

Title: Understanding, Explaining, and Intersubjectivity in Schizophrenia:
Introduction to this special issue.

Author: Christoph Hoerl

Address: Department of Philosophy

University of Warwick

Coventry CV4 7AL

UK

C.Hoerl at warwick.ac.uk

Word count: 3965

published in *Philosophy, Psychiatry, & Psychology* 8 (2/3), pp. 83-88. The definitive version is available at <http://muse.jhu.edu>

Understanding, Explaining, and Intersubjectivity in Schizophrenia: Introduction to this special issue.¹

Christoph Hoerl

Karl Jaspers once asked whether it would be possible for a community of schizophrenic patients to exist, a “community united in common delusions [the content of] which they mutually elaborate as true by means of their common experience of it” (Jaspers 1963, p. 284).² He professes himself unable to answer this question, but suggests that “[t]he putting of the question is more important than the empirical answers so far obtained” (ibid.). What seems to have motivated Jaspers was the idea that the ‘personal world’ in which healthy individuals live is constituted, in part, socially. It is, as he says, “characterised by objective human ties, a mutuality in which all men meet” (ibid., p. 281) and can thus be studied as a cultural, historical phenomenon. The world of the schizophrenic patient, by contrast, seems to resist such a study. Schizophrenic patients, Jaspers suggests, live in ‘specific, private worlds’, which are not mediated by communication with others and whose origins are to be sought in a psychopathological process which actually severs normal social ties.

Jaspers’ talk of different ‘worlds’ in which schizophrenic patients and healthy individuals live can be seen as an attempt at articulating a key concern for psychopathology, which is also central to the papers collected in this special issue. Psychological understanding may be thought to face a twofold challenge when it comes to making sense of the symptoms schizophrenic patients suffer from: Not only do we need to make intelligible the situation the patients find themselves in; we also need to make intelligible a sense in which this situation is radically different from our own, i.e. a sense in which that situation resists understanding ‘from the inside’. There is a strong intuition that any attempt at understanding which construes schizophrenic symptoms as manifestations of just another

subjective take on a shared reality misses out on the very feature that makes them so puzzling. As Naomi Eilan (2000, p. 97) has put it, our task is to “solve simultaneously for understanding and utter strangeness” when faced with such phenomena.

In this introduction, I cannot cover all the different ways in which the various authors approach this difficult issue, and the detailed suggestions they make. Instead, I wish to concentrate on a related, but perhaps less obvious thread running through the different contributions, which echoes the more specific link that Jaspers draws between the ‘specific, private worlds’ of schizophrenic patients and the question as to whether there could be a community of such patients who understand “amongst themselves something which we fail to understand” (Jaspers 1963, pp. 283f.).

There are in fact several, quite different, ways in which this link might be understood. Jaspers, it seems, thought that schizophrenic patients do not have a problem with communication as such; it is just that they don’t normally find anyone they can communicate with, because nobody has shared their experiences. On this view, it is just a contingent matter that there doesn’t appear to be a schizophrenic community of the type envisaged (though Jaspers (*ibid.*, p. 283) quotes the case of an apparent ‘family delusion’ which could be construed as an exception). An alternative possibility, however, is that there is a more radical sense in which the patients are debarred from communication, and that it is actually impossible for a real community of schizophrenic patients to exist. The suggestion would be that patients have generally become unable to regard others as subjects with whom they can exchange reasons and share experiences.

Variants on something like these two suggestions can be found in a number of contributions to this special issue. Sean Spence, whose discussion focuses specifically on various forms of alien control, notes at the outset of his paper that patients suffering from this symptom seem to be assailed by changes in subjectivity which, by their very nature, implicate an altered relationship with others around them. Two case vignettes he gives provide vivid illustrations of this. In one of them, a male patient with tardive dyskinesia is

temporarily under the impression that the reason for his impaired ability to speak is that the interviewer is trying to prevent him from speaking. In the other, a female patient seems to associate episodes of apparent thought insertion with other people's eye movements, and actually asks other people not to look her in the eyes.

Spence's own discussion focuses on mechanisms involved in the initiation and control of action, and their neural correlates. Drawing on his own imaging studies of patients reporting 'made movements', he suggests that a hyperactivation in the right inferior parietal cortex, which is involved in (normally unconscious) programming and adjusting of limb responses during reaching and grasping, might be a key factor in explaining the occurrence of abnormal experiences in these patients. If true, Spence's suggestion might go some way towards explaining changes in the subjective experience of these patients. Other authors, however, question whether an appeal to such abnormal experiences, on its own, can make intelligible the full extent of phenomena such as the ones described in Spence's case vignettes, and especially the marked changes in the way the patients see themselves in relation to others that Spence himself points out (see also Élisabeth Pacherie's commentary on Spence).

Alien control is one amongst a battery of eight 'monothematic delusions' discussed by Martin Davies, Max Coltheart, Robyn Langdon and Nora Breen. Further examples they discuss are the Capgras, Cotard and Fregoli delusion, the delusion of mirrored-self misidentification, reduplicative paramnesia and delusions sometimes found in case of unilateral neglect. A key element in Davies et al.'s discussion is the idea that such delusions are in fact the result of two factors: (a) a neuropsychological anomaly with some manifestation in the experience of the subject, coupled with (b) an abnormality in the cognitive systems that are responsible for the evaluation and fixation of beliefs.

Two observations in particular are cited in favour of this 'two factor' account of monothematic delusions. First, while there is compelling evidence for the existence of neuropsychological anomalies (and consequent unusual experiences) in patients with such

delusions (Davies et al. cite, e.g., impairments in affective processing, internal monitoring defects and loss of kinaesthetic and proprioceptive feedback), those anomalies can sometimes also be found in non-delusional subjects. Second, whatever unusual experiences delusional patients may have, the most natural explanation for the occurrence of these experiences seems to be that something has gone wrong in the patients' brain; and yet, the patients seem unable to endorse this explanation themselves, and instead adopt beliefs that are much more implausible (sometimes even in the patients' own judgement).

One possibility canvassed by Davies et al. is that delusional patients suffer from, as they put it, an inability to suspend the unreflective acceptance of the veridicality of perceptual experience, in addition to unusual experiences generated by neuropsychological anomalies. The thought, basically, is this. Normal subjects usually believe what they perceive, but they are also able to assess the credentials of their perceptual experiences more critically, in particular in cases in which endorsing the contents of experience would lead to implausible beliefs. If delusional patients have lost this latter ability to suspend the unreflective assumption of veridicality with regard to their experiences, it might explain a sense in which the delusional belief is elevated to a status such that the patient could no longer recognize anything as possibly counting against it.³

One interesting implication of this proposal concerns the relationship between the patient's own first-person perspective on the world and the understanding the patient has of other people's perspectives. As Davies et al. note, their proposal might help to solve what they call the 'appreciation of implausibility problem', i.e. the question as to why delusional patients are often not surprised that the people around them refuse to accept the delusional belief as true. If what they are saying is right, hypotheses generated from the patients' own perceptual experiences would be resistant to being critically assessed by them. But the same hypotheses generated by someone else would be assessed in the normal way, and might be found utterly implausible by the patient on that basis.

This proposal, involving one of two different routes from experience to belief that Davies et al. discuss, might thus be seen as one way of spelling out the idea that the inability to take other people's perspectives into account is a key factor in certain psychiatric phenomena. Note, however, that Davies et al. connect this idea primarily with the anomalies in the evaluation and fixation of beliefs in delusional patients. A further question is whether it might also contribute to an understanding of the specific content of delusional beliefs, such as the ones encountered in delusions of alien control. Consider again Spence's case vignettes mentioned above. Part of what is so striking about cases like these is the particular way in which the patients seem to implicate others (indeed sometimes the very person to whom they relate their experiences) in the occurrence of passivity phenomena. As Johannes Roessler puts it in his contribution to this special issue, reports of alien control seem to express a sense of the self as an object that is being manipulated by others in ways which are quite outside the scope of normal social interaction.

Roessler's chapter contains a detailed discussion of Louis Sass' 'solipsist interpretation' of schizophrenia, according to which schizophrenic symptoms can be seen as manifestations of a "pervasive sense of subjectivization" (Sass 1994, p. 40), or a sense of a universe that "depends for its existence on a constituting consciousness" (ibid., p. 49, see also Parnas and Sass, this issue). In particular, Roessler looks to this interpretation for a possible answer to the question as to why delusions of alien control take the particular form they do. One particular feature of the solipsist perspective that Roessler highlights is that, from this perspective, it makes no sense to engage with other people by way of normal forms of communication, to exchange reasons with them. This would imply a relation of reciprocity which the solipsist is unable to acknowledge. Thus, as Roessler puts it, the solipsist universe has no room for the idea of co-operation; manipulation would seem to be the only mode of interaction left if others can no longer be acknowledged as occupants of a conscious point of view on a shared, objective world.

For Roessler, the solipsist's inability to engage in normal interpersonal relations, also has consequences for his ability to engage with his own thoughts and impulses. Roughly speaking, the idea is that, in the absence of an ability to engage with others in the 'game of giving and asking for reasons' (as Robert Brandom, 1994, p. 230, has put it in a different context), a patient would also lose the ability to ask of his own thoughts and impulses whether they provide reasons. In effect, the patient would become unable to exert control over them by deliberating on their credentials, which might explain a sense in which he also becomes unable to see them as things he can be held responsible for (a similar suggestion is also explored in Hoerl, this issue).

The more general claim that abnormalities in interpersonal and social engagement are a fundamental aspect of the vulnerability to schizophrenic breakdown can also be found in Giovanni Stanghellini's contribution to this special issue. Stanghellini's proposal centres on the idea that schizophrenic symptoms are manifestations of a crisis of 'common sense', where common sense can be represented as both a body of socially inherited knowledge and an affective-conative capacity for attunement with others. The first aspect is perhaps more prominent in patients' own reports, which are cited in detail in Stanghellini's paper. Here, patients express difficulties in adopting conventional rules and norms, or rather a sceptical, and often disdainful, attitude towards taken-for-granted views. As Stanghellini observes, the patients seem to show a deliberate attempt to disengage from assimilating others' perspectives. Yet, he also raises the possibility that this disengaged attitude might be a manifestation of, or compensation for, a more fundamental lack of a capacity for intuitive attunement with others in face-to-face encounters.

At one point, Stanghellini connects this idea of a lack of intuitive intersubjective attunement with evidence for a 'theory of mind' deficit in schizophrenia. This evidence is often held to point to impairments in the capacity to understand what is going on in another person's mind, i.e. to recognize and reason about other people as bearer of mental states (though see Parnas and Sass, this issue, for a critical evaluation of this approach). It is not

entirely clear, however, how this fits in with Stanghellini's own emphasis on the affective-conative dimension of intersubjective attunement. The 'theory of mind' approach typically focuses on cognitive abilities involved in grasping the causal-explanatory role of mental states, and exploiting that grasp, for instance, in predicting what other people will think or do in a certain situation. As such, it primarily describes how we deal with others conceived of 'in the third person'. By contrast, talk of a lack of intuitive intersubjective attunement in schizophrenics might be held to indicate an inability to conceive of others 'in the second person', to recognize them as potential partners in joint and co-operative enterprises.⁴ Arguably, the grip on others as psychological subjects which is involved in the ability to engage in such joint enterprises is of a more practical nature than that measured in 'theory of mind' tasks, and it is only this practical grip which gives intersubjectivity an essentially affective-conative dimension.

The chapter by Josef Parnas and Louis Sass shares certain themes with Stanghellini's discussion. Their primary aim, however, is to argue that schizophrenic symptoms develop against the background of pre-existing anomalies of self-experience. They discuss a variety of ways in which self-experience might be said to be disturbed in the pre-onset phases of schizophrenia and schizotypal disorders. Among them are, as they put it, a lack or diminishment of the sense of being present in or to the world, alterations in the experience of one's own body, an experienced alienation from thoughts and feelings, transitivity (the inability to demarcate 'me' from 'not me'), and solipsism.

A key methodological claim made by Parnas and Sass is that the delusional transformation in schizophrenia can only be understood if changes of self-experience such as these, which predate the onset of psychosis, are also taken into account. In this context, they speak of an initial and ineffable self-transformation (which is possibly the outcome of disturbances in perceptuo-motor organization) that is progressively 'articulated' and 'thematized', culminating in a frank psychosis. There are, however, different motivations that may stand behind such a methodological claim.

One suggestion here might be that schizophrenic delusions can be seen to ‘emerge’ out of prior ideas, experiences and preoccupations, present in the pre-onset phase, in such a way that they can be genetically understood. ‘Genetic understanding’ is the term coined by Jaspers (1963, pp. 302f.) for the mode of understanding that we also apply, for instance, when we make sense of a person’s suspiciousness by appealing to her realization that she has been cheated in the past. This idea, that we can similarly make sense, from the subject’s point of view, of the occurrence of psychotic delusions in terms of other mental states it emerges from, would stand in stark contrast to Jaspers’ own view that schizophrenic delusions resist genetic understanding⁵.

An alternative suggestion, more in the spirit of Jaspers’ view, would be that, while something like genetic understanding might have a place in an account of features of the pre-onset stages of schizophrenia, the transition to full-blown schizophrenic delusions itself is beyond such understanding. Talk of such delusions as ‘thematizations’ of a self-transformation, on this picture, would be appropriate, if at all, only in the sense that elements of the delusion echo some of the patient’s earlier preoccupations, but are now removed from the earlier context in which they could still, to some extent, be made sense of.

There is also a third possibility, however, which lies somewhere between those two extremes. The basic idea would be that a central task for psychopathology is to explain the loss of meaning itself. Following Parnas’ and Sass’ line of thought, this would involve giving the patients’ experiences, beliefs and preoccupations in the pre-onset stage an explanatory role in accounting for why those patients ultimately reach a stage at which meaning (or at least ordinary meaning) can no longer be sustained. This idea is explored further, in particular with respect to phenomena involving hyperreflexivity, in Louis Sass’ commentary on Stanghellini.

Part of the aim of John Campbell’s chapter is to show that the root problem posed by delusions does indeed lie with the meaning of the words used in stating the delusion, and the question as to how far the patients themselves can be said to retain a grasp of that

meaning. The key point, according to Campbell, is that a subject's grasp of the meaning of a term seems inextricably tied up with a largely intact capacity for correct reasoning using that term. In particular, we ordinarily take it that a subject's grasp of the meaning of a term just is what provides her with the ability correctly to form and find the implications of judgements involving that term. To show how this issue affects the analysis of delusions, Campbell concentrates on the Capgras delusion (also discussed in detail by Davies et al.), in which patients maintain that people they know have been replaced by impostors. According to Campbell, the basic delusional belief characterizing this delusion, if we are to take the patients' words at face value, must be construed as a negative identity statement of the type 'that (currently perceived) person is not that (remembered) person', involving two demonstratives: a perceptual demonstrative and a memory demonstrative. What Campbell points out, however, is that Capgras patients seem to have lost their grip on what he argues is the canonical way of verifying a statement of this type, namely by trying to engage in joint reminiscing with the person they are confronted with, to look for shared memories.⁶ And the inability or refusal to engage in this kind of verification casts serious doubts on whether they actually grasp the meaning of the memory demonstrative.

Recall that Davies et al. also suggest that a central factor in delusions is the patients' inability to take other people's perspectives into account and to engage in intersubjective verification of their beliefs. According to Campbell, their proposal does not go far enough, since it only represents the patients' problem as an anomaly in the evaluation and fixation of beliefs and misses out on the connection between rationality and meaning. But there also seems to be a further difference between Campbell's proposal and that put forward by Davies et al., which has to do with their respective conceptions of the nature of the breakdown of rationality involved in delusions such as the Capgras delusion. We might bring this potential difference into focus by considering what Davies et al. call the 'monothematicity problem', a problem which they admit arises for any account of the kind they propose, and which they feel forced ultimately to leave open.

In short, the monothematicity problem can be stated as follows. If, as Davies et al. suggest, delusional patients suffer from some kind of abnormality in their belief evaluation system, what is it that protects them from adopting bizarrely false beliefs in other domains, which they don't seem to do? Davies et al. consider one hypothesis, which might provide the beginnings of an answer to this question. According to this hypothesis, delusions only arise in areas where the content of the belief to be evaluated is such that it cannot be readily refuted by using first-person experience. Yet, they also note that this hypothesis can't provide the full answer to the monothematicity problem, or else we should expect that delusional patients also form bizarre beliefs, for instance, when faced with visual illusions.

If Campbell's account is correct, however, we might think that there is also another possible way of delineating the domain of reasoning which is affected, say, in patients with Capgras delusion. Consider again Campbell's question regarding the Capgras patient's grasp of the memory demonstrative 'that (remembered) person', and the role Campbell assigns to joint reminiscing as the canonical way of verifying statements containing such a demonstrative. Verification, here, depends not just on the general ability to appreciate that other people might have information relevant to the truth of one's belief. Verification, in this case, is itself only possible as part of an activity undertaken jointly with the other person. Hence, a possible suggestion might be that a key factor in the psychosis lies just here: in the patients' inability to engage in such joint activity.⁷ As we might put it, there is an essentially social dimension to the kinds of reasoning and rationality which normally underpin our thoughts about other people and ourselves, and it is this dimension which delusional patients no longer have a grip on.

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¹ A number of the papers in this special issue had their origins in a series of interdisciplinary seminars in Oxford and London, and a workshop at the Novartis Foundation in London in 1999. They were jointly organised by the AHRB Project on Consciousness and Self Consciousness, University of Warwick, the Philosophy and Ethics of Mental Health Programme, University of Warwick, and the McDonnell-Pew Centre for Cognitive Neuroscience, University of Oxford. Thanks are due to Gemma Calvert, Martin Davies and Bill Fulford for organising these meetings. I also wish to thank the PPP Editors, Bill Fulford and John Sadler, for encouraging me to put together this special issue.

² I am indebted to Naomi Eilan for drawing my attention to this passage.

³ An alternative suggestion can be found in Gregory Currie’s and Jon Jureidini’s commentary on Davies et al., who dispute that delusions should be treated as beliefs. Instead, they suggest that delusions should be treated as imaginings which the patients can

no longer recognize as generated by themselves. This, they argue, might equally be able to explain why delusions are immune to conventional appeals to reason and evidence.

⁴ Here I am indebted to Jane Heal's discussion in Heal (1998).

⁵ See Eilan 2000 for further discussion of Jaspers' position on this issue.

⁶ Naomi Eilan, in her commentary on Campbell and on the paper by Parnas and Sass, discusses the question as to whether the patients simply fail to see the point of such attempts at evidential verification, or do not think that the statements they are making are of a kind that calls for such verification, or engage in attempts at such verification, but are unable to accept the outcome of these attempts. As she points out, each of these three possibilities yields a different picture of the nature of the patients' situation.

⁷ See also my remarks, above, on Stanghellini's proposal about disturbances of intersubjectivity in schizophrenia in general.