hallucinatory voice, then patients feel far more in control (Nayani and David, 1996). As avatar therapy facilitates such dialogue, patients feel empowered (Leff, 2014: 166), and thus this treatment may enable long-term improvement in schizophrenics’ experienced persecutory hallucinations.

Maintaining dialogue with invisible entities is difficult. Normally, moment-to-moment social interaction involves many embodied resources, including bodily orientation, posture, gesture and facial expressions (Keating and Sunakawa, 2011: 194), which we use to communicate our agreement, attention to, and signal turn-taking in conversation. However, with auditory hallucinations, these ‘dialogues’ are devoid of facial expressions or non-verbal communications. Therefore, the way Leff et al. (2014) chose to initiate genuine patient-voice conversational interchange was for patients to create avatars of their voices and encourage them to enter into dialogue with them. Leff said, “Opening up a dialogue between a patient and the voice they’ve been hearing is powerful. This is a way to talk to it instead of only hearing 1-way conversations” (Medscape, n.d.).

This chapter firstly discusses the set-up of avatar therapy and successful cases where patients benefited from significant reductions in their auditory hallucinations. I secondly argue avatar therapy can be considered a form of extended mind, offering three related arguments. I compare the recording of the session given to the patient after the therapy with Otto’s notebook (Clark and Chalmers, 2010: 34), proposing
that the MP3 recording accords with the trust and glue conditions that must be fulfilled for an extension of the mind (Clark and Chalmers, 2010: 38), and also allows for the required active manipulation of its content. I also suggest avatar therapy is an external representation of the patient’s internal auditory hallucination, and suggest the therapist thus sees the patient’s mind. I acknowledge this argument, although interesting empirically, makes the fallacious assumption that if one takes an internal process and externalises it, this is ‘extension’. Yet, I overcome this by exploring the nature of the coupled system, patient+avatar+therapist, arguing that, as the patient enhances their mental capacity to overcome the voices, the external avatar plays a constitutive role in actualising this cognitive capability. Thirdly, this chapter reviews these arguments in light of my exploration of the SCALED self, arguing that, similarly to Chapter 4, the external environment (i.e. avatar therapy) can be understood as an extension of both the SCALED self’s personal ownership and dialogical self. This is because patients gain ownership over their thoughts that they experienced as originating from external sources, and thus they develop new self-facets, such as ‘self-as-safe’ or ‘self-as-powerful’.

6.1.1 THE SET-UP
Leff accepted the patients’ experiences of persecutory voices, assisting them to create avatars, and asking them how closely the avatars resembled their persecutors both physically (i.e. how they imagined) and vocally (Leff et al., 2014: 171). Avatar therapy uses customised computer software that enabled patients to create avatars that match the voices of their auditory hallucinations (Stewart, 2013). Leff and colleagues made the patient consider how they envisaged the persecutor’s appearance, and therefore make a physical representation of this in the form of an avatar. Face customisation was possible using the FaceGen© Modeller Software and allowed a near infinite variety of 3-D faces to be created, starting with a visual array of around 250 distinct face shapes and types that covered a broad range of features.
The avatar’s voice was also customised, typically taking about 20 minutes. Firstly, the client was asked to select from a sample of about 20, which voice had the closest characteristics of their hallucinatory persecutor. The user interface was designed to allow multiple promising alternatives to be saved, enabling the best transform to be ultimately used\textsuperscript{14} (Williams, 2013: 3). Many psychologists and clinicians question this hands-on approach employed in avatar therapy, believing it is collusion with the patient’s pathology and therefore likely to perpetuate the symptoms. Whilst alternative therapeutic strategies may suggest the patient talks to an empty chair, avatar therapy goes beyond this; assisting the patient in creating a speaking image of their tormentor the therapist too can see and hear (Leff et al., 2014: 171).

In the sessions, the patient sits in a room facing a monitor displaying their avatar. The therapist sits in another room and controls it. They can talk to the patient directly, or via the avatar. Using two ‘push-to-talk’ buttons, the therapist controls whether his/her natural voice, or the converted voice is output to the client (Williams 2013: 4). Because the therapist controls the avatar’s speech in real-time, it is convincingly responsive to the patient’s comments, and thus realistic dialogue between avatar and patient is engendered (Leff et al., 2014: 172). Importantly, the

\textsuperscript{14} A challenge facing this pilot of avatar therapy was matching hallucinations of female voices to the synthesised voice; patients overall reported matching accuracy between 60-90%. However, there was limited realism in female voices that were generated from a male therapist’s voice, sounding somewhat strained and unconvincing for some patients.
client is also equipped with a panic button to turn off the avatar immediately and instead the monitor displays a scenic image whilst playing soothing music\textsuperscript{15}.

The therapist prompts the patient in their own voice to enter into dialogue with their avatar and oppose what it says. Leff encouraged his patients saying, “you mustn’t put up with this, you must tell the avatar…that you don’t believe these things, that he or she must go away, leave you alone, you don’t need this kind of torment” (Stewart, 2013). The content of the avatar’s speech slowly changes via the therapist’s manipulation, acknowledging the misery it has caused, and asks the patient how it can help, further encouraging the patient to do things that would actually improve their life (Stewart, 2013). This dialogue is in fact a ‘trialogue’, as the therapist plays two roles, firstly the persecutory avatar, and secondly the supportive therapist. As the sessions progress, these distinct roles begin to converge and the avatar gradually agrees to stop abusing the patient and rather be silent or make helpful comments that boost the patient’s self-esteem. Simultaneously, the avatar's facial expressions change from menacing or neutral, to neutral or smiling (Leff et al., 2014: 170-171).

Leff (2014: 170-171) says, “As the therapist, I'm sharing the patient's experience and can actually hear what the patient hears. But it's important to remind them that this is something that they created and that they are in a safe space…” This safe environment enables patients to gain the required confidence and courage to confront first their avatar, and then their ‘real’ persecutor (UCL, 2013). Patients can risk opposing their avatar, something they would not do with their voices for fear of reprisals.

\textbf{6.2 SUCCESS WITH AVATAR THERAPY}

The duration of time the patients selected for avatar therapy had heard voices ranged from 3.5 to more than 30 years. The median was more than 10 years (Leff et al., 2014: 167). 26 patients entered the trial and 16 received the therapy, benefiting from significant reductions in the frequency and intensity of the voices and in the disturbance to their life. The patients’ perceived malevolence and omnipotence of

\textsuperscript{15} This was rarely used, but its presence alone was useful in allaying some clients’ anxieties. A few patients nevertheless (numbers unspecified), when first confronted with the avatar, found its realism so great they were unable to view it for long (Williams, 2013: 3).
their voices was also reduced. Furthermore a follow up revealed that the intensity and frequency of the voices was further reduced after 3 months.

My table below details a selection of patients (persons A-D) Leff et al. (2014) encountered within the trial.

<table>
<thead>
<tr>
<th>PERSON (A)</th>
<th>Duration of their auditory hallucinations</th>
<th>Number of voices hallucinated</th>
<th>Taking antipsychotic medication (Y/N)</th>
<th>Voice(s) still absent at 3 month follow up (Y/N)</th>
<th>No. of sessions required for a cessation of their voice(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSON (A)</td>
<td>16 years</td>
<td>1 voice</td>
<td>N (Stopped 3 years prior to therapy)</td>
<td>Y</td>
<td>2 sessions</td>
</tr>
<tr>
<td>PERSON (B)</td>
<td>13 years</td>
<td>1 voice</td>
<td>Y</td>
<td>Y</td>
<td>5 sessions</td>
</tr>
<tr>
<td>PERSON (C)</td>
<td>3.5 years</td>
<td>1 voice</td>
<td>Y</td>
<td>Y</td>
<td>2 sessions</td>
</tr>
<tr>
<td>PERSON (D)</td>
<td>30 years+</td>
<td>Multiple voices</td>
<td>Unknown</td>
<td>Unknown</td>
<td>After 6 sessions, significant reduction in the voices</td>
</tr>
</tbody>
</table>

Leff’s strategy with patients differed depending on whether they possessed some degree of insight into the origin of their voice as being inside their own minds. Person D for example believed that around 50% of the multiple voices he heard came from thoughts in his head, thus indicating considerable insight. D chose to target in the therapy the voice of one woman who made unhelpful and sarcastic comments, for example “…Insane at least because you’re totally out of your skull as well as out of your face” (Leff et al., 2014: 169).
Focussing on D’s belief that this woman’s comments came from internal thoughts, D showed considerable improvement at the follow-up at one week after completing six sessions. His continuously disruptive voices had reduced to only talking for a few minutes a week and instead of the unpleasant and sarcastic comments, they now only occasionally were. Furthermore, D now believed that all the voices were completely self-generated. Also, his mild suicidal thoughts completely vanished and at a three-month follow-up, self-depreciation was absent. Leff suggests this can be attributed to the planned change in the avatar’s relationship to the patient, changing from continual denigration to a pleasant supportive role. As the avatar ceased her verbal abuse and expressed admiration of his good qualities, qualities D had never before acknowledged or experienced, his persecutory voices became far less frequent and rarely critical. His perception of himself was greatly improved (Leff et al., 2014: 169-170).

Person C was an elderly man who had been the senior executive in a large company. For 3.5 years before participating in avatar therapy, he had been woken daily at 5:00 by the voice of a woman who held business meetings until nightfall. He was continuously subjected to her and her colleagues’ business discussions, yet was never himself directly addressed. Unlike D, C was convinced of this woman’s existence, but unable to develop an explanation for her disembodied voice. When patients completely lacked understanding that their voices were hallucinatory, Leff accepted the reality of the avatar for that client, and dealt with it on that basis. Leff accepted C’s experiences as real, telling him the woman was being unprofessional.
and betraying her organisation by allowing him to hear these conversations, and that these meetings should be kept to business hours only. In the first session of 15 minutes, C was calm and polite when addressing his avatar, and after addressing her unprofessionalism, a week later he reported that her voice was quieter. Furthermore, the meetings only began at 8:00 and finished at 17:00. In his second session C was more assertive, telling the avatar, “it’s treason. Keep it to yourself”. C also demanded the woman confined her meetings to after 14:00, saying, “I don’t want to hear you at 8 a.m. I have a lot to do in the mornings and you disturb me” (Leff et al., 2014: 168-9). When beginning the third session, C reported sleeping until 7:00 and no longer hearing the meetings, as though the woman had “left the room”. Avatar therapy’s effectiveness is noticeable in C’s case, as after 3 months, the woman’s voice had not resumed.

What is philosophically interesting about these cases, and others I explore, is the parity between how patients deal with the avatar and how they deal with their auditory hallucinations. Importantly, avatar therapy does not externalise the ‘real’ hallucinatory voice, rather a replica of it is created. This important difference was demonstrated when Leff encountered one adolescent girl who angrily replied when Leff entered the room to ask for her feedback, “It’s a fake!” (Leff et al., 2014: 172). Leff responded that there was no attempt to pretend this was the ‘real’ voice she heard. Rather, it was her creation and thus it was safe to try out strategies to counter its abusiveness, which she would not dare do with the voices she heard (Leff et al., 2014: 172). I therefore suggest avatar therapy intends to evoke a functional similarity in how the person responds to the ‘fake’ and how they can respond to the ‘real’ internal voice after completing the sessions.

6.3 AVATAR THERAPY AS A FORM OF EXTENDED MIND
I suggest a similarity between Clark and Chalmers’ (2010) ‘conventional’ cases of extended mind and avatar therapy, because Leff’s treatment enhances the patients’ mental capacities to deal affectively with their auditory hallucinations. The patients’ interactions with their avatars make them develop different kinds of cognitive capabilities and behave differently. The schizophrenic can reconfigure their cognitive abilities and develop new strategies to combat their hallucinations. For example, one patient, known only as Claire reported, “It [the therapy] gave me the strength to say
no... I could tell the voices to stop, to leave me alone, and pretty much they have” (Feilden, 2013). I now give 3 arguments why avatar can, and should be considered within the extended mind literature.

6.3.1. ARGUMENT 1 – NOTEBOOKS AND MP3 PLAYERS

After the therapy session, the client is given an MP3 recording of their ‘trialogue’ with the therapist and avatar. Leff says “We record every therapy session on MP3 so that the patient essentially has a therapist in their pocket which they can listen to at any time when harassed by the voices”. Re-listening to sessions has proven helpful in allowing patients to recognise that their hallucinatory voices, “originate within their own mind and reinforces their control over the hallucinations” (UCL, 2013). Person A exemplifies this. A was a financier who, sixteen years prior to this study, began hearing the devil giving him poor advice on investments, causing serious debt. Like C, Leff treated the devil avatar as a real entity and encouraged A to oppose it, telling him to return to his rightful place in hell. A rigorously attacked his avatar in the first two sessions and reported that when leaving the second session, the voice began speaking to him and he firmly responded, “You are not coming back” (Leff et al., 2014: 171). Despite this breakthrough, at the three-month follow-up A acknowledged he somewhat relapsed. The voice, whilst absent during daytime, had returned at night. He admitted frequently using his computer until 1:00-2:00 a.m. and had not been using his MP3 player, as encouraged by both the therapist and avatar within the sessions. Leff advised A to sleep by 00:00 and listen to his MP3 before falling asleep, the aim being for it to remind him how he overcame the avatar previously. At another follow-up two weeks later, A said his voice had completely deserted him, which he attributed to the therapy (Leff et al., 2014: 171).

I question what it is about the media player that illustrates an extension of cognitive capacities. I think the answer lies in the player’s ability to fulfil Clark and Chalmers’ (2010: 38) ‘glue and trust’ conditions. These criteria are primarily meant to ensure the effect of ‘transparent equipment’, namely equipment “with which we are so familiar and fluent that we do not think about it in use, but rather rely on it to mediate our encounters with a still-wider world” (Clark, 2007: 106).

Clark and Chalmers (2010: 38) say, “First, the notebook is a constant in Otto’s life—in cases where the information in the notebook would be relevant, he will rarely take
action without consulting it”. Likewise, the insistence Leff places on using the recording daily to reaffirm one’s realisation that the voice can be combatted seems to suggest that this is a cognitive tool the patients can become so “familiar and fluent” (Clark, 2007: 106) with that they naturally know how to respond to their voice. This is similar to knowing song lyrics; the melodies supplement cognition and enable fluid recollection of phrases similarly to how the recording will remind patients of appropriate responses to pressures from auditory hallucinations. Furthermore, the action clients take is dictated to them by their previous encounter, just as information in Otto’s notebook directs his actions to find MoMA. Both the patients and Otto consult their external resources to reaffirm what their appropriate actions should be.

Secondly, “the information in the notebook is directly available without difficulty” (Clark and Chalmers, 2010: 38). This is similar to the portable MP3, which is directly available to patients whenever they need support. There is no interference, namely there is no additional taxing cognitive work required when using the players; clients can simply begin using them. Leff et al. (2013: 432) even describes the media players as being “a therapist in their pocket”. It is an external resource they can carry on their person that supplements their internal abilities to deal with their hallucinations.

“Third, upon retrieving information from the [MP3, the patient…] automatically endorses it” (Clark and Chalmers, 2010: 38), meaning that the patient does not have to verify the information or doubt its truth. This is because the recording is an accurate representation of their meetings, and clients, when reliving this experience can hear themselves successfully overcoming their persecutor. When using self-generated notes from previous experience, or recordings of our previous encounters, to perform cognitive tasks such as remembering, we assume the information is correct, in the same way as we assume our internal know-how is accurate. Thus, this strategy is automatically endorsed as a successful way to deal with immediate auditory hallucinations.

Yet, fulfilling these trust and glue conditions is insufficient for endorsing ‘extension’ claims. Critics may point out that a further necessary requirement for an extended cognitive system is that the individual concerned actively manipulates the external resource, namely interacts with it such that there is reciprocal causation in which
both human and artefact develop in response to each other’s interaction. The ‘pocket therapist’ however seems somewhat different; whilst it fulfils a cognitive deficit, it lacks possibilities to be manipulated further so as to elicit the desired effect (i.e. one’s ability to control one’s hallucination). The recording is passively listened to, it is fixed and thus one directional. However, I counter this by highlighting that the causal story behind the fixed recording is one of active manipulation. It is a recording of once active manipulation of an avatar, and features the patient positively overcoming it. Therefore, whilst critics may require active manipulation to achieve cognitive extension, the MP3 recording results from that interactive process, and thus is a verified way to overcome the voice. The pocket therapist is therefore a source the schizophrenic can tap into that is inevitably in the correct ‘format’, without requiring further manipulation.

Yet still, whilst a good diachronic story of its origin, claims to extended mind require more local synchronic loops of interaction where real-time simulation is generated: Otto for instance encodes his notebook, and then scans it for further information. Likewise, with music, you may fast-forward a track to reach the melody you desire, then begin listening. But, in making this claim, I suggest there is no longer any distinction between extending the mind via music, or via the MP3 recording. Cases of musically extending the mind seems plausible (Krueger 2013, 2014), with music’s ability to change the listener’s cognitive abilities (Sridharan et al., 2007: 528), sharpening and sustaining their attentional focus. When pushed, proponents of the ‘musically extended mind’ (Krueger, 2014) may suggest music’s capacity to extend cognition has further plausibility as one can manipulate the music itself. It is not ‘fixed’. For instance, one might decide to remove one’s headphones, and listen to the desired track on a stereo, thus “revving up” (DeNora, 1999: 34) one’s emotions. One may work through emotions via extended musical engagement by enhancing the bass, embed the track within a larger playlist, or even play with the mix. The music’s materiality is alterable. But, arguably, a voice audio is equally malleable in this sense: one may loop one select bit of the therapy recording over and over, or perhaps raise the patient’s voice so it sounds more authoritative. I suggest the MP3 recording, like music, has a materiality with which one can actively engage and manipulate.
But, it remains important to realise that this level of manipulation is not always required for extended claims. Music solicits entrainment responses (Krueger, 2014: 4), and thus calming lullabies can be used to regulate infant emotion (Trainor and Hannon, 2013: 427). Music, like the recording, “gives respondents a medium in which to 'work through moods’” (DeNora, 1999: 40), and thus simple engagement, like deciding when, where and for how long to listen to audio can create extended interactive feedback loops between the person and the external resource. Importantly, when clients use the MP3, they become coupled to it, and their listening to this ‘trialogue’ is therapeutic. They do not just listen randomly, but rather when they have been experiencing auditory hallucinations and feel unable to cope. Thus the MP3 serves as an extended regulatory device. The process of listening therefore creates a coupled system between themselves and their recording. They may listen to a previous session, and then employ those recorded strategies to deal with their current persecution. Then, if unsuccessful, the client may continue to listen. My point is how they interact with and use the MP3 depends on how successfully they are authoritative; if they are unsuccessful, then the coupling between themselves and the external artefact dictating and prompting their next moves will continue, as they will continue using the recording. Again, this has affinities with Otto’s notebook where he can become coupled to this resource whilst needing it to find his way, and once he completes his journey, he can pocket it until further required. Thus the notebook may be a ‘map in his pocket’, similarly to MP3’s role as a ‘pocket-therapist’. Leff et al. (2013: 423) postulate that patients’ continued improvement after the therapy’s completion was attributable to the use of the MP3. However, as this use was not quantified, this remains a hypothesis.

Nevertheless, I have suggested this avatar therapy provides an external object (the MP3) that performs cognitive work that would normally be carried out by ‘healthy’ individuals. It stores the patient’s know-how of how to respond in instances of persecution, and can be both easily transported and manipulated by the patient. When listening to the recording the client automatically endorses the information, and recognises that, as they have previously combatted the persecutor, they have the mental capacity to do this again, enabled and enhanced by this portable device. Therefore, this MP3 has affinities with Otto’s notebook, and can be considered an
extension of the client’s mind, allowing the patient to achieve stability behaviourally and emotionally that, outside of this coupled system, they cannot.

6.3.2. ARGUMENT 2 – EXTERNAL REPRESENTATIONS
My second point, whilst not arguing avatar therapy extends the mind, explores my initial interest in the therapy’s extended possibilities. One cannot fail to notice the physical replication of the client’s mental state in the external world; Leff and his team intended to make avatars that speak and ‘look’ identically to the auditory hallucinations afflicting their patients. Leff et al. (2014: 171-172) say “[b]ecause the externalised voice is part of the patient’s inner world, discounting it or refusing to acknowledge the patient’s experience of this split-off part as real negates the possibility of the patient reintegrating it into their psychic structure.” This phrasing almost suggests that the avatar physically is the persecutory part of the patient’s mind outside of their head. As described, Leff et al. wanted to open up the dialogue between the voice and the patient, such that real external dialogue between the persecuted and persecutory parts of the client’s mind was achieved.

However, physically representing internal mental states is not grounds for suggesting an extended mind occurs. The avatars themselves are not parts of patients’ minds merely because they replicate or simulate internal mental states. One cannot simply assess whether external artefacts work in the same way as the mind. Just because a calculator for instance can multiply numbers with the same outcome as human minds does not make the calculator ‘minded’. Taking internal processes and externalising them is not the same as extension. Consequently, noticing the avatar’s functional similarity to a client’s internal persecution is not to notice an extended mind. My claim of extension is rather motivated by the avatar’s ability to arouse cognitive abilities in the patient that the patient alone cannot instigate. 6.3.3 details.

6.3.3 ARGUMENT 3 – COUPLED SYSTEMS
As explored, patients experience increased control over the avatars they create. Within the sessions, their conversations with the avatar enhance and cultivate their cognitive abilities to overcome their ‘real’ persecutors. This is something unachievable without the therapy. Crucially, the therapist slowly manipulates the avatar such that it stops being abusive and controlling, and becomes increasingly supportive of the patient. The avatar praises their achievements and compliments
them for their good qualities. It also suggests ways they could improve their lives. In accordance with this, the avatar's expression is altered to appear more friendly and smiling. “This may be appraised subconsciously by the patient as a substitution of a loving parent for a punitive, denigratory, or neglectful one, enabling them to reintegrate the projected unacceptable part of their internal world into their psychic structure” (Leff et al., 2014: 171-2).

I interpret the external avatar therefore as replicating or mirroring the patient’s internal cognition, namely their hallucination. Patients such as A and C were unable to associate with or think positively about this internal voice, unless it was externalised. I suggest the set-up of the therapy instigates a reciprocal interactive process between the physical representation of the voice and the patient within the sessions; this is an active coupling. There is an interactive relationship in which the patient’s attacks change the avatar, and slowly the avatar’s changing facial expressions and words reflect back onto the patient. This is a feedback loop in which the avatar and the patient are functionally linked. The point is that whilst the avatar is not independently magically cognitive, as the patient’s brain has to be there to get the process going and plays a distinctly causal role, the avatar adds further resources that the patient, if simply talking to an empty chair, would be unable to capitalise on. The patient and the avatar therefore jointly govern the patient’s ability to oppose their persecutor.

Nevertheless, we must remember the therapist manipulates the avatar. The avatar is distinct from objects such as notebooks, phones or maps, as similarly to Chapter 4’s psychotherapy, another minded individual influences this external device. Thus, the prosthetic persecutor is not a static object, upon which the patient immediately imposes their will, but rather it has its own agency by way of the therapist’s manipulation. Yet, if we recall the therapy’s set-up as a triologue, we see that the therapist’s agency and the avatar are separated in the eyes of the client, and thus the avatar and patient, from their first-person perspective will establish a “mutually constraining cycle of affective responding and expression” (Colombetti and Roberts, 2014: 1258) which appears to them, independent of external intervention. This understanding therefore accords with Garrett and Turkington (2011) who argue that cognitive behavioural therapy provides a technique to bring “thing presentations”,

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namely thoughts or feelings experienced as external perceptions, back within the self's boundary (Leff et al., 2014: 172).

I think feedback loops are achievable in avatar therapy precisely because the patient knows that they themselves designed the avatar, and thus they distinguish between their mind and the avatar. The patient-avatar coupling enables the client to engage with their ‘persecutor’, recognising its similarity to their auditory hallucinations, and develop their own cognitive strategies and coping-systems that they cannot, if the external resource was absent. This is because, even though patients interact with the avatar as if it is real, they know it cannot harm them as they themselves created it, unlike their voices that may threaten them and their families. Consequently, the therapy enables patients to gain “confidence and courage to confront the avatar” (UCL, 2013). The transcript below of one therapy session illustrates this.

**Transcript of Therapy Session. (Source: Avatar Therapy Helps Confront Distressing Voices, 2014).**

<table>
<thead>
<tr>
<th>AVATAR:</th>
<th>“You’re worthless, you’re a waste of space”</th>
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</thead>
<tbody>
<tr>
<td>THERAPIST:</td>
<td>“Owen I want you to talk back to the avatar as strongly as you can”</td>
</tr>
<tr>
<td>OWEN:</td>
<td>“Stop it”</td>
</tr>
<tr>
<td>AVATAR:</td>
<td>“You’re worthless, you’re a waste of space, your life’s going nowhere”</td>
</tr>
<tr>
<td>OWEN:</td>
<td>“Stop saying those things”</td>
</tr>
<tr>
<td>AVATAR:</td>
<td>“You’re nothing”</td>
</tr>
<tr>
<td>OWEN:</td>
<td>“Leave me alone, stop that”</td>
</tr>
<tr>
<td>THERAPIST:</td>
<td>“Owen, that’s really good, I want you to be as strong and powerful as you can”</td>
</tr>
<tr>
<td>AVATAR:</td>
<td>“So you don’t think it’s right that you’re worthless?”</td>
</tr>
<tr>
<td>OWEN:</td>
<td>“No, it’s not true, I’m not worthless and I don’t have to listen to you saying that”</td>
</tr>
<tr>
<td>AVATAR:</td>
<td>“What’s good about you?”</td>
</tr>
</tbody>
</table>
OWEN: “There’s lots of good things about me, I don’t have to listen to you saying that I’m worthless”

AVATAR: “Like what?”

OWEN: “I’m a good person and the things you’re saying aren’t true”

AVATAR: “Tell me one good thing that you’ve done this week”

OWEN: “I did the shopping for my mum, that’s a good thing to do”

THERAPIST: “That’s really good Owen, you keep going telling him all the good things you’ve done”

OWEN: “I’ve come here, to do this, to speak to you, I’ve been going to my exercise group, I’ve done a lot of good things and it’s not fair you saying that I’m worthless”

AVATAR: “I can see I may have misjudged you, you’re stronger than I thought, but I’m not giving up that easily, you have given me some things to think about you”

In this dialogue, the avatar’s comment “You’re worthless, you’re a waste of space” affects the patient, and with prompting from the therapist, pushes Owen to respond, saying, “stop it”. As Owen experiences no immediate repercussions of standing up to the avatar, and as the avatar then asks, “So you don’t think it’s right that you’re worthless?” this arguably empowers Owen to further say that he does not have to listen to the abuse. This is because the feedback from the dialogue with the avatar influences Owen’s internal dialogues through the lenses of his various self-facets. From this short dialogue, we can see Owen growing in confidence and arguably self-facets such as ‘self-as-empowered’ and ‘self-as-unafraid’ come into play, governing how Owen responds to the avatar’s questions. The flow of this controlled dialogue is affected by the development of Owen’s empowered self-facets, in the sense that the therapist manipulates the avatar according to the patient’s responses. When Colombetti and Roberts (2014) claim that self-stimulating relationships can be forged between musicians and instruments “quite unlike the unidirectional causal link that holds between an environmental happening and a feeling response in ordinary cases”, arguably this has affinities with the above ‘trialogue’. From Owen’s perspective, this avatar is akin to his internal persecutor. Therefore, an improvised dialogue with the avatar will shape the self-facets Owen experiences moment by
moment and enhance his ability to overcome his auditory hallucinations. If we accept that couplings between humans and environmental artefacts with which they interact can be considered as unified wholes, then we can view the entire interactional looping activity between Owen and his avatar as responsible for eliciting his empowerment.

The continuous interaction with the avatar, and subsequent prompting of the therapist, enables Owen to achieve an enhanced level of governance over his hallucinatory voice. This would be impossible without the construction of the avatar and safe environment with which Owen can practise being authoritative. In its strongest form, the counterfactual can therefore be taken to support an extended-vehicle account of the dialogical self-facet, ‘Owen-in-control’ (Colombetti and Roberts, 2014). This qualitative feeling of power Owen experiences, evidenced in the development of his responses from simply “stop it”, to clearly communicating his good personality traits, depends upon and thus supervenes on the entire coupled system of Owen+avatar. Thus the self-facet, ‘self-in-control’ is “widely realized” (Wilson, 2004). But, Colombetti and Roberts (2014) suggest that even if one is unwilling to accept the metaphysical implications of this view, namely that extended affectivity is possible, it remains possible that for a complete account of the diachronic character of such a qualitative episode must refer to the entirety of the coupled system.

Arguably, because the third level of SCALED selfhood is a psychological concept that describes one’s ability to imagine different positions within one’s internal dialogue in close connection to external dialogues, avatar therapy’s external representations of the patient’s internal dialogues with hallucinatory persecutors will dramatically affect one’s rich dialogical self. The avatars will be parts of the metaphysical basis, alongside the patients that realise their individual self-facets that combat their persecutors. Consequently, I suggest avatar therapy can extend the dialogical aspect of SCALED selfhood.

6.4 SUMMARY DISCUSSION

This chapter has explored avatar therapy as an alternative method of treating auditory hallucinations; Leff et al.’s (2014) successful trial having shown immediate positive results in subjects who committed to the treatment. I suggested that by
extending the patients’ dialogical selves via the avatar, and creating coupled feedback loops, the dialogical self-facets such as ‘self-as-persecuted’ can be remoulded into ‘self-as-authoritative’, thus enabling schizophrenics to overcome their persecutors. Therefore, I conclude that avatar therapy extends the dialogical level of SCALED selfhood.

I think the success of avatar therapy’s trial (Leff et al., 2014) can be attributed to the cognitive extension of the individual that the avatar itself elicits. Whilst I accepted that simply externalising an internal mental state is not an extension of mind, replicating their persecutor and allowing the patient dialogue with it in a safe environment stimulates a cognitive rehabilitation in which the patient learns strategies to overcome their voices. One’s strategies can then be sustained by way of extended cognition, using the audio recording of their session. This external object functions with the same purpose as the patient’s internal processes of remembering their prior responses to the avatar, and thus aids the schizophrenic in standing up to their hallucinations outside of the therapy.

A larger trial of avatar therapy, consisting of 142 patients is soon to start in collaboration with the King’s College London Institute of Psychiatry. Professor Thomas Craig, who will lead the second study said, “The beauty of the therapy is its simplicity and brevity. Most other therapies for these conditions are costly and take many months to deliver” (Stewart, 2013). Therefore, further research should be conducted as to how to best administer this treatment; and I think that by acknowledging the cognitive extension of the patient in these sessions, one can therefore tailor the therapy to guarantee coupled cognitive systems emerge that will aid a schizophrenic’s recovery.
CHAPTER 7. CONCLUSION

7.1 THE SCALED SELF, SCHIZOPHRENIA AND EXTENDED MIND

This thesis has considered the cognitive integration of treatment strategies within a schizophrenic self. It has argued treatments can ‘repair’ the schizophrenic’s selfhood, both by supplementing the self’s bodily neurobiological dynamics and scaffolding one’s attention to one’s embodiment; and by constituting one’s awareness of one’s personal ownership over one’s experiences. Arguably, based on my model of SCALED selfhood, primarily intervention strategies should target one’s ‘bodily fluency’ as the SCALED self is grounded in the whole living body. Chapter 5 argued such therapies can be employed to treat hyper-reflexivity. After tailoring or reorienting one’s fundamental tacit acquaintance with one’s body via bodily orientated therapies like dance or yoga, other therapies, such as avatar therapy and psychotherapy, can then partly constitute, together with one’s body, more sophisticated levels of selfhood that suffer from diminished self-affection (see Chapter 4). Following my model of selfhood, these are personal ownership and dialogical self-facets, which require cognitive activity and online engagement with the external world. The interactive couplings between patients and others within therapeutic dialogues (e.g. psychiatrists and avatars), inform the emergence of dialogical selves that the patient experiences as their own. The treatments at times partly constitute the schizophrenic’s subjectivity, enabling coherent patterns of understanding that allow patients to act (more) skilfully in the world with regards to their discriminations between ‘real’ phenomena and those that are internally generated. Furthermore, Chapter 4 argued that psychotherapy’s languaging can constitute the personal ownership, which underlies the feeling of a self-facet being ‘mine’.

Therefore, treating schizophrenia treats not only its symptomatic manifestations, but also fundamentally subjects to whom these symptoms belong. Whilst diagnoses of ‘schizophrenia’ via the DMS IV-TR may offer clinical descriptions (Chapter 2), how symptoms appear to a first-person perspective differs in every case. Each patient’s report of schizophrenic symptoms describes a personal account of pathological disturbances of selfhood, thus I think taxonomies of ‘schizophrenia’ must wait on phenomenology (Strawson, 1999). Despite this assertion sounding somewhat
discouraging for patients who desire explanations of their warped self-experience, this is not the case. Upholding the self’s tacit acquaintance with itself as the validator of ‘a recovery’ is vital to understand when treatment strategies are successful. Whilst third-person clinical accounts of patients’ enhanced abilities to express oneself propositionally, act with ‘bodily fluency’ and overcome auditory hallucinations are common in psychiatric reports, true verification of ‘success’ lies within patients’ first-person subjectivities.

Once acknowledged, we see the applicability of a systematic taxonomy of the experiential SCALED self, via which we can then analyse where on the SCALE of selfhood a symptom strikes. My model of SCALED selfhood served to explain possible treatments of each level and thus distinguish ‘constitution’ from ‘supplementation’. Yet, for categorising the types of first-hand experiences of schizophrenia this SCALE requires refinement, for example, distinguishing Lysaker and Lysaker’s (2008: 81) monological self from the interanimating play sustained by ‘normal’ dialogues. This is because whilst monological selves entail perspectival and personal ownership, they still lack the flexibility of changeable, malleable self-positions with which most people are accustomed. And this too is distinct from “cacophonous” selves (Lysaker and Lysaker, 2008: 86) in which patients appear lost amongst disorganised unstructured narratives. This highlights the requirement for continued investigations into reports of schizophrenic episodes as they will continue to develop understanding of these divides, categorising both levels of selfhood and its pathologies.

7.2. IMPLICATIONS
My research has implications for psychiatric care. Interpreting treatments in accordance with Clark and Chalmers’ (2010) extended mind hypothesis is a new way to conceptualise the patient-therapy relationship and therefore one must consider multiple issues. Firstly, one must acknowledge the therapist’s role and the ‘power’ they have. There is an important distinction between a doctor treating a patient with a physical illness, e.g. a badly broken leg that requires significant repair; and a ‘badly broken psyche’, which equally requires intensive rehabilitation. The former, whilst challenging the numerical identity of the individual does not directly impact the qualitative “I” on which this thesis has placed significance, despite its
embodied groundings. The latter however, a ‘broken psyche’, means that the patient “loses his boundaries in time and space” (Bleuler, 1911: 143), and thus if the therapist’s words, as my analysis suggests, constitute a regeneration of the boundaries of their personal ownership, then this places the therapist in a position of power to influence and manipulate the qualitative identity of the individual concerned.

Secondly, the role of the treatment requires attention. The fundamental implication of my thesis is that aspects of talk therapy and avatar therapy may constitute a part of a schizophrenic’s rehabilitated selfhood. Thus a reinterpretation of how care can be administered (and what sort) is required so as to maximise success. Following my model of SCALED selfhood, I have already suggested bodily activity may be a first base, followed by more ‘reflection driven’ therapies that elicit reciprocal causal couplings between patients and therapies. I have argued for example, that avatar therapy’s ability to incite dialogue develops the patient’s cognitive abilities.

Consequently, I suggest alternative non-pharmaceutical treatments deserve equal (if not more) attention. Results from avatar therapy demonstrate external, interactive therapies can be effective treatments when patients fail to respond to antipsychotic medications (Leff et al., 2014: 174), implying research to develop this therapy further will be advantageous to psychiatric care.

7.3. FURTHER RESEARCH AND LIMITATIONS

This thesis has limited its analysis to three characteristics of schizophrenia; the related disorders of ipseity and then auditory hallucinations, and has by no means explored everything of these. I chose these areas of focus as diminished self-affection and hyper-reflexivity are “mutually implicative aspects or facets of the intentional activity of awareness” (Sass et al., 2013: 431), yet require substantial differences in interpreting their eradicative treatments. Chapter 6’s focus on auditory hallucinations alone was therefore chosen to further demonstrate the ‘reflective and cognitive’ element required in avatar therapy, and further highlight the distinction between ‘constitution’ and mere ‘supplementation’. Further research into non-pharmaceutical treatments for other schizophrenic symptoms such as visual hallucinations may enable me to develop this distinction further.
Whilst conducting research, I relied upon testimonies and evidence provided by other philosophers and psychiatrists, being unable to interview (or have access to) schizophrenic patients. Thus my arguments have been interpretative of schizophrenic reports. To further determine the correct patient-therapy relationships, interview questions specifically designed to elicit a patient’s reflection on their treatment is required. This is because, as stated, the subjective experiencer is the best validator of correct characterisation. I hope this thesis’ arguments influence such investigation.

Ultimately, this research has expanded the boundaries of the applicability of extended mind theory. Taken seriously, the ‘constitution claim’ will impact psychiatry, in particular psychotherapy and the developing avatar therapy. Exactly how remains undetermined, yet what is clear is that body, mind and world are intimately interconnected, and thus all three must feature in schizophrenic recovery.

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BIBLIOGRAPHY

BOOKS AND JOURNAL ARTICLES


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