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ADRIAN NICHOLAS SPREMBERG

ANOMALOUS EXPERIENCES OF SELF AND WORLD, ENACTIVISM AND SENSE-MAKING: TOWARD A MORE DYNAMIC APPROACH TO THE PSYCHOPATHOLOGY OF SCHIZOPHRENIA

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ADRIAN NICHOLAS SPREMBERG

ORIENTADOR: PROF. DR. CLAUDIO EDUARDO MULLER BANZATO
COORIENTADOR: DR. THOMAS MAURITZ MARIA FUCHS
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5. PROF. DR. DR. MAURÍCIO VIOTTI DAKER

Programa de Pós-Graduação em Ciências Médicas da Faculdade de Ciências Médicas da Universidade Estadual de Campinas.

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RESUMO

A esquizofrenia é um transtorno geralmente abordado a partir de uma perspectiva sintomatológica, com base na psicopatologia descritiva. Porém, outras abordagens teóricas, como a psicopatologia fenomenológica e o enativismo, abordam a esquizofrenia de outra maneira, integrando abordagens de perspectivas em primeira e segunda pessoa que apontam para a importância de se investigar mais afundo de que maneira as alterações entre sujeito com esquizofrenia e mundo se dão. Os objetivos do projeto são explorar as alterações das dimensões psicopatológicas, fenomenológicas (experiências de si e do mundo) e dinâmicas de pacientes com esquizofrenia, e avaliar suas configurações dinâmicas compostas por experiências vividas subjetivas e mundanas alteradas e a presença de negativas ou sintomas positivos e aspectos relacionados à vida e ao contexto social de cada paciente. A investigação foi realizada através de entrevistas com 12 pacientes com diagnóstico de esquizofrenia segundo a CID-10, com base nas entrevistas fenomenológicas semiestruturadas "Exame de Auto Experiências Anômalas" (EASE) e "Exame de Experiências de Mundo Anômalo" (EAWE). Ambos investigam uma variedade de experiências anômalas relacionadas ao self corporificado, percepção (criação de significado), agência, objetos físicos no mundo e outras pessoas. Os resultados encontrados no estudo mostram mudanças singulares de intensidade, frequência e conteúdos diversos, nas configurações de cada um dos pacientes entrevistados, quanto à sua sintomatologia, experiências alteradas e contexto de vida. Essas configurações são compostas por mudanças vivenciadas na experiência vivida e pela presença de sintomas negativos ou positivos singulares e aspectos relacionados ao contexto clínico e de vida de cada paciente. Os resultados encontrados no projeto apontam para mudanças singulares de diferentes intensidades, frequências e conteúdos, tanto nas mudanças mais vivenciais, como nas dimensões do self e na corporeidade, quanto na forma como os sintomas positivos, como fenômenos alucinatórios, aparecem, em cada um dos casos. No primeiro grupo de pacientes, as configurações aparecem de forma mais estática e cristalizada. Nesse grupo, as mudanças experienciais e sintomatológicas aparecem com mais intensidade, levando a configurações menos fluidas, dificultando a interação dos sujeitos com seu respectivo mundo da vida. O segundo grupo apresenta configurações mais dinâmicas, em que os pacientes entrevistados apresentam alterações experienciais e sintomatológicas mais brandas, que ainda os permitem interagir de forma mais fluida, embora frágil, com o mundo. Portanto, a inter-relação entre as mudanças nas dimensões experiencial e sintomática aponta para a necessidade de uma compreensão mais integrada dos transtornos dentro do espectro da esquizofrenia, uma vez que as intervenções

psicoterapêuticas, farmacológicas e sociais poderiam então ser baseadas no entendimento que enfoca as mudanças mencionadas como dinâmicas e sujeito a mudanças constantes, dependendo do contexto de cada caso.

Palavras-chave: Esquizofrenia; EASE; EAWE; Psicopatologia Fenomenológica; Enativismo; Sense-Making.

ABSTRACT

Schizophrenia is a disorder usually addressed from a symptomatological perspective, based on descriptive psychopathology. Other theoretical frameworks, such as phenomenological psychopathology and enactivism, approach schizophrenia integrating first and second-person perspective approaches toward schizophrenia, which are fundamental for a more in-depth investigation of how the subject with schizophrenia exists, in relation to his world. The objectives of the project are to explore the alterations of the psychopathological, phenomenological (experiences of self and world) and enactive dimensions of patients with schizophrenia, and to assess their dynamic configurations composed of lived altered subjective and worldly experiences and the presence of negative or positive symptoms and aspects related to each patient's life and social context. The investigation was carried through employing interviews with 12 patients diagnosed with schizophrenia according to ICD-10, based on the phenomenological semi-structured interviews "Examination of Anomalous Self Experiences" (EASE) and "Examination of Anomalous World Experiences" (EAWE). Both investigate a variety of anomalous experiences related to the embodied self, perception (creation of meaning), agency, physical objects in the world, and other people. The results found in the study show singular changes in intensity, frequency and diverse content, in the configurations of each of the interviewed patients, regarding their symptomatology, altered experiences and life context. These configurations are composed of experienced changes in lived experience and the presence of singular negative or positive symptoms and aspects related to each patient's clinical and life context. The results found in the project point to unique changes of different intensity, frequency and content, both in the more experiential changes, such as in the dimensions of the self and in corporeality, as well as in the way in which positive symptoms, such as hallucinatory phenomena, appear, in each one of the cases. In the first group of patients, the configurations appear in a more static and crystalized manner. In this group, the experiential and symptomatological changes occur more intensely, leading to less fluid configurations, thus making it difficult for the subjects to interact with their respective lifeworld. The second group presents more dynamic configurations, in which the patients interviewed presented milder experiential and symptomatological alterations, which still enable them to interact in a more fluid, albeit fragile, way with the world. Therefore, the interrelation between changes in experiential and symptomatic dimensions points to the need for a more integrated understanding of disorders within the schizophrenia spectrum, since psychotherapeutic, pharmacological and social interventions could then be based on the understanding that focuses

on the aforementioned changes as dynamic and subject to constant change, depending on the context of each case.

Keywords: Schizophrenia; EASE; EAWE; Phenomenological Psychopathology; Enactivism; Sense-Making

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SUMMARY

1. INTRODUCTION

1.1. Conceptualizing and Classifying Schizophrenia

The modern history of schizophrenia begins with Emil Kraepelin (1), who first gave this disorder the name of "dementia praecox." Kraepelin believed that "dementia praecox" had predetermined pathogenesis and course of illness. Moreover, he considered the condition to be a disorder that would, often but not necessarily, end in mental deterioration. For Kraepelin, a variety of alterations in perception and memory, as well as volition, for instance, would occur. However, these alterations were not supposed to be present in every case.

Eugen Bleuler (2) further developed Kraepelin's studies and gave the disorder the name still used nowadays, *schizophrenia*. According to Bleuler, this particular group of disorders would appear as a disintegration of various psychic functions, which would, in turn, lead to, among other conditions, such as "flat affectivity". The actual outcome, as well as the course of schizophrenia, would also be heterogeneous, in nature. For Bleuler, central aspects of schizophrenia would include, for instance, traces of autistic behavior, ambivalence and flat affect (2). These symptoms would mostly relate to difficulties in agency, as well as in expressing affectivity and a diminished capacity of relating to others in general, hence the autistic behavior.

A third central author is Schneider (3) who focused, like Bleuler (2), on symptoms that were *fundamental* to schizophrenia. However, in contrast to Bleuler, Schneider's focus was on the more flamboyant "first-rank symptoms". Schneider, *apud* Andreasen, would say that, in schizophrenia, "one critical component was an inability to find the boundaries between self and not-self and a loss of the sense of personal autonomy" (4, p. 107). This notion of a fragmented self would then lead to various symptoms like thought insertions and delusions, which nowadays comprise of symptoms present in the group of the so-called *positive symptoms*. Interestingly, Schneider was deeply influenced by Karl Jaspers' (5) work, a psychiatrist and philosopher, whose own work was very much based on a thorough investigation and *description* of altered states of consciousness in patients with schizophrenia. For Jaspers, the clinician would gain insight into the altered layers of consciousness by investigating these via an empathic encounter with the patient and relating the altered phenomena of consciousness. This

accurate description of altered states of consciousness gave rise to descriptive psychopathology, on which most present-day psychopathology is founded.

This kind of descriptive psychopathology would thus primarily rely on the patient's first-person narrative and how they describe their inner life and altered states of consciousness. Also, the clinician would *intuitively* gain access to these experiences. Jaspers would ground a part of his *General Psychopathology* (1913) on Edmund Husserl's (6) earlier phenomenological approach, arguing for the fact that the clinician thus could, through this grasping of the immediate experiential phenomena, gain a more thorough understanding of the *meaning* of the altered conscious phenomena, and how the structure of experience would bring about mental disorders. Without the approach of more formal and theoretical presuppositions, an empathic investigation would lead the clinician toward a more meticulous apprehension of the singularity of the disorder at hand. Over time, Jaspers has elaborated this method and his general psychopathology in many ways. Over the years, Jaspers' work was further developed by other important psychopathologists, such as Kurt Schneider (3), mentioned above. Schneider simplified many of Jaspers' formulations and added more distinctions by investigating the *form* of a specific psychopathological sign or symptom, rather than its *content*. Both Schneider and Jaspers profoundly influenced the contemporary classifications of the disorders within the schizophrenia spectrum. In the 1950' and 60's, the Schneiderian first-rank symptoms became more and more central for the classification and diagnosis of schizophrenia and disorders within this spectrum. While in north America, a more Bleulerian approach, based on negative symptomatology, would be preferred. In Europe, the focus rested on the work of Schneider and Kraepelin (7). During the mid-nineteenth century, classificatory systems such as the DSM II would then present a very broad understanding of schizophrenia, while the DSM III narrowed the symptomatology present in the clinical picture of this disorder down (7).

Recent discussions, such as the ones' put forward by Insel (8) put forward a dimensional approach to mental disorders, including schizophrenia. Insel's research framework, however, is largely based on a neurobiological framework, which seeks to integrate a variety of pathophysiological domains of functions, which are relate to different levels of analyzing these functions, e.g.,

> genetic, molecular, and cellular levels, proceeding to the circuit-level (which, as suggested above, is the focal element of the RDoC organization), and on to the level of the individual, family environment, and social context (8, p. 749)

The RdoC framework has, however, rightly been criticized for its strong focus derived from a naturalistic approach toward mental disorders (9). Insel's framework bestows too much causal power to possible alterations in the brain, leaving subjectivity and first-person experience aside. While the RdoC investigations seek to reduce levels of functioning to alterations in cerebral and neurobiological functioning, I believe that proposals such as that of Nelson et al. (10) are much more aligned with contemporary interdisciplinary research in mental disorders, given that it highlights the importance of relating different layers of experiential domains such as selfhood and embodiment to clinical stages.

Let me now return to how the ICD-10 (11) defines schizophrenia. The diagnostic criteria are presented as follows:

> A minimum of one very clear symptom belonging to any one of the groups listed below as (a) to (d) or symptoms from at least two of the groups referred to as (e) to (i) should have been clearly present for most of the time during a period of 1 month or more.
>
> a) Thought echo, thought insertion or withdrawal and thought broadcasting
>
> b) delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions or sensations; delusional perception
>
> c) hallucinatory voices giving a running commentary on the patient's behaviour or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body
>
> d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather or being in communication with aliens from another world) e) persistent hallucinations in any modality, when accompanied either by fleeting or halfformed delusions without clear affective content or by persistent over-valued ideas, or when occurring every day for weeks or months on end
>
> f) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms g) catatonic behaviour, such as excitement, posturing. or waxy flexibility, negativism, mutism and stupor

> h) 'negative' symptoms such as marked apathy, paucity of speech and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these are not due to depression or neuroleptic medication
>
> i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude and social withdrawal. (11)

Alongside this conglomerate of different symptoms, schizophrenia also presents a very heterogeneous course of illness (7). It is commonly divided into a premorbid and a prodromal phase, both of which linked to a range of cognitive, behavioral, and subjective *difficulties* the person may experience mildly, at first. Still, these will then usually end up in what has been called a *first psychotic episode.* It is during this first break that most persons first experience a more severe breakdown of cognitive dysfunctions. In contrast, others will refer to having had *intense* hallucinations or delusions for the first time, which lead to a complete or partial split from reality. After these phases, the disorder goes on to a stage of chronification or remission, depending on how symptoms appear, age, social background, genetics, treatment and so on (7). Regarding the outcome of the illness, as Tandon et al. put it,

> Outcome in the context of schizophrenic illness is a multi-dimensional construct comprised of distinct domains of psychopathology, different elements of social functioning, life-span and various aspects of quality of life, and societal impact. The outcome of schizophrenia is influenced by several factors including the circumstances under which the illness develops, characteristics of the illness, premorbid personality and abilities of the affected individual at the time of illness onset, available treatments, the social setting, and environmental factors. (7, p. 10)

Here, it is important to point out that contemporary descriptive psychopathology seeks to validate itself as a science within a neurobiological framework that gives its possible biological substrates much importance, even if it also considers social factors. However, such an approach still sounds overly reductionist, since it tends to approach psychopathological signs as excessively *concrete* and *objective* phenomena, such as a lack of volition or other more

observable symptoms, which may have their roots in neurobiological alterations. While such a perspective does help to delineate some of these disorders in a clearer manner, it still seems to lack in that it does not consider other phenomena, such as the subjective and worldly experience of the patient, as having equal importance, in regard to the *singular* ways in which they appear, in each patient.

On the other hand, phenomenological psychopathology seeks to validate itself in the subjective and worldly experiences *themselves*. These worldly experiences may relate to more concrete difficulties in maintaining social contact or having trouble finding a job or to alterations in the perception of others and the altered access to reality a patient might be experiencing. So, it seems important not to take contemporary classification systems at full face value, since they do not tell the whole story of how the disorders within the schizophrenia spectrum are classified and validated. Regarding a critique of contemporary criteriological validity and the place of psychiatric classifications, Banzato and Pereira (12) say that, "in psychiatry, more clearly than in other medical specialties, the mere restitution of a supposed biological normality is not enough to guide and ethically guide an intervention that needs to be made" (9, p. 4, *my translation*).

For the authors, a reductionist approach to the classification of mental disorders is linked to the fact that an ill person cannot be destitute from the complexity inherent that means being human. Thus, the classification of mental disorders should not exclusively serve as a concrete and objective way of diagnosing a particular disorder, but as one form of understanding what may occur in a specific case. After all, the symptoms would also need to be pragmatically integrated into the ill subject's lived world and intersubjective relations. Thus, it becomes crucial to understand mental disorders as *interactive kinds*, where specific "cut-outs" of different phenomena can be integrated into the clinical picture, pragmatically. (12) So, the function of diagnostics would not only be that of classifying and validating a specific diagnosis, but rather serve as a tool that integrates how a patient is inserted in a particular lifeworld, and how different understandings about that disorder reality can be combined (12). The author's perspective is aligned with this project, in that schizophrenia, being a disorder within an entire *spectrum* of disorders, may be of unique contours, given each specific case, the objective, experiential and worldly phenomena that can be present, in an intertwined manner. The signs present in each case would thus configure the dynamic entanglement between what is objective and experiential.

So, while most of the research within contemporary mainstream psychiatry is still based on the presumption that mental disorders are somehow “disorders of the brain”, thus reducing them to their possible neurobiological underpinnings, authors such as Fuchs (13) have developed engaging and thought-provoking approaches that consider the *horizontality* and *circularity* of the brain, arguing that the brain functions as a mediator between subject and world, only then giving rise to a variety of processes such as perception, agency and intersubjectivity. Fuchs's approach points out a dynamic and more integrated understanding of schizophrenia, which bases itself on the idea the altered experiences and symptoms need to be understood as entangled phenomena which expand in the world. This perspective is, I believe, also aligned with Banzato and Pereira's perspective (12) as well, since diagnostic criteria are *a part* of what makes the entirety of the clinical picture, the disorder itself. It a multiplicity of different factors that make up a more complete clinical picture.

1.2. Descriptive and Phenomenological Psychopathology

One more author that has begun pointing to the interrelation between experiential and objective phenomena in mental disorders is Kraus. For the author (14), a pure descriptive understanding preserves a merely objectivistic access to mental illness. Simultaneously, however, the phenomenological approach supports a better understanding of the functioning and explanation of the subjective and worldly phenomena, thus maintaining the singular unity of the schizophrenic person as a whole. So, it also becomes necessary to investigate the person's lived world, their relations with the world and others, their personality, all of the other neurophysiological processes involved in schizophrenia, and how they are interrelated. This implies a perspective that integrates both the first-person perspective (subjectivity) and the third person-perspective (symptomatological phenomena).

Regarding the difference between “symptoms” and “phenomena”, Kraus (14) also believes that symptoms may have certain neurobiological substrates; hence these belong to a more objectivistic psychopathological perspective. However, subjective and experiential features are also inserted into the patient's subjective dimension; they are felt from a first-person perspective and are therefore usually experiences related to a variety of other non-behavioral aspects. The author argues that one cannot, for instance, approach and understand a broken arm

in the same way as endogenous psychosis. While the endogenous process of psychosis appears to be an illness with a variety of subjective phenomena and instances, a broken arm is treated by the orthopaedist as a "physical" and concrete occurrence, which can be objectively investigated and, thus, treated as necessary.

Such objective and subjective frameworks, he argues, are closely intertwined with explanatory perspectives bound to the more traditional psychiatric and psychological grasping's of psychopathological phenomena, some of which were pointed to in section 1.1. For instance, there may be a presupposition of logical and causal inferences between symptoms of a specific disorder for the philosophical tradition of positivism, which would then lead to a specific diagnosis. Another theoretical perspective that leads the author to develop his framework is, in comparison to the positivist approach, an anthropological understanding, which integrates the entirety of the patients' lived world thus being a kind of explanatory framework toward understanding that considers the *boundarie*s of what is being investigated.

Kraus (14) also addresses further important questions regarding more descriptive and phenomenological discussions on schizophrenic disorders and considers the importance of having a holistic understanding of this disorder. A more comprehensive understanding of which dimensions are interrelated in a given case may be developed, leading to a more comprehensive treatment plan. Suppose one considers these other aspects as well. In that case, a diagnosis of schizophrenia can be reached much more quickly, given that different phenomena are also considered, and not just behavioral symptoms or neurobiological occurrences.

Interestingly, Valdés-Stauber (15) also complements the idea of a psychopathological framework based on a more dynamic, interrelated and pragmatic understanding of the grouping of disorders within the schizophrenia spectrum. The author develops his perspective from the notion of "understanding", in psychiatric and psychological phenomena. He argues for three different kinds of explanatory frameworks of understanding. He first says that the phenomenon of understanding may be based upon logical relational operations, as is the case in diagnosis. Secondly, understanding can be exemplified as a phenomenon that captures meaning in superordinate individual, psychological and typological categories. Finally, the author argues for understanding as a stance of acceptance, which is based on anthropological fundaments that assess patients' in their totality, thus not offering a kind of decoding of their behavior, but as a participation in their life, in their fate (15). It is interesting to see how these frameworks can be adapted to disorders within the schizophrenia

spectrum. The relation that can be made here is that while a more objective understanding of the alterations in this group of disorders is necessary (third-person perspective), it would make sense to integrate it into the entirety of the patients' lifeworld and his singular experiences (first-person perspective). When put together, these two perspectives would thus point to a dynamic second-person perspective, to an "in-between" of dynamic alterations between subject and world. Hence, it seems crucial to deepen an understanding of how a vast array of subjective and worldly experiences also fit into a more comprehensive account of schizophrenia, which does not leave aside categories such as *positive* or *negative* symptoms, but rather increments such a perspective by pointing to everchanging singular configurations between the experiential, worldly and symptomatologic dimensions. Investigating these singular experiential and symptomatalogical dimensions in-depth is crucial, given the importance of understanding schizophrenia not only empirically, assessing these dimensions more objectively, but also integrating this empirical data with a solid philosophical-conceptual background. So, before presenting the phenomenological and enactive categories that have been investigated in this project, I will outline the phenomenological method at its core, such as proposed by Edmund Husserl (6), to ground one of the conceptual, philosophical framework needed for the investigation of altered experiential, worldly and symptomatological phenomena.

1.3. Husserl and the Phenomenological Method

To introduce the importance of investigating subjective alterations in schizophrenia from a dynamic perspective, it is crucial to contextualize how the phenomenological method itself is inserted in contemporary research in the philosophy of psychiatry and psychology. Husserl's (6) phenomenology can already be understood as a method that aims to connect the structures of experience and attain a more comprehensive picture of how subjects understand themselves, from within a first-person perspective and in their attunement with the world and others. Husserl's phenomenological method of a descriptive analysis of consciousness emerges from the idea of *intentionality*, initially put forward by Brentano (16), but derived from a more recent conception of the study of consciousness conceived from that of which it is conscious about. The idea of intentionality itself that consciousness is always conscious of something makes it apparent that consciousness must be analyzed in its state of *being conscious*, not as pure and straightforward subjectivity. Subjects, even those with different types of

schizophrenia, understand and are in contact with the world, continuously, even if this contact has lost its fluid characteristics and has changed regarding its *integrated nature.* Subjectivity is not only a "feeling of being something", but it also arises in the interaction we usually have with others. The theory of intentional consciousness inaugurates, at least for philosophy, an alternative to the subject-object dualism, claiming that its core argument relies on the fact that the descriptions and analysis it makes depends precisely on what appears in the field of intentionality, in which consciousness and object intersect. In this field, consciousness is then always an awareness of something and is thus still intentional consciousness. So, the object is always that of which consciousness is conscious about (6).

So, phenomenology consists of a descriptive investigation of the intrinsic structure present in consciousness acts in its initial formulation. Put differently: the method consists in examining the different modes and modalities in which consciousness apprehends and confers meaning to what it perceives when it directs itself at the various objects that appear in its field, thus bracketing the assumptions about the ontological existence of these phenomena, an idea called "epoché". While in this state, the "pure ego" or the "I" can abstain from the world's naturalistic attitude. Whenever the epoché occurs, the natural attitude is bracketed so that consciousness itself and its acts gain a more rigorous understanding of the phenomena present for consciousness (6). By "suspending" the mundane attitude toward the world and objects, consciousness obtains equitable access to how phenomena appear for it. This description does not maintain itself on the same level as facts do, which means the contingent manifestations of experience. Still, it focuses precisely on the fact that the structural aspects of it must be meaningfully clarified. Regarding logic and theories of knowledge, more specifically, it would thus be essential to think, here, about a phenomenology of the cognitive experiences which would clarify concepts of both psychology and philosophy. Such an approach would confer to both disciplines the objective foundation that empirical psychology would fail to provide.

Methodologically speaking, an essential phase of Husserl's (6) thinking characterizes the so-called "transcendental turn" of phenomenology, which was heavily influenced by the philosophers Descartes and Kant, respectively. Here, the importance lies in the constitution of these objects and the modes through which they occur and how they appear. This method, which relates to the "epoché", for Husserl (and many of the phenomenological "schools") is crucial because it is only through the *epoché* that consciousness (the "I") can apprehend the world in its intrinsic significance, without any theoretical pre-conceived framework on how something works, for instance.

One further important point, which can be associated with a significant number of "schools of thought" within phenomenology, is that we are embodied subjects which are regularly and meaningfully engaged with the world. Essentially, processes such as perception, action, affectivity, and the overall feeling of being oneself (selfhood) and being with others (intersubjectivity), are deeply embodied. This fact relates to what is, I believe, intertwined with the purpose of this project: subjectivity, from my perspective, is not to be considered as a lonely phenomenon, apart from all the others. It would be incredible to separate occurrences in the "mind" or the brain, from those that occur in the body, be it in the so-called *objective* body (Koerper), or the *lived* one (Leib). When things go astray in this interwoven web of meaningful attunement between embodied subject and world, disorders such as schizophrenia may occur, as discussed over the next sections. In sum, phenomenology, broadly understood, claims to promptly investigate the structures of experience as they appear to consciousness (6). However, subjects also exist in an embodied manner: acts of perception do not merely occur "mentally" or "within", they are, along with agency, emotions and other processes, thoroughly embodied. It is not enough to simply describe or ascribe meaning to what is absorbed by consciousness statically. In schizophrenia, it is crucial to assess the continuum of how patients' altered symptomatology and experiential dimension changes, depending on socio-cultural factors and psychopharmacological or psychotherapeutic treatment. How schizophrenic persons understand themselves and the world, albeit in a different way, is crucial. While alterations in symptomatology, subjective and worldly experiential dimensions may be severe, these do not necessarily *stay the same* in different cases. So, it seems important to investigate the configurations of singular alterations also relate to other disruptions in dimensions such as embodied agency and sense-making. These will be further outlined in the next sections of the thesis, but they are related to the fact that processes such as acting or attributing meaning are disrupted, in schizophrenia. For instance, while the presence of positive symptoms or disorganized thinking may lead to a poorer prognosis of the disorder, merely stating the occurrence of these symptoms could would not be enough for such a diagnosis. Positive symptoms are experienced in unique ways by the patients, which leads to very distinct ways in which that specific person will interact with others and act in the world, for instance. Disruptions in these dimensions influence each other, thus changing the entire subjective and symptomatic configuration present in a specific case.

To continue the outline of phenomenological dimensions, let me now turn to the body and its crucial characteristics in contemporary phenomenology. The body itself serves as

an “integrated” medium through which subjects can meaningfully engage with the world through various possible sensorimotor and kinaesthetic capacities.[1] While alterations in the lived body in schizophrenia are common, it is their inter-relatedness with the entire experiential and symptomatological configuration that I argue for. Before focusing on enactivism as a framework that will further enlighten the *dynamic* intertwinement between body, sense-making, selfhood and intersubjectivity, I will outline some of the central arguments present in the philosophy of Merleau-Ponty (14), a prominent French phenomenologist whose work depicts the various ways in which the lived body is arranged in the world, via the subject's sensorimotor capacities and attunements.

1.3.1. The Body in Phenomenology

In the previous section, I have hinted to the fact that subjects exist in the world *through* his body, which gives him a way of meaningfully accessing the world and various kinaesthetic possibilities. As mentioned before, it is vital to keep the body (*Koerper*)/ lived body (*Leib*) distinction in mind. I will mainly discuss the work of french philosopher' Merleau-Ponty (17), who developed a phenomenology of the body, which is widespread within contemporary interdisciplinary research. Furthermore, Merleau-Ponty depicted how processes such as perception and agency are closely intertwined with the body itself. For the philosopher, the lived body appears as an intentional *medium* through which subjects engage with their world, meaningfully. Importantly, Merleau-Ponty argues for the fact that other phenomena, such as perception and action, for instance, are not to be considered “mental” ongoings per se, but instead thoroughly embodied processes. Looking beyond the mind-body division is fundamental for understanding disorders of embodied action and perception (dis-embodiment) as well, a group of disorders schizophrenia is a part of, as has been put forward by contemporary authors working in interdisciplinary research.

One of Merleau Ponty's (17) most important works is the *Phenomenology of Perception* (2012), in which he critically engages with the idea that the body is simply to be understood as a congregate of biological and physiological processes. Such comprehension of

[1] The emphasis on the body in phenomenology was given, among others, by French phenomenologist Maurice Merleau Ponty, whose work I will shortly outline in the next section.

the body can be found, for instance, in the medical and natural sciences, where physiological occurrences are the most crucial subject matter under investigation. However, as said above, for phenomenologically oriented researchers, mostly francophone "heirs" of Husserl[2] (6), there is another *kind* of body imbued with experiential qualities and attunements with the world. This *lived* body is a medium through which subjects meaningfully and actively engage with the world via various pre-reflexive sensorimotor and perceptual capacities and processes. Subjects are in constant relation with their world through what Merleau-Ponty coined the *intentional arc*, a set of fundamental experiential dispositions that already *displays* the world to the person as a space of meaningful possibilities. The world *affords* subjects to act. The lived body is not to be understood as a conglomerate of physical affairs and a vehicle through which perception and action occur. For the philosopher, perception also unifies other experiential structures, such as temporality, socio-cultural embeddedness, and aspects of the subject's historical elements. However, it is crucial to mention that these processes, such as Merleau-Ponty advances them, are not separate from occurrences of the "mind" or "brain", but very much associated with them.

Interestingly, Merleau-Ponty (17) also highlights that the body is *dynamic and exists in the world.* While his description of the lived body does not necessarily consider how the *distinct ways*, in specific persons, are intertwined with other experiential dimensions and how subjects uniquely *understand their lifeworld as a dynamic and everchanging process,* his account already hints at the fact that body and world are, indeed, intertwined. Furthermore, subjectivity is embodied and thus also depends on how specific sensorimotor arrangements may lead, or not, to distinct possibilities of action.

Also, the body is usually 'embedded' in certain worldly situations. The fluid capacities of the lived body's sensorimotor processes also depend on how attuned the subject is, or not, to his surroundings. The lived body creates or restricts lived space, depending, for instance, on factors such as illness or other physical restrictions. As we shall see, several disorders and diseases (such as schizophrenia) may alter this typically immediate and fluid embodied attunement the subject has with him or herself and the world. For Merleau-Ponty, "the body is the vehicle of being in the world, and, for a living being, having a body means being united with a definite milieu, merging with certain projects and being perpetually engaged therein". (17, p. 84). So, the lived body seems to have a fundamental relation to the world and

[2] Some authors include, for example, Michel Henry, Marc Richir and J-F Lyotard, among others.

its objects. It is directly related to, and thus also affected by, the world. Hence, the entire body is not "formed" of different parts of which each has another function. Instead, it does operate as a whole, a system that is integrated within the world. This system is constituted of experiential and more subjective aspects and cognitive processes such as action, perception, thought, and affectivity. These two domains of experiential/inter-relational and cognitive processes are not be presumed to be working on different "levels", independent from each other; rather, they are intrinsically intertwined, continuously functioning interchangeably.

For Merleau-Ponty, perception is thus linked to one's actively engaging with objects (and others), in the world. This means that our perceptual experiences are not merely created and only representations of objects perceived in the world, but they are somewhat intentionally connected to the active perceiver.

For Merleau-Ponty (17), perception occurs via a direct and embodied recognition of the world around us, through the lived body and other senses. I can grasp and perceive my surroundings, utilizing a vast array of interconnected processes of both experiential and cognitive nature. Perception is a dynamic process in which subject and world are frequently interwoven. What we perceive is thus very much related to an intimate sense of practical significance in which one realizes what the world itself offers as a place of action-filled possibilities. I can "organize" my perceptual experience in ways so that these are almost *one* with a specific project or action that I wish to carry out. Hence, it is quite clear to see that perception necessarily involves bodily and thus, sensorimotor skills. These possibilities for meaningful and immediate agency *readiness* also go astray in schizophrenia. So, bodily action is here, too, fundamentally based on the notion of using different sensorimotor skills, to carry out a diversity of action related processes. The lived body thus has, for Merleau-Ponty, abstract as well as concrete movements. Concrete movements function centripetally concerning the physical "objective" body, abstract movements centrifugally.

Interestingly, Merleau-Ponty (17) also mentions the notion of *structures of behavior and experience*: these refer to the idea that many times, a subject's ordinary engagement with the world occurs via patterns of habits, behaviors, and other processes. For Merleau-Ponty, structures are what define *how* we engage with the world. This engagement is ongoing and constant; the world is always soliciting us to participate in various forms. Hence, the subject must continuously re-evaluate and re-structure how he is in contact with the world. Of course, this evaluative movement is not always, possible, yet the idea of an ongoing and

embodied dynamic contact with the world fundamental for the enactive approach in cognitive science, which I will outline in the third chapter. The idea that processes such as agency, perception and intersubjectivity arise out of the subject's constant entanglement with the world is crucial for the argument developed here, since alterations in one dimension will most likely influence how the other dimensions are experienced, as well, given their inter-relatedness. The body's fluidity and capacity for being active in the world, of being a fluid medium through which we may even engage with others alters in schizophrenia, albeit quite differently. For instance, contemporary research has coined schizophrenia as a disorder of disembodiment (18). Before moving on to outlining the next theoretical framework, I will discuss one of the most essential phenomenological and enactive dimensions currently investigated in the context of interdisciplinary research in schizophrenia: the self. In this thesis' framework, it is crucial to recognize selfhood and its alterations as an experiential dimension that is influenced and influences other dimensions, such as agency or sense-making, in particular ways.

1.3.2. The Self

The notion of selfhood is a rather complex one, making it difficult to discuss all related philosophical nuances of it here, so I will focus on two authors who have developed thought-provoking philosophical frameworks applicable to research within psychopathology, more specifically schizophrenia. Let me begin by outlining how two authors, Dan Zahavi (19) and Shaun Gallagher (20) have developed their theories of selfhood, which, I believe, are entirely complementary to what I seek to propose in this project, regarding the heterogeneity of the alterations of selfhood in schizophrenia. Given the aim to offer a more integrated account on how the sense of altered selfhood in schizophrenia influences, in a unique manner, other experiential dimensions, I believe these two authors lay the foundations for a more *dynamic* understanding of how the concept of selfhood is considered to be an essential part of an approach to schizophrenia that aims toward *integrating* the variety of alterations present in this particular group of disorders.

The self is a central notion in contemporary phenomenology of subjectivity, intersubjectivity, and how these experiential structures are related to other phenomenological dimensions, such as embodied agency and sense-making. The self consists of a phenomenon which gives the subject the experience of feeling and perceiving his own “inner world”. It is

how the subject can, through reflexive or pre-reflexive stances toward himself, obtain immediate access to a variety of experiential sensations such as a variety of emotional experiences, for instance. For Zahavi (19), the structure of the self was initially conceived as being an intrinsic part of identity itself. For the author, different "kinds" of selfhood exist, from which it would be essential to highlight two. The first kind refers to the *narrative self*, which constitutes a fluid and flexible phenomenon that gives the subject an idea of how his historical narrative was and is construed (19).

This type of self is connected to what I understand the phenomenon of selfhood to be, namely not a static or somewhat fixed phenomenon, but rather as an everchanging subjective feeling of many parts of a transitory identity that continually changes, given the context in which the subject currently finds himself in, and how this actual perception of selfhood is a result of the intertwining of a variety of interlaced moments that also constitute how the subject sees himself. This self is thus formed by very *singular* characteristics and perceptions one has of oneself, and how these have changed over time. Thus, from the perspective developed in this project, the feeling of altered selfhood is always influenced by how the schizophrenic subject understands himself concerning the alterations that occur in his specific context. This means that alterations in the sense of selfhood of one particular patient might arise in an entirely different manner from the alteration experienced by another patient. The continuous dynamic intertwinement between subject and world gives this sense of selfhood its everchanging characteristics. It is moulded by how a subject is influenced and influences his environment and others, for example. However, the self may also be understood as a more intrinsic and somewhat "static" phenomenon, which give subjects a fundamental sense of being themselves. This makes it crucial not to take more inherent characteristics of the self in an *essentialistic* manner: even if there is space for very singular traits of one's personality, these traits are, at least from my point of view, also influenced by how the person understands and finds himself connected to a world that continually changes, thus altering subjectivity and the contact with the world, continuously. Even if only subtly. This particular "kind" of more static self has been coined, by Zahavi (19) and others the "minimal", or basic, self. This experiential structure gives the subject constant and immediate access to himself. The primary sense of self is experienced pre-reflexively, that is, subjects are perpetually aware of it through a direct apprehension of their inner experiences in general. This feeling of "being oneself" reflects with the most immediate and primary sense the subject has of being a unique individual which is intrinsically connected with his own subjective and worldly experiences, and how these affect

his sense of being an "I". This core sense of self cannot be disconnected from experience itself, given that it is this experiential structure that gives the subject immediate reference to the fact that a specific cognitive process or conscious act, such as perception, belongs to himself and not someone else. This is the pre-reflexive aspect of the basic self: when I feel a sudden bout of pain because I just stepped on a nail, the *feeling* of that pain is immediately available to me, in a sense, and they will be non-inferentially connected to me (19). The experience of pain is directly felt by me, not represented by an image in the brain of what pain "means". I have an immediate feeling of "what it is like" to experience the pain of stepping on a nail. However, this *pre-reflexive* sense of self is not yet able to thematize the experience as it is felt by the subject, per se (19).

The *reflexive* sense of self, on the other, presents itself as a structure that makes explicit the actual object such as it is experienced, which gives the subject the capacity of reflecting over that experience. So, it becomes easier to understand the dynamicity between the pre-reflexive and reflexive senses of "I": pre-reflectively, the sense of "I" is given to the subject as an immediate structure of felt experience regarding his acts, perception and so forth. The reflexive sense of "I", on the other hand, thematizes the lived experiences of the subject, giving him the ability of understanding and assessing *what* that specific experience is about. In this sense, the subject can be immediately aware that he is the agent of his actions, while also understanding *why* he is acting or feeling in a specific way, thus *transferring* to his consciousness the "aboutness" of that experience. For this project, it is essential to take both the pre-reflexive and reflexive *selves* as interlinked phenomena. I do agree with the more general description Zahavi (19) provides for the minimal and basic self; however, I believe that the minimal self is also modified continuously, given the fact that one's sense of selfhood changes given that subjects, in various degrees, relate to others and world, which in turn influence how one relates to one's feeling of being oneself. Importantly, I am not arguing that there might not be very singular selfhood characteristics that remain relatively stable throughout a lifetime. I just wish to highlight that it is crucial to keep in mind the interconnectedness between self (subject) and the world, which brings about processes such as subjectivity itself and agency, for instance. Even if this usually constant intertwinement is disrupted, as is the case in schizophrenia, it is vital to remain attentive to the *how and in what context the disruption occurs*, after all. Simultaneously, the sense of selfhood may have been altered; the patient's feeling of agency may remain more or less functional. This dynamics will already influence the entirety of the dynamic configuration between experiential and symptomatological phenomena.

Let me know turn my attention to the framework that Shaun Gallagher (20) calls a *pattern theory of the self,* where the author puts forward a more integrated system of a variety of interrelated selves. This framework is similar, in many ways, to what is also being proposed in this project. Gallagher argues that a pattern theory of the self would have to include aspects and characteristics of different selves, brought together to form a more comprehensive feeling of selfhood. Examples comprise, for instance, of the narrative, existential, cognitive, affective and intersubjective selves. For Gallagher, it makes much more sense to focus on how these complement each other, rather than think of each self as a separate and distinct experiential phenomenon. The author believes that these aspects could then be organized into patterns, which would if understood as a complex, yet interrelated grouping of characteristics, lead to a more integrated sense of selfhood. Gallagher (20) illustrates his argument using a pattern theory of affectivity. For the author, a grouping of specific aspects characterizes a particular emotion. However, the author also points out that such a theory should not rely on an "essentialistic" approach, which takes specific aspects to be necessary for the presence of a particular kind of self. Instead, the concept of self should be acknowledged as having a sufficient number of features that form a pattern that can be presumed as being a more integrated self. An essential characteristic of this pattern theory is to be found in its dynamic and temporal nature.

As Gallagher puts it,

> On this view selves operate as complex systems that emerge from dynamic interactions of constituent aspects. It may also be the case that self-patterns draw from components that, like the components of emotion, are set up as evolutionary adaptations. Indeed, emotion-related aspects may contribute to the constitution of a self. Different selves are constituted by different patterns, but within one individual these patterns may change over time. (20, p. 3)

This excerpt points to something fundamentally important: the fact that the sense of selfhood, in itself, should not be understood as a kind of "static" structure or phenomenon. As Gallagher says, different patterns constitute different *kinds* of self, and these may change over time (20). In schizophrenia, I would like to point to the fact that I do not mean to claim that all aspects of these patterns continuously change *all the time,* but would indicate that there are certain *degrees and intensities* in which these changes could occur, depending on how these selves also related to other experiential and symptomatological and dimensions, such as the

various possibilities of making sense of a specific situation, for instance. Thus, it would be essential to disentangle how the feeling of selfhood is actually affected, and accordingly changes, in a given context. The aggregation of specific characteristics of the various patterns could lead to a more salient feeling, of, say, the *sense-making* self. In another situation, aspects of the intersubjective self may take the lead. This heterogeneity and interrelatedness of elements present in different *kinds* of self are crucial for a more comprehensive understanding of the alterations present in the sense of selfhood and world in schizophrenia. Thus, no *kind* of self should be understood as being *over and above* the other selves. Instead, they influence each other equally, even if in different ways, depending on how the subject is currently attuned with himself and the world. This influencing also occurs in various degrees of strength which is also valid for other experiential dimensions, such as sense-making. These dimensions may also have intrinsic or singular characteristics, which also change over time, depending on the intensity and frequency in which they occur and the patient's lifeworld.

One more crucial point is that one's sense of selfhood is usually also very much intertwined with the world itself, regarding space as a possibility for meaning, and action, two other fundamental experiential dimensions discussed in this thesis. Legrand (21), for instance, argues that the feeling of experiencing oneself as a subject does not come from the fact that there is a kind of intentional self-consciousness that is aware of itself, and requires both pre-reflexive and reflexive stance to do this, but rather that the subject can experience himself as being an "I" through intentionally perceiving objects in the world. She believes that the subject is open to the world in his intentional embeddedness, he can *grasp the world* and its meaning, through embodied attunements. This is fundamental for the integrative approach developed in this project, given the interrelatedness of all dimensions (and its alterations) involved in schizophrenia. In a bit more detail, let me now discuss how the self should also be understood as a relational and intertwined phenomenon, specifically intersubjectivity.

1.3.3. Intersubjectivity in Phenomenology

Intersubjectivity is one of the most critical dimensions investigated and discussed, in this project, given the importance, here, given to the fact that this experiential layer is also deeply intertwined with how we act and take meaningful stances toward ourselves and the

world. Humans are in constant contact with others, in their surroundings, and beyond. The connection with other persons is not one that occurs passively, nor through any kind of theory of mind founded on the claim that we are able, through inference and "mentalizing", understand and "perceive" the minds of others. However, some contemporary philosophers and scientists would argue, that intersubjectivity occurs through direct embodied contact (22). This contact depends on a variety of possible engaged bodily attunements or not, on how our gestures and expressions are arranged, when in relation with the other. From a phenomenological and enactive perspective, intersubjectivity, which will also be further discussed in a section apart, presupposes a direct and meaningful engagement in various contexts and forms. We find ourselves attracted or repelled toward others and situations, depending on our current affective attunement and social norms and values, for instance. While we develop our ways of dressing, communicating, and approaching others, our interactions also profoundly shape our thinking and acting ways. This is where an essential connection to the other phenomenological dimensions investigated in this project can be made. For instance, intersubjective relations are usually thoroughly meaningful-they make *sense* to us. Otherwise, they would simple they would be interactions devoid of any resonant quality. Through embodied intersubjective relations, we can integrate new patterns of interacting with others, acquire new understandings about how certain norms and values are embedded in different cultural settings, and so forth. Gestures and expressions are thus also deeply intertwined with other processes such as perception and action. While embodied intersubjective connections are not always necessarily "active", as in a dance class, intersubjectivity is formed through the many ways we contact others, be that in a conversation, during sexual intercourse, a handshake, or other forms of interactions.

Gallagher (22) develops an interesting phenomenological viewpoint of intersubjectivity, which differs substantially from the theory of mind approach, which is usually the foremost framework in the contemporary philosophy of mind and cognitive sciences. The traditional *theory of mind* approaches, such as the "theory-theory" framework, put forward arguments on how we make theories based on how people behave and then infer their beliefs, thoughts, and so forth. Another somewhat *disembodied* perspective on intersubjectivity can be found in the "simulation-approach", which is based on the idea that no theory of mind for others' understanding is needed since we can "put ourselves in the other's shoes" and then *simulate* how the other person is feeling. For Gallagher (22), however, our understanding of others is not inferential, nor based on the capacity of manufacturing the other's feelings. Accordingly, the

other person's thoughts and feelings are not “hidden within”, but available to us through direct embodied interaction. This means that we can “feel” the other's sadness, by seeing, for instance, how the person's posture is curved, their eyes might have a somewhat “frozen” stare, or else. It is not possible to exactly know what is going on inside the other's mind; however, through attuned embodied interaction, it becomes quite possible to at least have a good idea of how the other one is feeling and what he or she might be thinking about. Also, Gallagher says that we do not only observe others but somehow engage with them, through means of second-person interaction.

Gallagher (22) also believes that interaction occurs embedded in specific socio-cultural contexts. Intersubjective interactions are not just embodied, but, he says,

> (…) embodied action happens in a world that is physical and social and cultural and political; a world that reflects not only perceptual and affective valiances, but also the effects of forces and affordances that are normative and social. (22, p. 64-5)

We interact with others by being thoroughly affected by them and what they do and how they relate to ourselves. However, others' immediate ways of being affected are entirely laden by the values of specific cultural and sociological backgrounds. The interaction we have with others very much arises, so Gallagher, of a second person perspective, in which we do not merely observe what someone else is doing, but engage with them in various ways. We are attuned to gestures, expressions, projects that we may be developing with a friend or colleague, and so forth. We do not merely imagine or represent what we want to do together with someone else. Still, we indeed act and understand each other in a dynamic way that is neither just observational, nor subjective, but rather, engaged in an attuned manner. This second-person perspective is also dynamic since it presupposes a relational stance two or more people might have with each other. For Gallagher,

> ...the mind is “out there” in our actions and interactions, in our gestures and communications, constituted in our engagements with the world and with others. Second-person minds are supported by context, situation, and the social roles in which we, as agents, are engaged. In most of our everyday situations we need go no further in order to gain an understanding of the other. (22, p. 118)

This quote is in alignment with what I propose in this thesis, namely an understanding of altered experiential and symptomatological phenomena in schizophrenia that is based upon a perspective that considers the interrelational nature of both phenomena a dynamic way so that it considers the singularity of how a specific patient relates to others and thus experiences alterations in intersubjectivity and the world. However, modifications in intersubjectivity will also influence any other alterations that might be present in a particular case. For instance, changes in intersubjectivity may alter how a patient understands and accesses and understands his reality (sense-making), which, in return, may also present itself in a very particular way, given the particular characteristics of a hallucination that a patient might be experiencing. So, it would not suffice to gain an in-depth *descriptive* understanding of the alterations of schizophrenic intersubjectivity. Neither would it be enough to simply assess a case by considering that specific difficulties in engaging with the world others are present. Preferably, alterations of intersubjectivity should be integrated into the specific dynamic configuration of the patient, which may also be connected with modifications in other experiential and symptomatological dimensions.

One more author that supports the argument toward a dynamic understanding of intersubjectivity is Dan Zahavi (23), who also offers exciting alternatives for the understanding and relating to "other minds". For the philosopher, one must go beyond the traditional "internal" X "external" discussion on whether intersubjectivity occurs in either of these realms, but rather focus on the idea that intersubjectivity occurs intentionality, that is, there is no need of inferring someone else's state of mind. Instead, understanding the other is based on their immediately perceivable bodily expressions, gestures, and so forth. For Zahavi, a particularly challenging approach to the problem of intersubjectivity lies in the fact that humans can be *empathically* attuned to each other. However, this empathic attunement is different from the inference and the simulation approaches to other minds. Instead, Zahavi (23) argues here that through the specific mode of consciousness of empathy, it becomes possible to perceive the other in his embodied comprehensiveness. Sensing the other is thus never merely trying to infer or describe what the other is feeling, but *feeling*, also through the lived body, what the other person is saying or expressing.

For Zahavi (23), it is crucial to focus on the triadic structure of intersubjectivity. Subject, world and others are intertwined, and it is only by considering that it becomes possible to understand the many ways in which we can relate to others. This idea also very much relates to what is at stake in this project: alterations in the various dimensions in schizophrenia do not

occur “within” or “without”, but are interrelated with changes in other experiential dimensions which are unique to each patient, as well as broader, more universal aspects that might influence each specific case, such as a variety of socio-cultural factors. As De Haan (24) interestingly points out, it would maybe make sense to replace the idea of a *minimal* self with that of a more *basic* self, so as not to think of the self in an essentialist way in that it is somehow cut off from its social and relational aspects. Kyselo (25) argues for something similar: in her perspective, subjectivity is already social, since it is constituted by a sense of “mineness”, which relates to one's sense of selfhood, and an “openness”, in which selfhood extends on to the social world. I agree with De Haan and Kyselo since their proposals offer a less “fixed” and static perspective on selfhood. Such perspectives also align, from my point of view, with the fact that the heterogeneity of alterations in the sense of selfhood in schizophrenia can be more thoroughly understood if they are put in the context of each case and also connected with alterations (or not) in the other dimensions and symptoms investigated.

After having presented the most important dimensions investigated in this project, I will outline the second theoretical framework, which is complementary to that of phenomenological psychopathology, namely; enactivism. The most important claim to keep in mind here is the fact that both frameworks complement each other: it does not seem to suffice to just describe and investigate the structure of altered experience; instead, this first-person perspective must also be brought into perspective with the fact that subjects are frequently in meaningful attunement with the world, through a variety of processes such as action and perception. Enactivism (26) is thus a useful tool to bring together both description of altered experience and the world and a more objective approach that organizes symptoms in schizophrenia by groupings of disorganized speech, positive and negative symptoms, for instance. A dynamic and interrelated approach contextual toward schizophrenia would thus also not be based on a “top-down” hierarchy of phenomena and alterations that begin in a specific place, say, in the brain, and then bring about other alterations in different dimensions. No, the horizontality and interconnectedness between experiential and objective phenomena focus on their mutual influencing, presence, heterogeneity in content, and intensity.

1.4. Toward a Dynamic Understanding of the Psychopathology of Schizophrenia

1.4.1. Defining Enactivism

Enactivism provides a promising alternative to classical understandings about the mind and its relation to the subject and world, because it enlightens the dynamical character toward subjectivity, cognition and its alterations, in psychopathology. While psychopathology does focus on altered and worldly subjectivity, it is exactly this dynamic character that enactivism brings to the fore, here, mores specifically, in schizophrenia. (26). While phenomenological psychopathology does consider the importance of subjectivity, it still somehow maintains a "one-sided" ontological position regarding experiential life. It remains focused on the description and not too much on how the structures of experiences are interrelated. Intersubjectivity, for instance, constitutes a crucial phenomenological dimension overall, also investigated in this framework. However, enactivism seeks to further deepen the interconnectedness of the subject-world-organism (body) triad, by insisting that subjects bring about subjectivity and other processes such as perception through their constant engagement with the world. Enactivism highlights that experiential life and more objective processes such as behavior are understood to interconnected phenomena, which influence each other differently. So, phenomenological psychopathology is interested in thoroughly describing alterations in experiential dimensions, enactivism focuses on the *dynamic and everchanging* aspect of how subjectivity, life and cognitive processes such as perception, occur. For instance, Gallagher (22) argues that perception and other processes that give subjects the feeling of *being themselves* or *experiencing something are closely intertwined* with bodily sensorimotor knowledge. Crucially, this bodily knowledge is not necessarily to be understood as objective behavior, but also as a lived body that engages with others and the world in a wide variety of ways. This approach is thus more dynamic since experience, here, depends on active bodily engagement.

Interestingly, though, for traditional and some contemporary approaches in the cognitive sciences, the brain was and still is understood as the main locus of cognition. These posit the "mind" to be a phenomenon constructed and brought about by the brain and its neuronal network. Accordingly, cognitive processes are mostly thought of as being

disembodied and that the body/organism would only play a secondary role in most cognitive processes, or none at all. This is also somewhat still present in contemporary psychology and psychiatry: authors like Insel (27) argue toward an understanding of mental disorders that occur mainly "within" the brain, focusing on alterations that might be present in specific neurophysiological pathways. Alternatively, regarding psychotherapeutic theories, such as psychoanalysis, for instance, the mind is still driven by unconscious desires and drives. More embodied approaches, such as brought forward by Roehricht et al. (28) try overcoming this still very general comprehension that aims at explaining mental disorders reductively.

Enactivism aspires to interconnect the mind (subjectivity), body (organism) and the world, and, consequently, the alterations in these dimensions. Thus, it is crucial to point out that I also take psychotic disorders not to be solely brain diseases, but rather a group of illnesses that occurs in quite distinct configurations and their contextual singularity. Such a non-reductionist approach is a consequence of the enactive approach, since it aims to integrate alterations in subjectivity, body and organism (13). So, I believe enactivism helps pointing to a perspective that integrates that even persons with schizophrenia somehow "make sense" of the world through contextually dependent or independent situations they might find themselves in. Persons with schizophrenia are also inserted in a world, albeit a different one. Usually, subjects organize and regulate cognitive processes through an active, ongoing and dynamic relation with the world. The outcome of a specific action, for instance, depends on the regulation and functionality of the entire organism, its adaptability (or not) to the environment, and so forth. Varela et al. (26) developed the concept of *operational closure,* an idea borrowed from systems theory that refers to the fact that living or cognitive systems have a self-regulating and organizing arrangement that allows for various cognitive processes to take place. It is the organism itself that regulates action, perception, thought and other functions.

However, in humans' case, it is not only the functionality of the organism that brings about these processes, but the relation physiological and organismic events have with phenomena that belong to the realm of human experience. It is because of this that there can be no mind/body/world divide: instead, whatever happens in one dimension, will undoubtedly affect the rest, as well. So, enactivism shall provide the more all-encompassing epistemological "glue" that brings together accounts of subjectivity, more objective schizophrenic symptomatology, such as positive or negative symptoms and the world (sociality). Thus, the main point is to gain a more all-encompassing apprehension of the alterations of subjectivity and world, it is fundamental to point out that subject and the world and interlinked, depending

on factors such as (in)capacities of embodied action or sense-making, for instance. While it is a fact that alterations occur, these frequently *change*, depending on how a patient might be making sense of his surroundings and acting in it, for instance. Significant relations to the world are only built through constant interaction with it, in different ways. Enactivism thus helps to bring together the seemingly disconnected array of alterations found in persons with psychosis, arranging into a whole encompassing framework, more specifically the dynamic interrelatedness between altered symptoms and experiential phenomena, within the singular configurations (and context) of each patient. Importantly, enactivism does not simply take schizophrenic symptomatology and altered experiential phenomena as static phenomena, but rather as interrelated and everchanging alterations that continuously influence how the subject might be able to understand what is happening to himself, and how this influences his entire being in the world.

Nowadays, the diversity of theoretical frameworks that arise and are interlinked with enactivism are many, so that, for this project, I will mainly focus on the work of Varela et al. (26), Thompson (29), Di Paolo et al. (30) and others, who argue that cognition is profoundly embodied. These authors follow along with the principle of self-organisation, in that a *mind and life continuity* exists, which, very roughly, assumes that many of the processes found in different living systems. While the process of self-organisation is quite different in different systems, the principle of self-organisation is similar, since it describes the self-maintenance of an autonomous system (or living being).

From basic needs such as having to eat to more complex processes like imagining, this interaction between subject and world matters for the variety of cognitive processes the subject can perform, depending on their embeddedness into a specific context and their socio-cultural background. Given that this project's focus is schizophrenia, it aims to clarify the modifications occurring between the subject with schizophrenia, his altered world, subjectivity and symptomatology, and how this happens in various interrelated ways. An example of behavioral modification that can be found in this project is that of agency, for instance. This particular process depends on the fluidity of particular corporeal schemas and sensorimotor dispositions, which give a subject the capacity of engaging with his or her world, affectively and through direct normative access (*sense-making)* which will provide the subject with a precise understanding of what he or she is doing. The concept of sense making will be further developed in section 1.4.3.

For enactivism, there are basic concepts which relate to one's sense of self, identity and agency, which are intrinsically interrelated. These concepts give the subject a fluid feeling of having an integrated identity which is in constant contact with the world. The other important concept is that of cognition (behavior) for enactivism, which is deeply ingrained with significance. Subjects usually regulate their cognitive processes by adapting to different circumstances. Varela et al. (26) developed the concept of autopoiesis, which describes human beings' capacity (and simpler organisms) to auto-regulate themselves through their organismic systems. This is also related to the notion of operational closure and how humans are *coupled* to their environments, through relations to others in a more complex and abstract way, or satisfying basic physiological needs such as eating (26). The very act of eating is an essential and necessary human physiological requirement, needed for molecular energy so that more complex organismic needs can be fulfilled. Basic and more complex processes are, for enactivism, also intertwined, since they occur both circularly (in contact with the world) and vertically ("within"). The concept of operational closure relates to the fact that living systems, in our case humans, are self-sustaining from "within". Thus, living systems are constituted by several components that interact with each other and give rise to various processes, such as agency. For these processes to sustain themselves, the system may need to be in direct contact with the outside, to gain energy and matter such as the example of food, as mentioned above. However, it is still able to maintain a constant self-organizational constancy (26).

The arousal of meaning, a sense of selfhood and processes such as agency are, for enactivism, of a profound dynamic nature. They are not simply static features of one's identity or the environment, but rather interconnected phenomena that give the subject a particular experiential and cognitive perspective about himself and the world. This dynamic nature encompasses sense-making and accommodates the idea of operational closure, bringing to the fore the circular loop of the living system, with the fact that it is also *dynamic*. Processes such as action, perception and a variety of other functions arise in patterns. They may change over periods, depending on how the system adapts to the environment, its biological needs, and how the current existential meaningful attunement (in humans) to the world is. Cognition thus does not arise out of an "input/output" exchange of information with the environment, as if it were structured exactly like a computer, but in the constant circular interaction, the living system (subject) has with the world (29). Behavior, in general, and the processes mentioned above such as perception, thus need to be understood in terms of *complexity*: that is, behavioral structures do not present, all the time, a linear way of functioning, but may also occur in irregular patterns,

depending on how the system is coupled with the world (environment), or not. Patients with schizophrenia may present a variety of disruptions in their feelings of agency, depending on their possible attunement with the environment as well as difficulties in understanding the meaning of certain happenings in their surroundings. This difficulty may relate to specific positive symptomatology (e.g. hallucinations) that may be present at a specific point in their illness.

It is important to continuously keep in mind that dimensions and processes, as investigated in this project, such as selfhood, agency and sense-making and intersubjectivity, also arise from the constant exchange the subject has with his world and how he can adapt to certain situations. *Becoming* human depends on various fundamental and complex necessities and processes, which cannot be separated. When disruptions in this ongoing process between the living system (human) and world occur, mental disorders may arise. I wish to point to the fact that both more objective aspects such as altered behavior or thought as well as alterations in experiential dimensions such as intersubjectivity are related to each other, thus influence how the illness progresses, stagnates and how the patient can engage with the world, how he or she relates to his symptoms, meaningful experiences and so on, thus accessing reality in unique ways. These ways of accessing reality may be fragmented, *yet they still exist*. It is the everchanging dynamics between schizophrenic subject and his world that need to be thoroughly investigated, since phenomena such as delusions or hallucinations are not just "static" productions that appear in certain phases of the illness only. However, they change in frequency, intensity and the nature of their contents, even subtly, throughout the illness.

1.4.2. Enactivism, the Network Perspective and Schizophrenia

In severe psychopathology, more specifically schizophrenia and the disorders within this spectrum, the complex intertwinement of experiential and world bound processes often goes astray, in different ways. However, it needs to be said that these alterations do not only occur in degrees of *severity*, but the way in which alterations influence each other is also crucial. These alterations depend on how the person is afflicted and on whether their contact with reality has been severely affected, for instance, on whether the possibility of interacting with others is present. As said above, various cognitive and experiential processes arise from

the coupling humans have with their environment. Thus, it could be said that the dynamic interrelation between subject and world opens up a specific personalized configuration of a network interconnected system that affects the subject world in an everchanging manner.

Authors such as Borsboom and Cramer (31) have developed a heuristic framework for understanding the dynamic aspects of mental disorders, which is based on the idea that symptoms, in mental disorders, are causally interconnected with each other.

That is, no symptom, from the authors perspective, is taken to be a solitary causally efficacious phenomenon, such as a disruption in the flow of dopamine, for instance. Symptoms are instead to be seen in a complex intertwinement between each other. These related symptoms may also reinforce each other through intensity, given their role within the broader complex system of interactions. In the author's words,

> Instead of passive receptors of the causal influence of a medical condition, symptoms are causally active ingredients of the mental disorders themselves (31, p. 96-7).

Such an approach already points toward the fact that psychopathological symptoms, be these of more subjective or behavioral nature, should indeed be taken as dynamic phenomena that appear, within the context of a particular case, as heterogeneous and interconnected.

Schizophrenia would appear as a system of intertwined symptoms, both subjective, worldly and more objective, mutually influencing each other. Importantly, also, there is no "top-down" or "bottom-up" hierarchy between the causal influencers, but instead a horizontal interconnected system in which each variable (here symptom) sustains equal importance. The structural basis of the network is described by Borsboom and Cramer (31) as follows:

> Networks consist of two building blocks: nodes and edges. Nodes are usually visualized as circles and represent any conceivable variable (e.g., symptoms, persons, airports, neurons). Edges are lines that connect these nodes, and they can represent any conceivable sort of relationship [e.g., (partial) correlations, odds ratios, neuronal connectivity]". (31, p. 98)

These nodes and edges also represent a fascinating challenge: the kinds of "building blocks" also present different characteristics. In the case of schizophrenia, they may, for instance, relate either to an anomaly with a neural circuit, or to the more phenomenal experience

of joy. The crucial aspect here is to take their interconnection seriously, so that the more comprehensive network may be analyzed in a more personalized and contextual manner. For instance, a certain kind of causal network might support the other, or not, depending on whether it is present in the system, and *on how it may be present and influencing the others.* This is where Borsboom and Cramer' (31) framework meet an important proposal of my project: to investigate the dynamic and everchanging alterations of subjective, worldly and symptomatological phenomena in their interconnection and from a relational perspective. It is essential to understand how changes in the experiential layer of say, selfhood, alters and influences sense-making changes. Thus, such an approach would go beyond a merely descriptive and static approach, binding together experiential, neurobiological and symptomatological alterations present in schizophrenia, in a particular case.

This dynamic network-system approach by Borsboom and Cramer (31) also supports the enactive framework, in that it focuses on the dynamic interrelation between the subject (self), world and organism. This triad, also in the case of mental disorders, cannot be dismantled, given that this would lead to reductionism, be it of experiential or neurobiological nature, thus also applying to more traditional psychopathology. The conceptual framework of enactivism is vast, but to focus more specifically on some of the processes gone astray in psychosis and, more particularly, in the patients which have been interviewed for this project, the focus here is to show the interrelatedness of the three dimensions already outlined above (selfhood, embodied agency, sense-making and intersubjectivity). The enactivist concept of sense-making relates to how living systems (here, humans), generate meaning in the world. This concept generates meaning regarding goals by the living system, primarily self-preservation, but also more diverse meaning with increased complexity. This meaningful attunement occurs in different ways and will be further outlined in the next section.

Regarding enactivism and psychiatry, I would now like to point to De Haan’s (32) very thought-provoking work. The framework the author suggests is based on four interrelated dimensions which should all be considered if a more all-encompassing theoretical framework for mental disorders is to be delineated. For De Haan, the first dimension psychiatry needs to consider investigating are *experiential* aspects of the patient's narratives. The second dimension refers to the *physiological* elements that need to be considered. These include genetic, neurological and other bodily processes which may be altered, given a particular disorder. The third dimension De Haan includes in this group is that of the *socio-cultural* realm: here, it is essential to recognize the fact that external factors, such as the patient's relations to others and

the culture in which he finds himself in, among others, may influence the originating of the illness. Finally, the last dimension refers to the *existential* sphere, which is associated with the fact that humans *make sense* of themselves, and the context they find themselves in. De Haan (32) says that,

> From an enactive perspective, the complex system of a person in interaction with her world can thus become disturbed in many ways, involving factors from any of the four dimensions. There is no reason to regard only some factors (notably physiological processes) and not others as causally influential. Moreover, the relevant quest is not to uncover hidden mechanisms behind or underneath disordered patterns of sense-making, but rather to find out (1) how such patterns develop, and (2) how they persist and solidify. Regarding the first aim, the complexity and dynamics of the system make it likely that a combination of factors are involved and that there are a variety of developmental trajectories leading up to the disordered pattern. Secondly, it is not only the developmental factors that are relevant, but also those factors that maintain the disturbed pattern, as well as the factors that provide a positive influence. (32, p. 286)

This quote is worth exploring in further detail since it markedly shows how many complex psychiatric disorders are. Psychosis certainly figures in this group, prominently. The author argues that this complexity can be disentangled and made clearer from an enactive perspective, a framework I will outline in the forthcoming section, also relating it to psychosis, more specifically. De Haan (32) argues that the diversity of factors that needs to be considered if one is to argue for a more context-oriented and pluralist account of mental disorders is not to be kept apart or cut off from each other. Instead, these factors are interwoven and mutually influence each other in the broader context in which a specific disorder occurs. So, it is not as if one element, say a social one, bears more importance than others, such as neurobiological or subjective ones- they are connected and influence how psychosis develops, in a dynamic way.

The author defends an understanding of psychiatric disorders that are to be considered from a *global* to *local* or *local* to a *global* perspective, in which aspects that show more local alterations, such as modifications in specific synaptic dysfunctions are equally as crucial as dysregulations of the person's impossibility of connecting well and meaningfully toward others, for instance (32). So, no symptomatological, experiential or functional (cognitive) aspect can be taken to be over and above all others, in regards to causal importance

and (dysfunction, but is rather interwoven with all other possible facets that are involved in the how the psychiatric disorder originates and develops.

The overall dysregulation of these domains in psychosis thus takes on a very particular presentation, in each case. I thus very much agree with De Haan's (29) proposal of a rather contextual and unique approach to psychiatric disorders, in this case, schizophrenia. The fact that specific symptoms and experiential alterations are present or not is not enough in a given case. Instead, the entirety of dimensions must be investigated and consequently treated. How the dimensions relate to each other is crucial. Also, their singular content and life context-related aspects, such as a job, should be investigated and how they change, over periods. So, some patients will be less severely affected by the many factors that contribute to the onset of the illness and development. Others, particularly those who continually present, at any given moment, more 'acute' symptomatology, seem to be much more compromised regarding cognitive regulative functioning, possible meaningful relation with the world and affection, for instance. The importance of assessing the changes in the subject with the world in a dynamic way, over time, is also clearly accentuated by De Haan (32):

> Secondly, relations are dynamic; they evolve over time. This requires another move of zooming out, one which enlarges the scope of the explanandum in time. It is not just the whole organism in its environment that we should look at: we should more specifically look at the organism in interaction with its environment. This interaction is a constant back and forth, acting and reacting, mutually adapting and changing. (32, p. 95)

Accordingly, in schizophrenia, I would like to point to the importance of investigating how the dimensions change and are interconnected, say, from the first psychotic episode, on to the chronification or remission of specific symptoms and experiential dimensions. It is essential to be attentive to how the schizophrenic person is affected by his environment, and how this, in turn, also affects both the experiential and physiological dimensions, in De Haan's terms (32).

I will now outline the important concept of sense-making, which in enactive cognitive science refers to how subjects meaningfully engage with their worlds, through reflexive and pre-reflexive stance-taking endeavours. The concept of sense-making is crucial

for a more nuanced understanding of how alterations in the patients' access to reality and general *meaning* occur.

1.4.3. Sense-making

It is first essential to characterize the notion of sense-making as it is used in this thesis. The idea that subjects encounter the world via a meaningful dynamic relation suggests that alterations in sense-making may influence alterations in the world, for instance, a specific social/cultural factor, which may also influence neurobiological components. How one phenomena or factor influences the other do not arise out of an ontological basis that prioritizes, say, the neurobiological over the experiential, but rather a circular and *enactive* perspective that would characterize a dynamic approach toward schizophrenia, in which neither the purely behavioral and symptomatic, nor an entirely experiential dimension has a priority of the other, regarding abnormal functioning.

This said, the concept of sense-making relates to the fact that living beings can bring significance to perceiving and acting, for instance. While less complex organisms encounter their environment via more basic needs, such as food and the need for shelter, humans can make sense of their world in much more complex ways. For a living system to maintain its most basic sense of autonomy, it needs to be in constant contact and interaction with the world. So, in humans' case, they can minimally sustain their own identity and develop different perspectives of meaning and normativity, which influences their behavior, how intersubjective relations are formed, and so forth (33). Given the focus of this project, mental illness, and more particular schizophrenia, the notion of sense-making comes into play in the case of hallucinations, for instance. In schizophrenia, the entire idea of the person's possibility of maintaining her sense of autonomy and identity (selfhood) becomes disrupted, since the person is often able to define the boundaries between herself and the world clearly. So, the intrinsic meaning and value-laden stance one can have toward others, and the world also suffers modifications. For now, I would like to discuss two more forms of sense-making, such as De Haan (32) proposes. Apart from the fundamental value and valence laden stance on the world humans have, which refers to more basic necessities, such as having to eat and sleep, De Haan develops a further kind of

possible meaningful attunement subjects have with the world, which she calls *reflexive* or *explicit* sense-making.

For the author (32), reflexive sense-making occurs whenever the more immediate and essential sense-making is interrupted, and one begins taking a more reflective stance on one's thoughts, for instance. This more complex form of sense-making is a characteristic of humans since most other organisms are not necessarily able of such complex and cognitive processes such as rational thinking and evaluating situations from different perspectives. The second kind of sense-making relates to reflexive sense-making, in that it opens up a world of meaning the person finds herself engulfed in. After it becomes possible to reflect on things, the meaning becomes intrinsically a part of how we act in the world and ourselves. Everything we do then becomes, in a sense, a part of who we are: how we dress and how we speak, for instance. This is fundamental, given that we find ourselves, during our lifetime, in a variety of situations that often need a complex moral appraisal. We do not only think about good or bad but also *why* a particular situation is bad. For De Haan (32), these "kinds" of sense-making occur in loops, that is, they are connected, depending on the context the person finds himself in. While most basic needs such as food are always necessary for the person to maintain a minimally stable exchange with the environment, more complex value-laden decisions depend on where the person finds himself and the goal of a specific situation.

Thus, sense-making is quite a complex process, given the very particular meaning, humans infer onto phenomena such as language. Accordingly, sense-making is also socio-culturally embedded, thus shaping many of our socio-cultural skills and capacities. Being able to make sense of things, both in the more basic form and through more complex processes such as language, is fundamental for humans because it gives them a grasp of the entire lived space they find themselves in. Meaning is also dynamic; it changes over time, always depending on how the person is in contact with the environment and how it changes and affects the person's sense of autonomy.

In schizophrenia, however, one's sense of selfhood, and thus a feeling of unified identity becomes fragmented. Often, the person cannot control some of her actions and unsure whether he thinks about his thoughts. These alterations lead to a modified perspective of the world, as well. De Haan (32) calls this interaction between subject and world the "person world" system, and it is precisely this entire system that suffers alterations, in schizophrenia. De Haan argues that in psychiatric disorders, the processes of sense-making become rigid, in specific

ways. That is, sense-making loses its immediate, meaningful unity, becoming fragmented or repetitive. The possibility of gaining insights into their life context is, for instance, something that gets lost, in schizophrenia. Blankenburg (34) describes a “loss of natural self-evidence” frequently present in persons with schizophrenia. This experience relates to a loss of one’s usually most basic meaningful attunement with the world. For instance, people with schizophrenia may lose an understanding of what it means to eat or brush one's teeth. Hallucinations are also experiences imbued with altered sense-making. It is the entire way in which schizophrenic persons encounter the world and others, that has changed.

Given the focus on the interrelatedness between experiential phenomena and symptoms, and how these are organized in a personalized configuration of mutual influencing, it is essential to point out that the alterations of meaning that occur between a schizophrenic subject and the world. Since intersubjectivity and agency, for instance, emerge altered, it is fundamental to consider meaningfulness and a sense of reality from a second-person perspective. That is, alterations in subjectivity will, I believe, also be influenced by *how* the patient with schizophrenia will access the world, given the particularities of the positive symptoms present, at a specific moment of the illness. However, the specificities of this access to the world and others change throughout the illness, depending on the severity of the experiential and symptomatic phenomena, thus having to be considered in a unified manner. Ratcliffe (35), for example, argues that the appearance of phenomena like verbal hallucinations and thought insertion can be traced to:

> (a) the modal structure of intentionality and its susceptibility to disruption; (b) the extent to which the integrity of experience depends on relations with others; and (c) the various ways in which erosion of trust, confidence, or certainty can come about. (35, p. 234)

For the author, these phenomena usually grouped within traditional psychopathology coins *positive symptoms* develop very heterogeneously. Importantly, however, Ratcliffe argues that they have strong intersubjective and relational characteristics. The content of phenomena like hallucinations may be perceived differently and have external factors influencing them, such as objects or others. The immediacy of one's access to reality and others is disrupted, in schizophrenia (35). The phenomena of trust and confidence, for

instance, usually permeate our intersubjective relations with others in that they are built upon a foundation of relationality between the subject and the world which is generally felt as being naturally experienced. In schizophrenia, a sense of loss of trust and confidence in the surrounding world and others may lead to a change in the patient's intentional and relational horizon to his surroundings. The background of familiarity and certainty in the world is shaken, which may provide the patient with a sense of not knowing if his surroundings and even himself are still what they used to be. Ratcliffe (35) also points out that phenomena like verbal hallucinations should indeed be inserted into a broad socio-cultural context. The meaning of these phenomena and how the patient accesses their world (reality), and others depends on how the *attunement* and the *way of functioning* the patient is having with himself and the world, at that moment. How disrupted feelings of sense-making then appear to depend on the incapacity a patient has of maintaining the dynamic *constancy* of the usual horizontal and circular intertwining between herself and the world. This constancy rests, for example, upon the capacity of acting meaningfully and of engaging with others. Ratcliffe (35) also says that,

> One of the things that distinguishes hallucinations from veridical perceptual experiences is that they lack the full horizontal structure of perception. An entity, as hallucinated, does not present itself as amenable to various kinds of perceptual, practical, and interpersonal access. (35, p. 196)

Ratcliffe (35) coins a "full horizontal structure of perception" and involves a circular and *integrated* dynamic structure in which a subject perceives an object or someone in the world by employing a dynamic and embodied interaction with it. When this circular and relational interaction is disruption, changes in sense-making also occur, give phenomena like uncertainty and doubt of whether a particular thought, object or else is real, or not. Persons with schizophrenia may thus be unable or at least find it difficult to distinguish between their thoughts and "reality", and that of others and the world, in general. So, the singularity of sense-making depends on how severely the dynamic relationality between subject and world is fragmented. *How* delusions and hallucinations appear is crucial, and how these can also be embedded in the patient's broader socio-cultural context, for instance.

Fuchs (36) also argues that alterations of intersubjectivity in schizophrenia also relate to difficulties in sense-making. The capacity of making sense and reflecting on specific issues that need intersubjective engagement depends on our attunement toward others and the

world. For the author, perception in schizophrenic delusion may, for instance, become subjectivized: reality itself becomes represented, objects perceived lose their intrinsic qualities, turning to *pseudo objects*. An inversion of the perceptual field's intentionality may occur, leading to a sensation of self-referentiality, given that perception lost its transcendental quality. Interestingly, the attributes of reality itself, as well as objects and others, are quite particular. There is the *how* a specific patient will understand his reality and surroundings, which then directly influences his sense of selfhood and feelings of altered embodied agency.

Everything considered I will now, after having outlined enactivism as an essential theoretical foundation which serves, in this project, to provide a more all-encompassing framework for understanding the heterogeneity of schizophrenia, outline phenomenological psychopathology. This approach focuses, mainly, on the thorough description of the altered structures of experience present in some of the realms investigated in this project, such as selfhood, intersubjectivity and embodied agency. However, as I have pointed out before, pure description would not be enough, rather, a focus should be given to thorough description *and the* interrelatedness of symptoms and experiential alterations.

1.5. Phenomenological Psychiatry & Altered Dimensions in Schizophrenia

Traditional psychopathology has broadly understood the symptoms usually present in psychosis in a nosologically too 'objective' manner, as I pointed to the in the first sections of the thesis. Symptoms may be, for instance, negative and positive. Also, speech and thought disorganization are essential features that may be present. Moreover, they are commonly evaluated through behaviorally “accessible” phenomena: they can be seen and perceived by the clinician, per se. Phenomenological psychopathology, on the other hand, is mostly preoccupied with the subjective or “first-person” phenomena present in psychotic psychopathology; for this framework, the main focus lies on whatever is happening “on the inside”: alterations in the domains and structures of selfhood, temporality, the body and others. A further, recently added, important “group” of phenomenological domains that are closely “bound” to both subjective and more behavioral experiences and phenomena is that of “worldly” and intersubjective alterations in psychotic disorders, as well as alterations in contact with the world (reality), which in this project also relates to the concept of sense-making, as introduced by enactive

cognitive science. As already pointed out above, these phenomena can manifest themselves in various ways but are closely intertwined, so that alterations in one dimension will likely also influence or bring about alterations in other dimensions.

Phenomenological psychopathology has been, for quite some time, an important scientific endeavour that can be traced back to the work of German philosopher and psychiatrist Karl Jaspers (37), which can be found in one of his most important textbooks, the *Allgemeine Psychopathologie (General Psychopathology),* first published in 1913. In his *opus magnum*, Jaspers outlines crucial concepts which are nowadays still diffused in clinical psychiatry and psychology. Since I have already presented Jaspers' most essential ideas in the first section, I would like to focus on the contemporary approaches to phenomenological approaches.

These approaches, which build on form Jaspers descriptive phenomenological psychopathology and Kurt Schneider's (3) focus on identifying pathological symptoms, begin pointing out that it is not enough to describe symptoms simply and bring together the various altered dimensions present in severe psychiatric disorders. Stanghellini (38), for instance, points to one more direction in contemporary phenomenological psychopathology, namely that of *structural* psychopathology. This phenomenological psychopathological school focuses on how the varied altered phenomena form a meaningful, unified Gestalt of a particular disorder. The comprehensive combination of these phenomena and symptoms appear as associated with each other so that a more integrated structure arises. Such an approach is undoubtedly promising, given that the phenomenological dimensions are interrelated and need to be contextualized in each case to be more thoroughly investigated.

Fuchs also offers a much more integrated framework for psychiatric disorders and, more specifically, schizophrenia (13;39) For the author, mental disorders should not be understood as disorders of the "brain", but rather as dysregulations between subjects and their worlds. Neurobiological alterations also play an essential role here. They cannot be neglected, but it is hardly plausible to simply associate the appearance of symptoms with reductionistic paradigms that take the brain to be the centre of psychiatric disorders. Instead, Fuchs argues that it is crucial to look at psychiatric disorders from an ecological perspective: subjects are always engaged with their worlds and others. In this dynamic interplay, things may go astray. Accordingly, the brain is not to be taken as the *causal source* of disorders, but as an organ that mediates the connection between subject and world. It is not the person's *brain* that gets ill, but the embodied person and his entire life world (13). The argument Fuchs puts forward relates to

this project well, since the suggestion that mental disorders are not merely "within" the brain also point to a more interconnected and dynamic understanding of the particularities present in each case. Some of the more contemporary debate in phenomenological psychopathology already aims to bring together alterations in various dimensions, yet I believe the framework would gain much from integrating a more dynamic perspective to it.

1.5.1. The Minimal Self Debate

Many contemporary authors working interdisciplinary within schizophrenia research have been developing theories around the "minimal self" theories, such as Sass and Parnas (40). In this section, I will discuss some of the central issues revolving around this debate. As I have already pointed out before, more thoroughly investigating the nuances in the alterations of the feeling of selfhood is crucial, for a more comprehensive understanding of its heterogeneous nature, in schizophrenia. However, the alterations present in selfhood should also not be understood as being only "subjective", in nature. Preferably, alterations of selfhood in schizophrenia should be interposed with alterations occurring in the other dimensions as well, such as embodied agency and sense-making, or intersubjectivity.

While the more fundamental sense of selfhood relates, in schizophrenia, to alterations in the person's *core* sense of being an autonomous agent about his or her feelings and actions, the narrative self often also alters, given that the person may not be sure of certain particularities of their life history up until the present moment. For instance, persons with schizophrenia are often unable to fully integrate and organize experiences they may have had in the past, with those occurring in the present.

As pointed out in the section about selfhood, the "minimal" or basic sense of self is also profoundly tied to actions, perceptions and other processes. These typically require an immediate sense of "I", a feeling of being the owner of one's thoughts and actions. In psychosis, however, this minimal self (in connection with other processes) becomes gradually or more radically fragmented. Thus, one can find a variety of difficulties related to the sense of selfhood itself, one's possibilities to act, perceive and understand the world. In psychotic experiences, this fluidity and immediacy of feeling oneself as an autonomous agent are fragmented and dissociated, since the subject may often be- wholly or partly- unable to meaningfully interact

with reality and him or herself. Given the presence of positive symptoms such as delusions or hallucinations, for instance, it could become quite challenging to distinguish between which thoughts are one's own and which are not. Many people with schizophrenia may feel that others are inserting thoughts into them, from the outside. Alternatively, that supernatural entities might be having direct influence over their actions and perceptions. The person might not be able to literally *understand* the meaning of very *ordinary* situations, thus having difficulties with regulating their action, accordingly. Parnas and Sass (41) argue that this minimal sense of self, in schizophrenia, becomes altered in two, not necessarily complementary ways. In their words,

> on our view, there is a sense in which the person with schizophrenia has both too little awareness of self (diminished self presence or self affection) and also too much self consciousness (hyper reflexivity). This means that a certain heightening of phenomenality of self consciousness (increased focal awareness of the normally "inner") is intimately bound up with a failure to experience the normally implicit foundations of self presence, namely self affection... (41, p. 537)

It is essential to point out here that this dual exaggeration of the disrupted sense of selfhood in schizophrenia brings about changes not only in the person's experiential sense of being, so to speak, "whole", which relates to the feeling of immediate "mineness" mentioned above, but it also modifies the entirety of the person's possibilities to be affectively engaged with the world and others and of acting in specific situations. This view is very much compatible with the one pursued in this project. While changes in specific dimensions of all the *interrelated and dynamic intertwinings of a particular patient* may indeed occur in varying intensities, thus bringing about more focused alterations in particular dimensions, it is very likely that the person's entire sense of selfhood will be affected, in different degrees. A disorganized and fragmented embodied self-presence in the world will lead to fewer possibilities of interaction with others and regulate oneself's possibilities of being affectively attuned, toward others.

It is interesting to see that self-consciousness takes on very different distinctive features, thus intensifying reflective self-consciousness. Processes that usually imply a more or less fluid and embodied contact with the world and others may become mechanized or overly "objectified", regarding thought processes (41). While we usually tend to reflect on what we will say, in a specific situation, persons with schizophrenia tend to exaggerate this reflective stance, given that they are many times not even able to distinguish whether they have a thought,

or if this was somehow “implanted” into their brain, for instance. However, it is essential to state that these alterations occur in quite a heterogeneous manner, and they need to be considered alongside the other symptoms. The intensity of these phenomena varies from person to person. However, they should be contextual and interrelated, as in a dynamic, personalized network system in which alterations influence each other, depending on the person’s current contact with the world. I will now discuss the next important group that will be more thoroughly investigated, in this project, which refers to the realm of embodied action and its alterations in schizophrenia.

1.5.2. Agency and Disembodiment

Fuchs (39) coined schizophrenia to be a disorder of disembodiment, in which the person’s lived body loses its natural fluidity in the world. Usually, the body is a tacit medium through which one perceives and acts in the world, fluidly. The embodied subjects are continually acting and in interaction with others. In schizophrenia, however, the body loses its natural and intentional directedness to the world and fragments. Sass and Parnas (40) argue that people with schizophrenia have a fragile sense of “basic self”. This impairment of ipseity is also very much associated with the lived body itself, and its usual functioning in the world, through a manifold of sensorimotor possibilities. For Fuchs (39), the once unified body schema disintegrates and becomes “mechanized” in schizophrenia, making it difficult for the schizophrenic person to engage with his surroundings naturally. What was usually a fluid engagement with the world, loses its intentional and meaningful directedness. Since the commonly unified bodily schema comes apart, in schizophrenia, so do parts of the patient’s perceptual field as well. This, in turn, may lead to phenomena such as hallucinations, where it may seem as if objects from the “outside” world could invade the person. The entire perceptual field may take on very distinguished and fragmented aspects, since the person with schizophrenia may have lost his capacity of perceiving the world and others in their *entirety*. In this project, it is crucial to point out that alterations in embodied agency occur in different degrees, depending on the patient’s overall cognitive capacities and its relatedness to alterations in other dimensions. For instance, feelings related to agency are also closely related to alterations in sense-making, given that the patient’s entire perceptual field changes.

If a patient is experiencing intense delusional experiences, it might be difficult to distinguish whether it is himself or "someone else" wishing to act upon some external factor. Suppose a patient has the delusional experience, for instance, of believing that two of his friends are talking about him behind his back. In that case, this may lead to patient to become aggressive toward his friends, even if unjustifiably. Having a specific experience of altered meaning may lead to difficulties or changes in how the patient acts and reacts, in his surroundings. Thus, simply stating that a particular alteration is present does not suffice. In this case, this bodily alteration needs to be inserted in the entire dynamic configuration of altered phenomena.

1.5.3. Intersubjectivity in Schizophrenia

As pointed out before, this particular phenomenological dimension relates to how we relate to others in the world. It is crucial to point out that intersubjectivity is not a kind of related experience that only occurs via a "representational" or mentalist understanding that the other exists, but it is a profoundly embodied experience.

Henriksen and Nilsson (42) also have contributions to make concerning alterations in intersubjectivity, in schizophrenia. The authors speak of three ways in which persons with schizophrenia try compensating for what they call a fragile sense of *we intentionality*. Usually, we can interact with others in groups, in various activities that presuppose a sense of acting together toward a specific goal, of working together toward a particular objective.

This feeling of co-participating with others in social life also usually gives meaning and structure to one's sense of selfhood. For Henriksen and Nilsson (42); however, persons with schizophrenia have difficulties participating in non-focused activities that occur inter-relationally. They argue that people with schizophrenia may use three compensatory strategies through which they would be able to cope with this fragile sense of interrelated selfhood. First, persons with schizophrenia often try balancing how they engage or withdraw themselves, from social situations. This does not mean that they are necessarily unable to maintain those, neither that they are constrained to withdraw completely. It means that they must try adjusting to meaningful relations with others, given alterations in their sense of selfhood, for instance. A second strategy relates to how persons with schizophrenia tend to focus on less, but more focused on social interactions and activities. When people with schizophrenia choose to pursue

a specific activity, they enjoy doing and are still able too; this will help them delimitate their interaction and workspace and the *kind* of interaction they will have with others. This leads to the final strategy, which relates to the fact that if it is possible to maintain a specific common social interest, the schizophrenic person will interact with others, via this more objective intersubjective setting. Henriksen and Nilsson (42) point out these three points are very much in correlation with this project's objective, which is to more carefully delimitate the heterogeneous nature of, in this case, alterations (or not) of intersubjective capacities in persons with schizophrenia. It is fundamental not only to divide these alterations concerning their intensity, but also to investigate their content, how they begin, and develop. Alterations in intersubjective relations are also connected with the other dimensions, such as selfhood and sense-making, also investigated here, given that they are always imbued with affectivity, meaningfulness, among others.

Fuchs (43), along the lines of what Shaun Gallagher proposed, also puts forward a phenomenologically oriented understanding of alterations in the intersubjective realm, in schizophrenia. For Fuchs, these disturbances also do not occur through disrupted capacities in "reading the others" mind, but rather because of the dissolution of the embodied "being with others" the schizophrenic person is not able to maintain, anymore. Disruptions in this intersubjective attunement occur very heterogeneously, and arguing that anomalous intersubjective experiences are either present or not, is simply not sufficient enough. These alterations must be investigated more thoroughly regarding their qualitative aspects, as well. During the interviews, the patients' narratives showed quite different capacities of being intersubjectively involved. In some cases, the possibility of engaging with others would depend on the intensity of overall symptoms.

Fuchs (40) argues toward a multi-perspectival approach to these variations in altered schizophrenic intersubjectivity. For the author, these may occur in three kinds of intersubjectivity. The first, primary subjectivity, a term coined by Trevarthen and Hubley (44) relate to the early years of childhood, in which the child learns, employing imitation and bodily expression, ways of understanding interactions between others. Newborns are thus slowly able to incorporate, into their body schema, expressions and gestures others make. Many times, people with schizophrenia already have difficulties understanding and engaging with others meaningfully through this form of basic intersubjective connection. We are usually immediately aware of others, through our embodied intersubjective attunements and dispositions. These allow us to understand different contexts, ways of interacting, and much

more. This immediate aspect of fluid embodied intersubjectivity that is often altered in schizophrenia; albeit in different ways, of course.

Another critical kind of intersubjectivity has been named *secondary intersubjectivity* (44), in which children begin to understand interactive contexts more objectively, through their gaze toward others and things, they are slowly more and more able to perceive the actions of others toward themselves, in general. This more pragmatic way of understanding and acting in specific contexts now depends more and more on how the infant is attuned to the space of interaction itself, and the first abilities to form symbolic interaction potentials, with others. From this perspective, the last "step" of intersubjective development relates to tertiary intersubjectivity, in which the subject can develop other perspectives, beyond the one that revolves around one's one subjectivity. In schizophrenia, these three *kinds* of being able to interact with others become altered. The once dynamic and fluid perspective-taking may have gone astray. Fuchs (43) says that,

> In the intercorporal encounter, the patient's emotional expressions and verbal utterances do not seem to correspond to each other or to the context (parathymia); bodily movements and expressions are not integrated to form a harmonious whole through which the person could manifest himself. As a result, one could say that others will experience the schizophrenic patient more as an object-body than as a lived body. This impression corresponds to the experiential disembodiment of the schizophrenic person. (43, p. 201)

For persons with schizophrenia, this immediate embodied attunement with others thus becomes affected. The capacity of understanding and recognizing others gestures, expressions and emotions, in specific social contacts, may have lost the necessary intentional and immediate stance it once had. This may occur because of difficulties the person may have in disentangling the boundaries between their sense of selfhood and autonomy, what the other person may want, and how they behave toward the patient. So, it could become difficult to measure which amount and which kind of affective engagement is necessary for certain situations, for instance. Bodily attunement is in direct relation with one's affective state and disposition, so that the person's capacity of having contact with others is, in fact, usually integrated with all the other phenomenological dimensions investigated in this project, as well. Thus, when alterations in the intersubjective realm occur, this will also infer changes in the rest of the *schizophrenic configuration* per se, even if only subtly. As said before, it is crucial to

consider the *entirety* of the person's contextual life world, which encompasses subjective, neurobiological and worldly aspects.

Kyselo (45) argues that schizophrenia, also taken to be a disorder of the "bodily self", should also be seen as essentially inserted into the social context. The author argues that approaches that rely too heavily on subjectivity and the so-called "minimal self" on the one hand, and reductionist neurophysiological approaches, on the other hand, tend to miss out on a more integrated comprehension of this particular group of disorders. This understanding should consider that minimal selfhood is not only an "inner" feeling of being oneself; instead, it is relational and distributed into the social world. We are shaped by our relations to others, while being in contact with them, in a variety of different situations. Kyselo (45) adopts an enactivist framework to bring forward the idea that persons with schizophrenia, even if affected with various symptoms, still strive toward a more or less regulated sense of "self". However, while the schizophrenic person is trying to maintain a somewhat constant sense of "self", his or her auto-organizational and autonomous system also suffers serious impairments. After all, existing in the social world usually requires a dyadic relation in which two or more persons participate or distance themselves regarding specific activities and social norms. For Kyselo, the notion of distinction refers, to the capacity (or not), the enacted and autonomous self (subject) finds to separate him or herself from the others. On the other hand, participation relates to active engagement with others, and it is via participation that selfhood "extends" into the social world. As the author puts it,

> Subjectively speaking, a disorder of the self is a state of suffering from experienced (continuous) violations of either the goal of distinction or of participation, or of what the person evaluates as an appropriate balance between them. Objectively speaking, psychopathology is a form of self-organization that exhibits particular struggles in the oscillation between and integration of the two dimensions. (45, p. 611)

This quote clarifies how schizophrenic disorders involve a much more complex "kind" of system than "reductionist" accounts, which seems disrupted in very particular ways. Both the subjective and the interactional "sense-making" and organizational autonomous self-regulating system seem to be unbalanced. Interestingly, in some cases, the person "succeeds" to maintain a minimal form of "mineness", there also exists a struggle between specific types

of goals, plans and ways of "being" in the social world that the person cannot seem to balance, any longer. From an enactive point of view, these processes are the ones that refrain or bind us to the social world, as "ways" of psycho-social interaction. So, this more integrated concept of selfhood aims toward the fact that humans are in a constant tension between being autonomous beings in need of distinction from others and in need of relating socially, through embodied attunement. So, for the author in the specific case of schizophrenia, these dialectical processes become seriously impaired, because the ill person is trying to maintain some kind of autonomous self-regulation, it is also difficult to engage in meaningful social contact, because the boundaries between one's self and the others have become blurred.

Consequently, schizophrenia becomes an illness in which the relation the subject has to the world becomes disrupted. However, this does not mean that the schizophrenic person has, necessarily, lost all of his or her sense of mineness or subjectivity; this would again depend on the severity and the extent to which the subject-organism-world triad is disrupted and on meaningful relations to others the person may still have. This relational-social component may lead to an incapacity of the schizophrenic persons' experiences regarding, for instance, normative evaluations we make about others and decisions regarding intersubjective relations that may include specific affective regulations. For the author, this constant human strives to maintain one's autonomy and the need to engage with others that disintegrates, in schizophrenia. I would now like to pass on to the project's methodological and empirical considerations and connect these with what has been put forward in this theoretical introduction.

2. OBJECTIVES

1) To explore the alterations of the psychopathological, phenomenological (experiences of self and world) and enactive dimensions of a sample of 12 patients with diagnosis of schizophrenia.

2) To assess the configurations between phenomenological (experiences of self and world), enactive and symptomatological dimensions in their everchanging dynamic configurations, in each case, depending on the illness and life contexts the patient finds themselves in. Also, considering how the singularity of these experiences and symptoms vary in their intensity, frequency, content and how they influence each other.

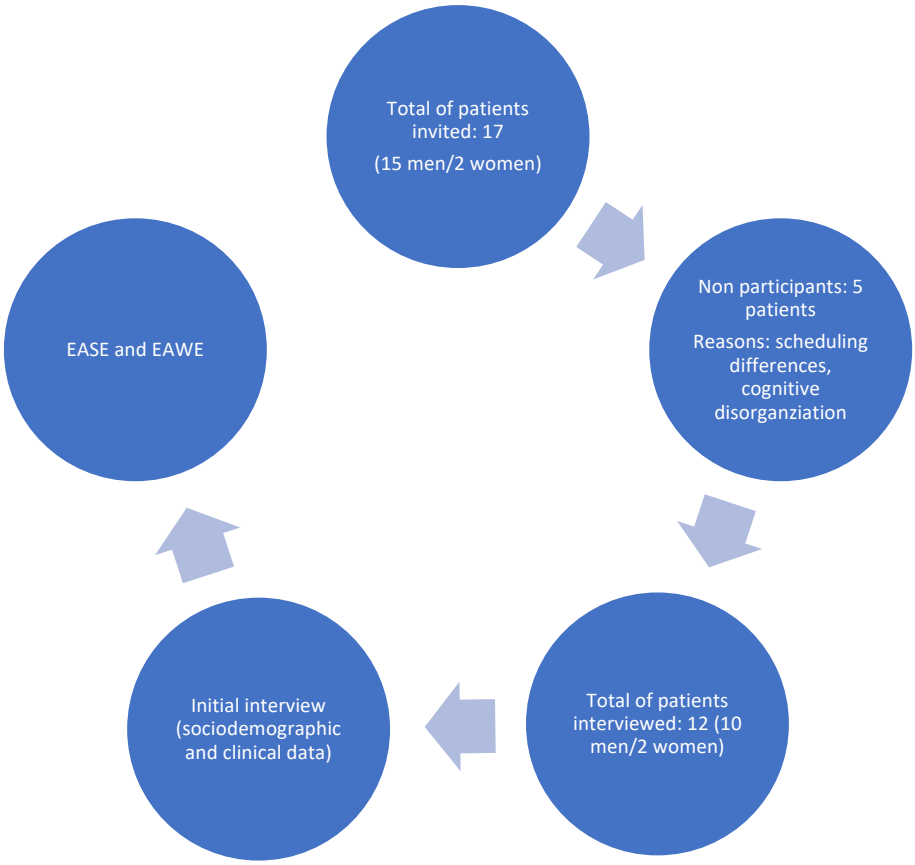
3. SUBJECTS AND METHODS

3.1. Patient Selection and Participation

In this study, patients diagnosed with schizophrenia were selected for participation, at the psychiatric infirmary and ambulatory for refractory psychosis of the University of Campinas (Unicamp) and the Unifesp University schizophrenia programme (Proesq). After having announced the research project verbally, professors, residents and other students did approach me, also suggesting patients that would fit the project. At the Unifesp schizophrenia programme, the approach was similar, since I was already participating, as a volunteer, in some of the treatment activities proposed. After having officially added Unifesp as a co-participant institution, I would have a first interview (anamnesis) with the patients. If they accepted continuing, I would apply the instruments (EASE & EAWE).

The fluxogram below delineates how the process of interviews and patient selection was carried out. Of the 17 patients initially asked to participate in the project, five patients were not interviewed, due to difficulties of coordinating schedules for the interview and cognitive disorganization. So, these patients were excluded from the project. The selection of patients was also made considering the possibility of participating in all 4 interviews, which was the average number of interviews I made, given that I would also usually be at the Unicamp ambulatory or infirmary once a week. The other 12 patients (10 men/2 women) accepted participating and were thus initially requested for a first clinical interview, in which a socio-demographic investigation was carried out. Following this initial evaluation, the remaining interviews were made, focused on both EASE, utilized in its entirety, and EAWE, which was adapted, given its length and the fact that the more critical dimension of EAWE investigated in this project was the “Other Persons” domain. The selection of his specific domain was made given that the domain of intersubjectivity is fundamental for assessing the altered dynamic interconnectedness between subject and world.

Flowchart – Patient Selection and Participation



Source: Author, 2021

3.2. Subjects, Inclusion and Exclusion Criteria

Inclusion criteria for actual participation in the project were:

1) a diagnosis of schizophrenia according to the ICD-10;
2) the consent given by the patient or legal guardian if the patient is between 14 and 18 years old;
3) being treated in ambulatorial or infirmary regimen, at one of the locations where the interviews were carried out (Hospital de Clínicas, University Hospital of Unicamp or the Unifesp Schizophrenia Program-PROESQ);
4) a minimum age of 14 years;
5) clinical stability.

The diagnosis was made, in both locations, by psychiatry residents being supervised by experienced professors. The exclusion criteria utilized were patients:

1) presenting severe intellectual disability;
2) severely disorganized thought processes
3) incapacity of oral expression by means of interview.

3.3. Characterisation of the Services *(Hospital de Clínicas, University Hospital of Unicamp and Schizophrenia Programme of the Federal University of São Paulo)*

All patients were interviewed at public mental health services, which provide multidisciplinary approaches to treating severe mental disorders. They were interviewed at the Hospital de Clínicas, University Hospital of Unicamp, more specifically the outpatient clinic for patients with refractory schizophrenia, for the general population of and around the Campinas region. The total number of patients seen in the outpatient clinic revolves around 360. The outpatient clinic mainly provides treatment pharmacological treatment for patients with refractory psychosis. Most patients are seen monthly. PROESQ, the Schizophrenia Program of the Federal University of São Paulo, oversees 200 patients, with most of them being seen in the city of São Paulo, also provides a multidisciplinary service for patients within the public health system. Patients can, aside from the psychopharmacological treatment, participate in psychotherapeutic groups and occupational therapy, for instance. These are sometimes limited, given various factors that directly influence the Brazilian public health system, such as "internal" institutional bureaucratic agendas, the lack of physical space necessary for all activities' actual development. However, it is essential to point out that both universities are services of reference and excellence in offering the general population mental health treatment.

3.4. Instruments

Before applying the main instruments utilized in the project, a thorough anamnesis was conducted, where socio-demographical data was collected, such as age, family history and overall psychiatric history such as beginning of illness, number of hospitalizations and possible suicide attempts. The access I had to medical records was also crucial, since I was able to gain more in-depth details on each of the patient's clinical history.

The instruments used in the project were the EASE (Examination of Anomalous Self Experiences) and EAWE (Examination of Anomalous World Experiences) interviews, developed by Parnas et al. (43) and Sass et al. (44). EASE was initially developed for research with patients first admitted at the University Department of Psychiatry of Hvidovre, Denmark. Both interviews investigate, respectively, anomalous experiences related to the "self", and those related to alteration in the world and others. They were initially developed to explore various subjective and worldly related modifications in patients with psychosis; however, some of these phenomena can also be found in other disorders. Both interviews are descriptive and aim more thoroughly investing the qualitative features of the experiences mentioned in the sections above. EASE was thus developed for a more systematic investigation of psychopathological phenomena inspired by the descriptions of psychopathologists such as Ludwig Binswanger (46), Wolfgang Blankenburg (31) and Klosterkoetter (47) were also a significant influence, given that this group of German psychiatrists began investigating subjective experiences, or, as they called them, "basic symptoms". The interview scoring is to be made as follows: 0 means that the experience is *absent*, 1 that it is *questionably present*, 2 that it is *mild*, 4 that it is *moderate* and 5 that it is *severe* (1).

In this project, the EASE interview was used in its entirety, and the EAWE interview adapted since the researcher wished to focus on the "Other Persons" domain, which examines, more specifically, alterations in the interpersonal and inter-worldly domain the patients may have. EAWE was also not utilized in its entirety, given that its complete application would tire the patients quite a bit, some of which already had difficulties with the complete EASE interview itself. It needs to be pointed out that neither EASE nor EAWE, were officially validated for use in Brazil/Latin America. However, both instruments were translated, the leading researcher being the co-author of the (cross) translation of EAWE (45). While both instruments were not validated, it is crucial to point out that EASE and EAWE are not

psychometric scales per se, but rather semi-structured interviews. The leading researcher has also received supervision in applying EASE in Germany and more theoretical supervision in Denmark, consecutively. In Heidelberg (Germany), 5 patients utilizing the EASE interview were interviewed, under the supervision of Prof. Dr. Dr. Thomas Fuchs. These 5 interviews were conducted in German leading to some interesting insights I will discuss in the discussion section.[3] In Denmark, I met Prof. Dr. Julie Nordgaard, with whom I had discussions regarding EASE rating criteria.

A first important group of alterations investigated in EASE relates experiential alterations in the *Cognition and Stream of Consciousness* domain, where a variety of changes in the patient's stream of consciousness and thought processes are investigated, such as in the sub-items ''Thought Block'' or ''Thought Interference'' (43). A second important domain in this project is called *Self-Awareness and Presence*, in which alterations related to the patient's feeling of selfhood are investigated, like in the sub-items ''Diminished Sense of Basic Self'' or ''Distorted First-Person Perspective'' (43). The third crucial dimension in which alterations were often found, in this project, refers to changes in the patient's *Bodily Experiences*, in which sub-items such as ''Morphological Change'' or ''Cenesthetic Experiences'' can be found (43).

3.5. Ethical Aspects of the Investigation

This investigation has been carried out with patients diagnosed with psychosis, those within the schizophrenia spectrum. The investigation has been carried out employing semi-structured interviews which were consented too and carried out at the infirmary and outpatient clinic of the University Hospital, at Unicamp and PROESQ Project at the Federal University of São Paulo (Unifesp). Participation in this Project was voluntary. The interviews per se did not present risks for the patients, except the possibility of some kind of subjective discomfort the interviewed person might feel. Also, there was no gain, material or otherwise, given that this is an exploratory investigation for the patients. All data collected has been treated to protect the total confidentiality of the subjects. Finally, the subjects who chose to participate

[3] The interviews were conducted in German, so as to maintain a good *rapport* with the patients. Since I have proficiency in this language (KMK Sprachdiplom 2), I was able to adapt to the interview nuances necessary for the questionnaires, in this language.

in the study have been selected to participate only in the oral interview or consent to the subsequent recording. A separate authorisation form has been prepared for eventual consent by the patient and legal guardian for recordings. The research project was approved by the University of Campinas and Unifesp University's ethics committee, under the numbers 4.458.379 and 3.376.660, respectively

4. RESULTS

4.1. Socio Demographical Data

The table below displays the main socio-demographical data found in the sample of patients' interviewed, in this project. The first column of the table, from left to right, indicates the patients' gender, most being adult males. The second column specifies the age of the patients', most being adults, with the exception of two young adults (D. and E.). Regarding the third and fourth columns, these represent the time of illness and beginning of illness, of each patient. Overall, most patients had been diagnosed for a long period of time, except three, whose time of illness was below the 10-years threshold (A., D. and E.)

Table 1 – Socio Demographical Data of Patients

Patient	***Age***	***Time of illness***	***Age at the beginning of illness***	***Education (completed)***	***Current work status***
A. (Male)	28	1 years	27 years	High school	No formal job
B. (Male)	36	14 years	17 years	High school (second grade)	No formal job
C. (Male)	26	11 years	15 years	High school	No formal job
D. (Female)	14	1 year	13 years	Elementary school (ninth grade)	No formal job
E. (Male)	19	2 years	17 years	High school	No formal job
F. (Male)	53	36 years	17 years	Higher education	No formal job
G. (Male)	48	19 years	29 years	High school	No formal job
H. (Male)	31	14 years	17 years	High school	No formal job
I. (Male)	48	20 years	28 years	High school	No formal job
J. (Female)	41	20 years	21 years	Technical high school	No formal job
K. (Male)	39	26 years	13 years	Higher education	Post-graduate student
L. (Male)	50	24 years	26 years	Higher education	Post-graduate student

Source: Author, 2021

4.2. EASE/EAWE Scores

The table below presents the main alterations found in this project, regarding the EASE and EAWE instruments. The main domains in which alterations were found refer to *Cognition and Stream of Consciousness*, *Self-Awareness and Presence* and *Bodily Experiences* (43). All patients presented alterations in the first two domains, albeit in different intensities and frequencies. It is also important to point out that while the table presents a more general description of the alterations found, their *singularity* and *interrelatedness* are crucial, as will be pointed to in the results section, and developed in the discussion.

Table 2 – Overview of Domains

Patient/Predominant EASE/EAWE Domains	***Cognition and Stream of Consciousness***	***Self-Awareness and presence***	***Bodily Experiences***	***Demarcation/ Transitivism***	***Existential Reorientation***	***Other Persons***
A. (Male)	X	X				
B. (Male)	X	X	X		X	
C. (Male)	X	X				
D. (Female)		X				
E. (Male)	X	X				
F. (Male)	X	X				
G. (Male)	X		X			
H. (Male)	X	X				
I. (Male)	X	X				
J. (Female)	X	X				
K. (Male)	X	X	X			X
L. (Male)	X	X			X	

Source: Author, 2021

Regarding the interviews made with EASE and EAWE, the entire process of interviewing patients also varied quite a lot as well as how each patient would show interest in the questionnaire, and *understand* it. Some patients did not want to participate in the study from the first moment on, since they would say they did not feel comfortable answering questions that would "expose" quite intimate details of their subjective and relational lives. Listening to the interviews and discussing these with the supervisor and co-supervisors also lead to exciting viewpoints, as, the appearance of the grouping of specific alterations in particular dimensions would differ, form case to case. Interestingly, some patients were quite frank in saying the interviews had certain *therapeutic qualities,* given that they had never thought about the experiences they were having, in that way, and that this even made them understand some of their own experiences more straightforwardly. This is compelling since the framework of enactivism itself proposes a perspective-based dynamic second-person perspective. During the interviews, the interaction that occurred already pointed out that each experiential and symptomatological configuration was singular, given how the patient would apply meaning to his alterations and those that were occurring in the world and others, for instance. The interconnected and dynamic component of both EASE and the EAWE "Other Persons" Domain also became clear in the interviews, since the patients would narrate their alterations and *act upon* these, each in their unique way.

Also, regarding the socio-demographic interview, it would diverge significantly how most patients would construe their routines, be able to have support from family and friends, as well as mental health professionals, in general. While most patients showed significant cognitive impairments and low inter-relational capabilities, some would be able to adjust themselves to a more or less organized (yet somewhat impoverished) routine and lifestyle. This will be explicitly shown in each case outlined, here. The possibility of a more or less organized routine would depend on several factors, such as completing some degree of formal education, for instance. However, patients with a more limited routine, which would essentially be restricted to household activities, and sometimes not even these, showed more difficulty in dealing and coping with the social barriers schizophrenia many times imposes. Throughout the interviews, these heterogeneous experiential and dynamic characteristics also influenced how the interviews were conducted, depending on how each question affected the patients, themselves.

Regarding the conduction of the interviews, other curious aspects arose. The reactions to the central instruments utilized in the project (EASE & EAWE) were quite diverse.

Some patients would have no problem whatsoever answering the questions, and this would depend on the presence, the severity and intensity of their current experiential and symptomatological configuration. In contrast, others had great difficulty in understanding the questions.

I would now like to flesh out the alterations in their unique configurations between subjectivity, world and symptomatology, and how these are *dynamically interrelated*. While similarities between symptoms and experiences may appear, the task of this project is to also aim at the singularities these different dynamic configurations present.

I will now exemplify these findings with the help of interview excerpts, which will shed further light on the heterogeneous, yet intertwined nature of the phenomena investigated in this project. As I began highlighting in the previous introductory sections of this thesis, I would like to point out that the alterations present in this particular group of patients I interviewed should be considered in their everchanging singular interconnected and mutually influencing configurations of experiential dimensions such as embodied agency and sense-making, as well as symptoms such as delusions, hallucinations, and anhedonia. While other dimensions such as affectivity are also crucial, a focus in this project is given to the following realms:

1) Alterations of embodied selfhood and intersubjectivity (social life);
2) Alterations of agency and sense-making.

The *intensity and content* of these symptoms and phenomena vary from case to case and how they are related to each other. It is also crucial to also be observant of the singularity of how positive symptoms appear in a specific case and how the subject makes sense of these, both subjectively, and in his interaction with the world (reality).

To concretely show the importance of contextualizing and interrelating the investigated phenomena and symptoms of each case, I will now present the most important clinical features of each patient interviewed, and relate this information with vignettes taken from the interviews, to show the unique interrelatedness and dynamic nature of the anomalous experiential and symptomatological features present, in each patient.

4.3. Individual Clinical and Phenomenological Examinations

PATIENT A.

Clinical history/anamnesis:

When I interviewed him, Patient A[4]. was a 29 years old male patient, diagnosed with schizophrenia. Since then, he is being treated for his condition, for which he has also already been hospitalized. A., at the time I interviewed him, was living with his single mother; he has never married and has no children. When I interviewed A., his overall cognitive functionality was well preserved, and he was able to communicate well with me. A. was, at the time of the interview, being treated with olanzapine, and denied having any positive symptoms. Having studied music, A. was continually looking for work in this area, since he is nowadays also able to practice his instrument. A. used to feel his sense of "I" was diminishing, because of the contact he used to have with a friend. He used to feel this other person was somehow controlling him so that he was not able to know whether specific thoughts were "his", or his friends. This episode made him suffer quite a bit. It even made him depressed, since he was, beyond the trouble with differentiating between himself and the other person, also having difficulties discerning his actions and those that came from the friend. It seemed as if this friend "owned" his feelings, thoughts and actions, entirely. Also, A.'s mother said that he began having auto referential and persecutory delusions while studying at the university, believing his colleagues wanted to harm him intentionally. Also, he has spent some time away from his parents' house, his mother saying that over this period, he has not contacted them at all. A., during that time, would also not attend his classes.

When the mental health professionals saw him, it was ascertained that he was indeed suffering from audio-verbal hallucinations and persecutory and auto-referential

[4] In order to maintain complete anonymity of the patients I interviewed, I will utilize the letters of the alphabet successively, yet it is important to say that the letter used DOES NOT represent the first letter of the patient's name, respectively.

delusions. A. was then very resistant to being treated with antipsychotic medication. A few months before having to present his thesis, A. began feeling more and more anxious. He also stopped his pharmacological treatment, starting psychotherapeutic treatment. However, having lost the registration deadline for his course, A. was cut off from the scholarship program. After having been cut off from the university, A. kept the musical instrument he needed for his studies at his student housing, without consent, which led to further trouble. A. then started to be less and less communicative and would lock himself inside his bedroom. His mother would come to visit him, finding A. paranoid and with dysregulated humor. It was then found that A. had not taken his antipsychotic medications. He then began wandering around, looking for foods in garbage cans and displaying soliloquies and verbal aggressiveness. Then, A. had to be hospitalized in the Psychiatric infirmary, given that he could not seem to "organize his thought". He would have difficulty describing his sensations and feelings, being only tangentially able to describe those.

At the time, professors and residents understood these experiential alterations as a difficulty to symbolically represent meanings and not be able to distinguish between objects (materiality) and words (narrative), which seemed to be on the same level. A., being hospitalized, would complain of a constant feeling of being "inferior" to others, and judged by them because he would not be sure whether he should play his instrument while hospitalized since maybe the others would not like the sound of him playing. He would also have anomalous bodily experiences, saying that he felt the ligaments that sustained him were "altered". The pressure of thought and psychophysical dissociation were also experiences he had during his hospitalization. A. would also refer that he felt like video cameras are surveilling him. When I interviewed him, A.'s positive symptomatology has dramatically improved. He does not complain about feelings of persecutory nature anymore, neither of being somehow "melted" with the "friend" aforementioned. However, A. maintained a lack of volition, even though he can maintain a more or less active lifestyle. A. says he is currently able to go to the gym and he wishes to return to university as a "special student" to once more study music. Also, S. wished, at the time of the interview, to pursue post-graduate studies.

While A. would be able to have a social life, when I interviewed him, these would still lack, from my perspective, *depth*. A. would still struggle to have more *structured and meaningful relationships*. Concerning A.'s positive symptoms, they were, when I interviewed him, controlled. However, there remained an essential lack of volition to gain back some sort of control of his life. It seemed A. was somehow still "living in the past", not fully and

meaningfully living in the present. However, A. is insightful about his disorder, which helps him understand his current situation. The interviews with A. were relatively fluid, although they lacked some sort of affective resonance. His overall cognitive capacity allows him maintaining a desire to further studying and wanting to work, which is something that most other patients did not show, in the least. While he had good support at home, he seemed to be very careful trying to resignify his life, relationships and possibilities of working projects, for instance.

Phenomenological and dynamic analysis:

While interviewing A., I had the impression that volition and affective attunement were somewhat "misplaced". However, A. was very articulate during all interviews, empathic with me and interested in the phenomena investigated. As said above, A.'s positive symptoms slowly faded throughout his illness, until residual negative symptomatology prevailed. However, as described above, A. did experience anomalous experiences of the self, during his hospitalization. His case is that of more *acute* onset, in comparison to the other patients interviewed here, regarding persistent feelings of altered experiences of self, intersubjectivity, agency and sense-making. However, it was nevertheless interesting to notice the "melting" of his sense of "I" that occurred, as exemplified here. Apart from alterations of the "I" and the sensation of having lost the feeling of "natural common sense" of things during his hospitalization, A. seemed to function well when I interviewed him. His relation to the world and others was relatively good, obviously considering other factors such as the negative symptomatology that still somewhat impaired a specific functionality. Here is a vignette of the episode in which he was not sure whether his feeling of being an "I" was his, or not:

> I have a friend, a person I consider a friend, but I do not know if I should be friends with this person, but at least in the past, no, currently this friendship is ok, but in the past the person had… it is as if he or she were trying to control me, you know, controlling my thoughts, controlling me. In the past, there was a bit of this problem. And…in this attempt of controlling, I remember that sometimes it seemed that I started to think just like this person.

Also,

> (…) all attitudes I took were attitudes that other people would take in certain situations, not the ones I would take. And I was simply taking them, kept thinking, and that, I was thinking like the person, and my thoughts were as if they were the person's. All I did and happened was as if it was another person and not me.

In both vignettes, it is interesting to see how the feeling of selfhood and agency are intertwined, thus circumscribing a particular kind of subjective and worldly configuration. While the patient had these experiences, it was difficult for him to play his instrument and engage in other activities. Even while he nowadays still lacks volition, the feeling of literally "becoming" someone else has vanished.

Regarding feeling somewhat distanced from the world, A.'s distancing occurred through a depressive episode, which he characterized like this,

> I got into a deep depression, it was the biggest chaos I had in my life… then it was when I had this problem with my friend. It is as if I had managed to get him off me and then there was nothing, it was empty. Then I was depressed (…).

A.'s feeling of his self being surpassed by that of someone else's was permeated by affective qualities that made him feel distanced from himself and the world.

A. would also feel monitored continuously by others, feeling that he needed to tell this "Other" about it. Also, he thought that this feeling of being watched would persist event after the "other" left him. He said that,

> It is as if the person was monitoring. People really monitored me. Everything I did, I had to tell this other person. As if it was. Then when this person left, it is as if they were still monitoring me.

Table 3 – EASE (Patient A.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference	X	
1.10. Inability to discriminate modalities of intentionality	X	
2. Self-awareness and Presence		
2.5. Derealization	X	
2.3. Hyperreflectivity	X	
2.7. I-split suspected		X
2.9. Identity Confusion		
2.16. Diminished Initiative	X	
4. Demarcation/Transitivism		
4.1. Confusion with the Other	X	

Source: Author, 2021

Synopsis of the case:

A.'s case displays an interesting configuration of altered subjective and worldly configurations since it has progressed to acute phases in which his sense of selfhood has been strikingly invaded and permeated by *another one*, which has robbed him of the capacity of feeling, acting and contacting the world *as himself*. He would feel as if another self had taken complete control over his thoughts and actions. Over time, however, these experiences have faded, leaving A. with a more accentuated feeling of a lack of volition and difficulty engaging with the world and others in meaningful ways. It is as if the intrusion of his sense of selfhood has left residual feelings in A. that can be associated with the fact that he might never be himself again, ultimately. While A. was able to function relatively well daily, when I interviewed him, it was as if his sense of self had somehow crumbled to a state of immobility, where it is difficult to regain a more or less meaningful contact with the world and others. His entire dynamic subjective and worldly configuration did allow for a more or less stable presence in the world, even if with significant losses regarding a more active positioning toward himself and his surroundings. However, given that A. was, at the time of his interview, an enthusiastic musician, this socio-cultural interested also helped him maintain a somewhat meaningful encounter with the world, albeit a reduced one.

PATIENT B.

Clinical history/anamnesis:

When I interviewed him, B. was a 39 years old male patient. His family is intensely religious, all being followers of Jehova's witnesses. He used to live with his parents and has three siblings. B. has been hospitalized several times. His father, uncle and grandmother are also diagnosed with schizophrenia. B. has no children himself and was never married. When he was a child, he used women's underwear, saying it was "weird" that men had penises. During his early childhood and adolescence, B. questioned his religious beliefs and whether he indeed of the "right" gender. B. was, in general, a quiet and reserved child, who did not have many friends and some difficulty in dealing with frustrations. As a child, B. would also have nightmares, and he slept with his parents until he was almost an adolescent. Regarding his school achievement, B. was generally a good student. However, he was held back in the third and fifth grade. Concerning his sexual development, B. says that he would find it weird when he was small that he had a penis and dress in women's clothes. During adolescence, he would watch pornographic material since he did not like to see naked men. In his youth, he had two brief relationships, but without having sexual intercourse.

B.'s symptoms began developing soon after he had an accident in which he had to amputate a finger. B. says he began living in a "world of illusions" and phantasy. After this very accident, he began developing a clinical picture of mania, feeling restless, psychomotor agitation, insomnia and unmotivated laughter. Then, a close uncle of B. passed away. He began feeling sad and quiet, which led to his last hospitalization, when he also underwent ECT treatment, displaying catatonia (mutism), refusing to eat and presenting depressed mood. After being treated with ECT, B. would say he believed he is a girl, even buying women's clothes and accessories. Also, he developed a mystic/religious discourse, saying he felt like God. He thus began a delirious sermon saying he had families in other worlds that told him that the best way would not be a Jehova's witness. B. and his family's religious socio-cultural background is crucial for a more integrated understanding of his case. B. was then once more hospitalized after trying suicide. This suicide attempt happened since B. felt his family did not understand

him. He could continue saying that, since he is a child, he thinks that a part of him, is a woman, but a lesbian. B. would say that God was a woman because this meant "purity". B. would thus frequently express his wish of also having a relationship with another woman, but not a "carnal" one since this would be considered impure. For some time, B.'s delirious activity would continue, however with variations in content. He would say that many other children lived inside of him, one being a fairytale character, for instance. B. also felt as if "Armageddon" was nigh, and that in his dreams he was the chosen one that would decide what would be the fate of the earth. After this event, B. said that all children would flee the earth, leaving only him and his "alias".

B.'s. constant struggle relates to the fact that he conflicts with what he believes is the "truth" and the reality in which he lives. His routine consists of regular activities and social events, which are also related to religion. So, he believes that while his family presents an important intersubjective bond, he feels this bond is limited compared to what he claims is real in his world.

B. is a patient with continuous and too prominent positive symptomatology. His delusional activity revolves around religious themes, gender-related issues, and a variety of hallucinatory phenomena and auto-referential thoughts. B. has always been afraid of not being acknowledged by his family, which has also led to suicide attempts in which he would grab a knife, but he says that suicidal ideas are nowadays less prevalent and that when they occur, he tries to fight them. Interestingly, however, B. has indeed "lived inside" of his delirious and hallucinatory experiences, finding a way to express his experiential setting and phantasy fulfilled lifeworld through these. He expresses much fear and anguish about his identity, not being sure how to "transpose" his "alias" to the shared world. When I interviewed him, B. still had prominent positive symptoms and is currently undergoing treatment with clozapine, valproic acid and folic acid. Even if frequently in delusional and hallucinatory activity, my impression was that B. could maintain a very specific kind of autonomy, since he seemed, at the time of his interview, to feel at ease in his own created reality. However, this would not be enough to the extent of being able to work. His positive symptomatology "accompanies" him, and, contrary to other patients that have been interviewed in this project, B. is by some means able to "insert" his positive symptoms in his daily life, and thus seems not to suffer from their presence. B. is also currently frequenting fortnightly psychological treatment at the psychosocial centre. His delusional discourse continues revolving around gender-related and identity-related issues. B.'s entire life world and contact with reality are altered, keeping in

mind the project's objective to present an outline toward a more complementary approach to schizophrenia, much valued.

He is, along with H., the patient with the most prominent positive symptoms. B.'s life is permeated with a variety of hallucinatory and delusionary activity, which directly influences his way of being in the world. I would say that while B. does not share, in a more literal sense, the *reality* in which we live, since he has created a reality of his own, thus living *within his delusions and hallucinations,* which give him a unique perspective on how he connects to the world. Therefore, it cannot be said that B., like other patients that have been interviewed here, literally *suffers* from his disorder. Instead, he lives in the reality he has created for himself, which is much aligned with the proposal of this project: alterations in experiential realms are deeply interconnected with the world and are modified by each other, influenced by each other. For instance, while B.'s intersubjective relations are permeated by delusions that he might be a woman trapped in a man's body, this *still is a way of relating to others and the world*.

Given the prominence of B.'s positive symptomatology, his capacity to relate to others is scarce in a shared intersubjective world. While he mostly seemed not to suffer from his altered experiences and symptoms, his unstable sense of self would neither allow him to engage in meaningful intersubjective relations nor have an integrated sense of his actions in the world.

Phenomenological and dynamic analysis:

When I interviewed him, B.'s positive symptomatology was varied and quite fluid. He believed he had travelled many worlds, and that many "others" have traversed his self. For instance, he said that,

> … I came from another planet. Then, I got here recently, I looked with my mind for other people that came from another planet, and I could not find anyone. Then, I felt lonely, unique. But a lot of people went through this body, one of them taught me to create things with the power of the mind. I cannot do it now, but in the future, I believe I will be able to, and I will create a planet for myself.

In this particular case, it is interesting to see how the entirety of the B.'s engagement with the world (reality), via hallucinatory experiences, becomes a singular way of finding himself in the world. He believed that others had also passed through his body, having taught him to create things in his reality (a planet). The intersubjective realm is also connected to his thoughts of *being* from another planet. B. also had a very fluid sense of selfhood, where he would feel as if his *core self* is that of a princess:

> I am, actually, a Princess. I am in a body called B., but my basic identity is that of a princess. But many have passed through this body, so I am a bit lost, without being able to identify the feelings surrounding me, because there were also too many thoughts, around. Nowadays, I can be myself (…).

The last sentence of the excerpt is quite intriguing: the patient said he could, at the time of the interview, be himself. This patient has somehow integrated many of his hallucinatory and delusional experiences throughout his illness. Also, many of these phenomena present themselves in dynamic ways and vary in intensity and frequency. He would find himself continually switching how he contacts the world. One more example of the salient intertwinement between the schizophrenic person (self) and the world, and the dynamical aspect of how this contact may present itself can be exemplified here:

> I grew up studying the bible, and in there, you have Jehova's story, the story of Jehova against the devil...I used to live in this world...I was...(), normal…I wanted to get married, to have children, a normal life. Then the accident happened, and things also changed in my head, and I saw that I was not a man on the inside, but a girl. Then I saw that the story between Jehova and the devil was much more complex than I had imagined.

Over some time, B. said he would like to lead a "normal" life and that he *used to live in this world*. Then, an "accident" happens, and "things change in his head". His sense of selfhood feelings would alter, he felt he is not a man, but a woman, and with this change, his contact with the world also becomes more delusional. It is essential to point out here that these changes may occur very subtly. As Sass and Parnas (53) rightly say, the prodromal phases of schizophrenia are often permeated by more nuanced introspection experiences, of slight

changes in perception, but reality itself often already seems modified. Then, in the first psychotic episode, full-blown positive symptoms appear. This *transition* from subtle to more full-fledged symptoms is interesting since it makes clear that neither subjective nor relational phenomena or more behavioral symptoms should be understood as static phenomena that are only present or absent. No, they vary in their intensity, frequency, and should thus be integrated into the dynamic context the person currently finds himself in. There may be various ways in which the person perceives specific alterations in the realms of selfhood, intersubjectivity and sense-making within, but also without (in the world).

B.'s anomalous experiences of self and world were, in a way, already embedded into his lifeworld. The experiences he had varied in frequency, intensity and their qualitative aspects. This means, I believe, that they need indeed to be investigated more comprehensively, and this can only be done if the clinician also considers how the current life world of a specific patient is arranged, depending on the severity and presence of both symptoms and experiential phenomena. The *constancy* and interrelatedness of B.'s altered experience indicate that the interlacing of both subjective and worldly affairs indeed point toward a particular kind of configuration, that may extend throughout the illness, maintaining themes that remain similar (the feeling of being a woman). However, other features change, such as how B. adapts the feeling of being of another gender and how this influences his relation to the world and others.

Table 4 – EASE (Patient B.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		X
1.1. Thought interference		X
1.2. Loss of thought ipseity		X
1.3. Thought pressure		X
1.4. Thought block		X
1.4.1. Thought fading		X
1.6.1. Pure rumination		X
1.6.3. True obsessions		X
1.6.4. Rituals/compulsions		X
1.7.1. Perceptualization of inner speech or thought (internalized)		X
1.7.2. Perceptualization of inner speech or thought (equivalents)		X
1.7.4. Perceptualization of inner speech or thought (external)		X
1.8. Spatialization of Experience		X
1.9. Ambivalence		X

1.10. Inability to discriminate modalities of intentionality	X	
1.12.1. Attentional disturbances (captivation by details)	X	
1.12.2. Attentional disturbances (inability to split attention)	X	
1.14.2. Disturbance of time experience (disturbance in existential time)	X	
1.15. Discontinuous awareness of own action	X	
1.16. Discordance between expression and expressed	X	
2. Self-awareness and Presence		
2.1.1. Diminished sense of self (early in life)		X
2.2.1. Diminished sense of self (from adolescence)	X	
2.2.2. Distorted first-person perspective (experiential distance)	X	
2.2.3. Distorted first-person perspective (spatialization of self)	X	
2.3.2. Psychic depersonalization (self-alientation) Unspecified depersonalization		X
2.4.1. Diminished Presence (not being affected)		X
2.4.2. Diminished Presence (distance to the world)		X
2.5.1. Derealization (Fluid global derealization)		X
2.5.2. Intrusive Derealization (Intrusive derealization)		X
2.7.1. I-split suspected		X
2.7.3. I-split (Concrete spatialized experience		X
2.7.4. I-split (Delusional elaboration)		X
2.8.2. Dissociative depersonalization (dissociative visual hallucination)		X
2.9. Identity Confusion		X
2.10. Sense of change in relation to chronological age		X
2.11.2. Sense of change in relation to gender		X
2.12. Loss of common sense		X
2.13.2. Psychic-mental anxiety	X	
2.13.3. Social anxiety	X	
2.13.5. Paranoid anxiety	X	
2.14. Ontological anxiety	X	
2.15. Diminished transparency of consciousness	X	
2.17. Hypohedonia	X	
2.18. Diminished vitality (trait-like)	X	
3. Bodily Experiences		
3.3.1. Morphological change (perception of change)	X	

3.2.2. Mirror related phenomena (perception of change)	X	
3.3. Psychophysical misfit and psychophysical split	X	
3.6. Spatialization (objectification) of bodily experiences	X	
3.7. Cenesthetic experiences	X	
3.8.4. Motor Disturbances (desautomation of movement)	X	
3.9. Mimetic experiences	X	
4. Demarcation/Transitivism		
4.1. Confusion with the other	X	
4.3.1. Threatening bodily contact and fusion (Feeling unpleasant)	X	
4.3.2. Threatening bodily contact and fusion (Disappearance)	X	
4.4. Passivity mood	X	
5. Existential Reorientation		
5.1. Primary self-reference phenomena	X	
5.2. Feelings of centrality		X
5.3. Feeling as if the experiential field is the only reality	X	
5.4. “As if feelings” of extraordinary creative power	X	
5.5. “As if feelings” that the experienced world is not real	X	
5.6. Magical ideas linked to the subject’s way of experiencing	X	
5.7. Solipsistic grandiosity	X	

Source: Author, 2021

Case Synopsis:

B.’s case represents a unique configuration of both alterations of the self and world, given the intensity and how the patient relates to his own experiences and the world. B.’s alterations have been present over quite a significant period, but varying in intensity. However, it is as B. had found a way to integrate his alterations in subjective and worldly experiences. They did not seem to make him suffer and are the way he engaged the world and others, even if for clinicians this way of “being in the world” may seem odd and even bizarre. The fluidity of B.’s alterations of the self, for instance, contribute to a feeling of selfhood that does not seem to allow a more *stable* sense of minimal selfhood. Of all interviewees, B. is one of the patients with the most alterations, which shape his entire contact with the world, in different ways. His

religious and socio-cultural background continually influences how he shapes his hallucinatory and delusional activity and how this leads him to act in the world in very specific ways. Thus, his sense of agency takes on very particular characteristics and these changes all influence his everchanging sense of selfhood, at specific points of his life.

PATIENT C.

Clinical history/anamnesis:

When I interviewed him, C. was a 26 years old male patient that began his treatment at a University Hospital, when he was hospitalized in the psychiatric infirmary because of psychotic behavior. C. was living with his maternal grandmother, who also accompanied him to the interviews. C.'s parents got divorced when he was a pre-adolescent, and his grandmother reports that his father beat him when in this period of this life as well, at which point he also started talking to himself. When C. was an adolescent, he had his first psychotic episode. Furthermore, C. is blind in both eyes. After these episodes, C.'s symptoms got worse, and he began developing stereotyped movements, persecutory delusions and inadequate behaviors (C. feels attracted toward women's feet). C. would feel aroused by women's feet, wanting to touch those.

His grandmother also reports that C. was a good student at school, frequenting classes normally and learning to read and write in Braille when he was young. She also says that when he was an adolescent, C.'s mother was arrested for drug possession. During that time his soliloquies developed more strongly, and he would feel "agitated". C. says that during this time, his father would also hit him and leaving him without food. His grandmother says that she went on doing forensic reports because of this aggression. C.'s grandmother would say that his father would take him to be treated at a CAPS centre but did not follow through with the treatment. She also says that during the time, the patient's father would frequently visit the church and that C. began having a religious discourse and a preoccupation of whether he was of Jewish descend, or not.

C.'s grandmother says she suggested C. should make a massotherapy course, given that he liked touching feet and he agreed to this. He then went on living with his grandmother. He began the course, but soon his teachers would notice restless behavior and stereotypical movements. He would feel persecuted by the professor, and thus stopped the course only a couple of days before beginning it. Regarding fetish, his grandmother would also say that he sometimes asks to massage her feet and gets aroused with this, but then his grandfather needs

to intervene. C. also would say that he had the gift of "foreseeing things" and that his mission is to "touch women's feet, that these will save him".

During one of his hospitalizations, C.'s clinical picture worsens, and he would begin acting aggressively, and display thought and speech disorganization. After this hospitalisation period, C. was released from the infirmary and continued taking olanzapine, however, since he gained much weight, a medication change occurred, and the patient began being treated with sulpiride. When I interviewed him, C. was treated with Clozapine and folic acid. The patient's functionality was relatively low, since he was, most of the time, at home, where he cooked and did other activities. C. would still "talk" to some important cinema characters. Apart from a few home-based activities, C. is catholic and would sometimes go to the church, but did not develop other activities. Regarding his positive symptomatology, C. usually had religious audio-verbal religious hallucinations, which also revolved around the fact that he wanted to be a Satanist. C. was hetero-aggressive since he was and adolescent, and his fixation for women's feet continued since then. He believed that he had the gift of foreseeing things, and that women's feet would save him.

C. is a patient who presented significant mystical and religious positive symptomatology and his prominent fetish for women's feet. Given that he is blind in both eyes, C.'s contact with the world and others would be impaired by this fact, yet his anomalous experiences were still quite developed.

C. would lack severe social initiative, and he would usually be quite withdrawn from the world and others.

Phenomenological and dynamic analysis:

I remember interviewing C. well. Given that he is blind, his contact with the world is different from the other patients interviewed. While C. has learned to adapt to his surroundings minimally, his sense of self and the other phenomenological domains investigated remained very fragmented and "dissolved". For instance, while investigated Domain 1 of EASE (Cognition and Stream of Consciousness), C. would say that,

> I was thinking a lot about ****** and it was not my thoughts that were speaking. It was transmitted through my brain, it was a different image of him that I intended to picture. I did not like him and started to like him after he died. Then I had this thought.

C. would create other characters in his mind regarding famous singers, some of which would still "accompany" him daily. Religious delusions were also very present in C.'s clinical picture. C. also believed that he needed God's approval to act on some decisions he wished to make. For C., God also influenced the passing of time, he says, "I feel that God is shortening the day because of his anger. The Bible says so".

Regarding EASE Domain 2 (Self Awareness and Presence), it is interesting to analyze C.'s early childhood. He said that he used to feel quite inferior to others and very lonely. When C. felt like this, he would begin looking for support "in his mind" and start conversing with the characters he was creating, especially famous pop musicians. This fleeting sensation of feeling his sense of *I* thus led C. to "become" these characters and take on other, new "identities".

Regarding EASE Dimension 3 (Bodily Experiences), C. has not had, when I interviewed him, more specific alterations in bodily experiences, such as bodily disintegration. Still, he once had a feeling of being very fragile at school, believing that others were harassing him. This particular experience relates to EASE Dimension 4 (Demarcation/Transitivism), in which patients are usually unable to maintain a clear demarcation (both physically and psychologically), between themselves and others. A final item C. scores in relates to EASE Domain 5 (Existential Reorientation), more specifically sub item 5.4. (5.4. "As if" Feelings of Extraordinary Creative Power, Extraordinary Insight into Hidden Dimensions of Reality, or Extraordinary Insight into Own Mind or the Mind of Others). C. said that,

> Yes, I feel I have the power of messing up with the weather…I did not even know that I had a power of creation. So that you can see it. I found out now that I have it. I can mess up with nature…who serves to God has the power to do many things.

In sum, C.'s alterations of the self would present themselves in a more or less structured manner. However, if compared to A.'s alterations, for instance, how the entire experiential configuration between subject and world already changes. A.'s contact with the world occurs through various delusional and hallucinatory experiences that structure themselves differently, thus being associated with various themes ingrained in their subjective lives. C., on the other hand, has developed positive symptoms that are more restrained to religious phenomena, in general.

Table 5 – EASE (Patient C.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness	X	
1.1. Thought interference	X	
1.2. Loss of thought ipseity	X	
1.7.1. Perceptualization of inner speech or thought (internalized)	X	
1.8. Spatialization of experience	X	
1.12. Attentional disturbances (captivation by details)	X	
1.13. Disorder of short-term memory	X	
2. Self-awareness and Presence		
2.1.1. Diminished sense of basic self (early life/adolescence)	X	
2.2.2. Distorted first-person perspective (experiential distance)	X	
2.4.1. Diminished Presence (not being affected)	X	
2.4.2. Diminished Presence (distance from the world)	X	
2.7.1. I-split suspected	X	
2.13.5. Anxiety (diffuse, free-floating)	X	
2.16. Diminished initiative	X	
2.18. Diminished vitality (state-like)	X	
3. Bodily Experiences		
3.7. Cenesthetic Experiences	X	
4. Demarcation/Transitivism		
4.4. Passivity Mood	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena		
5.4. "As if feelings" of extraordinary power	X	
5.7. Existential or intellectual change	X	

Source: Author, 2021

Case Synopsis:

Patient C. is a patient who still demonstrated significant selfhood alterations. His case is interesting since he is blind in both eyes, which alters his contact with the world differently. Being a patient with a history of symptoms deeply embedded in his own religious experiences, C.'s connection with the world and others is also deeply permeated with religious content experiences. His alterations of self are saturated with experiences of being controlled by God and other entities. C.'s experiences vary in intensity and have also changed, over the periods of his illness, but they remain present in his contact with the world and others. When I interviewed him, his functionality was still impoverished, given his blindness and lack of more meaningful and structured work possibilities. However, C.'s relation to his altered experiences is similar to B.'s, in that both seem to have somehow integrated their experiences, and appearing not to suffer because of them.

PATIENT D.

Clinical history/anamnesis:

D. is the only female adolescent I interviewed for this project and was, when I interviewed her, one of the most cognitively disorganized patients. She had not been hospitalized and was being treated in the ambulatory. However, I felt she was still able to communicate well enough to be included in the project. It is also my impression that she represents the heterogeneity of different altered subjective and worldly configurations well, that appear in this project. She was 16 years old, at the time of the interview. D. was included in this project because of her diagnosis of schizophrenia when I interviewed her, even though her diagnosis is still being discussed, given the affective components of her clinical picture. However, given her episodes of cognitive disorganization and positive symptoms, schizophrenia remained an appropriate diagnosis. D. began her treatment at the psychiatric outpatient clinic for children and adolescence, in her adolescent years. Her mother says that D. did not have so many friends and would usually spend a lot of time by herself. D. would cut herself and present altered stream of thought. D. had also had several suicide attempts, as her mother told me.

D. would say that her eyes appeared having two independent dimensions and because they simultaneously relate to one's own eyes, as well as independent eyes, that "move around", that have their sense of agency. The eyes would "communicate" bad things to D., she says. D.'s affect was, during the interviews, extremely puerile, and her narrative prosodic. Regarding other kinds of altered experience, D. said that when she swallowed saliva, her "body would get evil", she "become arrogant and evil". D. justified this by saying that the saliva has DNA and this can alter people. She said that by swallowing the saliva of someone who has prayed, it could make a person better. She also says that the voices can disguise themselves as thoughts. Also, D. would refer to voices of other people in her school that said that "they hate her", and that "this girl will not be able to handle you". The speech content seems comprehensible in D.'s overall environment, but not how they appear, since D. refers to

understanding their cruel meanings even if the voices are not present at a specific point in time. It is as if D.'s hallucinatory experiences would somehow spatialize and "leak" into the world.

She refers to having used alcohol and cocaine before beginning her treatment at the university hospital. By that time, she was referred to the emergency room because of auditory hallucinations, though disruption, soliloquy, and general disorganization. She would, for instance, take showers fully clothed. Initially, D. was given risperidone, but her symptoms did not improve. In April of this same year, the patient began taking olanzapine, showing a gradual improvement of symptoms. During this time, the patient displayed new self-injury symptoms, thoughts of death and suicide ideation. Sertraline was then introduced, and the patient's symptoms improved.

In June of that year, D.'s symptoms worsened, and her positive symptomatology once more emerges. She claims that parts of her body were talking to her, she had audio verbal hallucinations with self deprecative voices of command, which is when the choice was made of changing olanzapine to Clozapine, which again improved D.'s clinical picture. D. was then living with her grandfather, sister, brother, mother and two uncles. D. had returned to school and said she has been enjoying this. Her mother denies that D. has been having behavioral alterations. Two years later, D.'s mom noted that D. has significantly improved her behavior and that she does not speak to herself anymore, is organized and taking care of herself, regarding hygiene and overall self-care. D. also said that she rarely had auditory hallucinations, that they would usually occur when she was taking a bath, she would start hearing screams. D. also says that she had not been feeling sad, at the time I interviewed her. However, her daily life is still relatively low, revolving around staying at home, sleeping or watching T.V. with her grandfather. D. is currently being treated with Clozapine (100mg), sertraline (50mg) and topiramate (50mg).

D. shows relatively poor social functioning. When I interviewed her, I had difficulty interacting with others and myself. While she showed some affective attunement, this was not enough to establish a meaningful interview connection. Regarding others, D. also has a relatively shallow interpersonal contact, in general.

Phenomenological and dynamic analysis:

D.'s interview was difficult to make, given that she was, at the time, still quite disorganized, cognitively. However, she seemed to develop a rapport with me quickly, even if with a very dysthymic and childlike behavior. Regarding EASE Domain 1 (Cognition and Stream of Consciousness), D. said that, "For instance, in my head, I feel many people talking… some talk in my head, they scream… sometimes, when I am quiet, they begin to scream…"

D. also told me that she used to overthink things quite a bit and that this was many times related to what people in school said.

However, the Domain in which D. presented the most prominent alterations of experiences is EASE Domain 2 (Self Awareness and Presence). She said, for instance, that she smoked sometimes "because of an emptiness that you sometimes have..it helps me, calms me down…makes me forget the problem."

Or,

> It is a hole. Do you know that hole that you see like a pencil? You pick up a big pencil, make a hole in the ground and start digging. You dig a hole and see the bottom of the black hole. Then you smoke and forget about the emptiness… this feeling is there since I was 12.

This feeling of emptiness and "deadness" also emerged in other ways. D. said that "there is a device in my heart that turns because on the inside, it had died many times…dead. There is nothing here to survive".

When asked about the world around her, about things not affecting her anymore, which relates to EASE sub item 2.4. (Diminished Presence), D. said that, "I don't know; it is like they say… it touches my body, but not my soul… it touches and hurts when I sometimes feel like dying…"

D.'s feeling of deadness and a certain "numbness" points to the fragility of the self that confers to her "I" a certain distance from the world and herself. D.'s self seemed to display a consistent quality of profound derealization and lack of meaning. Her contact with the world

was “liquid” and arranged differently from the one A. demonstrated, for instance. It is interesting to point out how the sense of altered or fragmented “I” *moulds* how the subjects also relate to their own experiences. The intensity in which the experiential alterations of this relationality between subject, world and others is, too, different.

Table 6 – EASE (Patient D.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference		X
Though pressure	X	
2. Self-awareness and presence		
2.1.1. Diminished sense of basic self (early in life	X	
2.1.2. Diminished sense of basic self (from adolescence)	X	
2.2.1. Distorted first-person perspective (mineness/subjecthood)	X	
2.2.2. Distorted first-person perspective (experiential distance)	X	
2.3.2. Psychic depersonalization (self-alienation) Unspecified depersonalization	X	
2.4.1. Diminished presence (not being affected)	X	
2.5.1. Derealization (Fluid global derealization)	X	
2.7.3. I-split suspected (Concrete spatialized experience)		
3. Bodily Experiences		
3.6. Spatialization of Bodily Experiences	X	
3.8.1. Motor disturbances (pseudo-movements of the body)	X	
5. Existential reorientation		
5.5. “As if feelings” that the experienced world is not truly real		

Source: Author, 2021

Case Synopsis:

D.’s case presents an interesting perspective because she was the only adolescent I have interviewed in this project. Her alterations of self and world were quite intense, given an essential component of affective dysregulation that impregnated her entire *fragile* being in the

world. D.'s. feeling of a more basal sense of self was fragile, given her age and a critical difficulty in expressing her thoughts. D. displayed a vital sense of *distance* between herself and the world, which accentuated the fragile state of her feeling of selfhood even more. Also, many of her statements describe a lack of meaningful attunement to the world and others. Her sense of self is continually being invaded by the world, which fragilized her contact with her surroundings, thus also fragmenting the critical sense of meaningful *coherence* subjects usually need to act, perceive and feel in the world.

PATIENT E. (Interviewed Hospitalized at Infirmary)

Clinical history/anamnesis:

I met E, a male patient, when he was hospitalized at the psychiatric infirmary. He was then 19 years old. E. had been diagnosed with schizophrenia at that time. E. had, by then, completed his high school studies and was currently living with his mother, two sisters and a brother. His parents were divorced. His brother had also been diagnosed with a psychotic disorder, and the patient also used to undergo psychotherapeutic treatment. E. said that his childhood was good, that it was "humble" and that he would enjoy playing soccer with his friends, but he was also a bit shy. Regarding hobbies, E. would generally enjoy playing soccer and reading. He says that he would very much enjoy reading a book. One year before being admitted to the infirmary, E. had his first psychotic episode. The episode began with sensations that colleagues talked about him behind his back and that they had afterwards hacked his cell phone and social media accounts. E.'s persecutory delusions then got worse. E.'s medication was exchanged a couple of times, given a gain in weight from olanzapine. He was then given risperidone, which he stopped taking in two years after his first psychotic break. When his symptoms again worsened similarly to those he experienced before having the first psychotic episode. E. then spent three months in the infirmary once more, and Clozapine needed to be introduced in his treatment plan. E. would deny having an illness, but the family did help with the treatment. E. maintained, when I interviewed him. that he had gotten better on his own without needing medication. His mother would say that he has been learning because he wants to do study administration to work with his uncle. When I interviewed him, he denied using psychoactive drugs, but would regularly ingest alcohol. He was also talking to a girl, which he claimed he is interested in, at the time. E. did not periodically practice any exercise, and he complained to me about some weight gain. E. was taking Clozapine and haloperidol when I interviewed him.

E.'s positive symptomatology was very much in remission when I interviewed him. His interview transpired well, and it was quite tricky for me to gain a more profound understanding of possible anomalous experiences he might have. In general, E. would say that

he would sometimes ruminate about happenings of the past, about other people. Also, some "life experiences" would intrigue him and make him curious, but he did not develop specific themes when asked. He would say that he is in general very anxious, but his sense of self, in comparison with some of the other patients interviewed here, such as patient B., for instance, would not seem so fragile. E. says that most of the time, he would "think like himself", and just sometimes he would "feel" like someone else, but this seemed, at the time of the interview, to relate more to a kind of empathic or transferential phenomenon, rather than a more basal kind of anomalous experience. He says his anxiety makes him feel like his head is sometimes "very filled up" with ideas and thoughts.

Regarding E.'s intersubjective capacities, the patient maintained a good communicative relation with me during the interview. Since I interviewed him in the infirmary, I briefly experienced him interacting with other patients, and he seemed quite cheerful, to me. Given his young age, E. showed a quite energetic way of expressing himself and being with others, mostly when he talked to me about his "life on the outside".

Phenomenological and dynamic analysis:

The interviews I made with E. occurred in the psychiatric infirmary when he was hospitalized. E. was, when I interviewed him, cognitively organized, both regarding speech and thought.

E. for instance, talked about sometimes experiencing thought pressure (EASE Domain 1, subitem 1.3.). Yet, his experience seemed more related to obsessive symptomatology and anxiety in general, than to a more basic anomalous experience. He would say that,

> When like, there are many things to do to alleviate that. It is what it is. Because everyone has a burden, you know, it is human and spiritual. Both are what we call pressure. It is a pressure on the mind… a pressure, so you have to do things to make this better, to feel free of that.

Or,

> Anxiety is my middle name, you know?... anxiety gets to me really easily. But I am too young, I think that your mind opens. And you begin like… so many things, you know? Then anxiety comes…but if I want something, I will go for that. I'll tell you, I have anxiety, I have stress.

E.'s narrative seemed quite tangential during many parts of the interview, and I found it difficult to believe all that E. was saying. He says that he already had the feeling that "someone did something against him", but did not elaborate on this. However, even if E.'s interview did not turn out to be valuable in terms of EASE experiences' presence and intensity, it remains interesting to see that the alterations of self and world are indeed arranged precisely for each patient. Considering the case of A., for instance, who, in a period of his illness, exhibited a considerable alteration of the self, but then his illness progressed on to residual negative symptomatology.

Table 7 – EASE (Patient E.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.3. Thought pressure	X	
1.4.1. Thought blocking	X	
1.6.1. Pure rumination	X	
2. Self-awareness and presence		
2.13.5. Diffuse, free-floating anxiety	X	
2.13.6. Paranoid anxiety	X	

Source: Author, 2021

Case Synopsis:

E. was the only patient I have interviewed in the infirmary, and his self, world and symptom configuration is compelling, because of an -almost- complete lack of altered experiences. E. had developed a substance-induced psychotic episode, which seemed relatively stabilized when I interviewed him. E. would naturally tell me about his life outside of the hospital. However, his narrative seemed entirely tangential at times, and there appeared to be an essential baseline of psychotic symptoms and possible alterations of the self and world, which he did not further elaborate on. So, while his dynamic configuration of altered self and

world experiences was somewhat impoverished at the time of the interview, this still points toward an essential point regarding alterations of subjectivity, world and symptoms: the fact that these may indeed appear in different grades. Some may seem more subtly or prominently, also depending on how severely the patient may have chronified.

PATIENT F.

Clinical history/anamnesis:

F. was a 55-year-old male patient I interviewed, diagnosed with schizophrenia, induced from years of psychoactive substance abuse. The patient then began his treatment at the psychiatric outpatient clinic for adults. Both F.'s mother and his father had passed away. F. used to work as a lawyer but stopped working since he began using psychoactive substances. He says he began using marijuana and then cocaine, in his youth. F. also made use of mushrooms and crack. He was, when I interviewed him, a catholic. At the beginning of his illness development, F. would also compulsively practice physical exercises and avoid eating calories. F. also developed a compulsion toward sexual activity, which seriously caused harm to his marriage. When older, F. would start working a little again, and he began being treated with Fluoxetine. However, he also began making abuse of medication and started showing signs of convulsion. During this time, he developed a series of cognitive losses. F. was then also prescribed Stilnox and began developing irritability and an incoherent discourse, which lead to a psychotic episode. F. started complaining about thoughts that were "out of reality". He began being medicated with Haldol and Phenergan.

After a while, Quetiapine, Donaren and Venalfaxin were introduced, with an improvement of F.'s clinical picture. During that time, he maintained his smoking habits. His diagnostic hypothesis continued being discussed toward that of substance abuse induced schizophrenia. F. was thus prescribed Clozapine and Quetiapine. Then, Venlafaxine, Topiramate and Flunitrazepam were introduced. By then, F. began having trouble with sexual dysfunction, which reduced his libido. Bupropion was also inserted. F. also has a daughter whose diagnostic hypothesis is a borderline personality disorder. Over the course of this same year, F. would complain about not having much contact with her daughter, saying that she did not appreciate him, thus accusing him of being an absent father. In one of the interviews I did with him, he would complain that his daughter said that "he was not her best friend, anymore".

F. also has a very labile affect. In the initial phases of his illness, he would feel "depressed", lacking the energy to leave his home. A lot of F.'s hallucinatory and delusional

activity had sexualized content. In this same year, he would say he felt jealous of his daughter's new boyfriend. His self-esteem would also be very impoverished, which would lead to the worsening of sensorial hallucinations and delusions. For instance, he would say that his "essence would leave from his feet" or that he had a sensation that his "penis would shrink". Other interesting anomalous experiences relate to hallucinations in which his perception would expand into space: he would see faces and naked women drawn on walls. He also describes that when he needs to defecate, he feels that this occurs through one "side" in which the faeces are kept, and through the other side that expels faeces.

When I interviewed him, F. would continuously worry about his daughter, stating that she has begun using drugs once more. He also sometimes dreamt about using marihuana and smoking cigarettes. F. said that when he feels "normal", he can deal with things in the world and keep his hallucinations aside. However, he would say that sometimes he still feels that others are reading his mind, and he has the feeling as if time is somehow altered. However, he would say that he did not feel like using these substances daily. He said that he felt like he saw animals such as flies or a vulture, but would generally be feeling fine. F. was then using Clozapine, fluoxetine and clonazepam.

F. is a patient whose capacity of maintaining a logical discourse was severely impaired, when I interviewed him. During the interviews, a fluctuation of humour/affectivity would also come to the fore.

The sensation I had of F. was, when I interviewed him, that he could not maintain healthy, enduring and meaningful relations with others. His connection with me, during the interviews, was quite bizarre, given the content of his positive symptomatology. F.'s personality is also permeated with complexity, given that he used to be very much involved with substance abuse. This left significant cognitive impairments and profound difficulties of engaging with others and work, for instance.

Phenomenological and dynamic analysis:

F. was a patient that demonstrated a considerable number of anomalous experiences in EASE Domain 1 (Cognition and Stream of Consciousness). For instance, his stream of thought would continually be interrupted so that he needed to "force his head" to remember what he needed to do. In his words,

> You have to force the head to try remembering what you were doing. For instance, I go to the kitchen and do not remember what I was going to do there. But then I go back to the room, because I was in the room and then I had to go to the kitchen, then in the room I see something that makes me remember. Then I pick that up and return to the kitchen.

F's. speech was also many times disorganized, and he was not able to construe meaningful phrases.

F.'s thoughts would also spatialize (EASE sub item 1.8.) as when he said that, "I look at the wall here and keep on looking; suddenly, I see a trace there. Of that trace, I see another one, an eye and a mouth…many faces… the body… I draw a woman naked from behind, with her hand in the front".

The above excerpt relates to much of F.'s positive symptomatology. He is a patient who would talk a lot about sexualized content in general, which appeared markedly in his experiential life.

Concerning EASE Domain 2 (Self Awareness and Presence), F. did not show a considerable amount of altered experiences. He talked about feelings of inferiority during adolescence, but these were not basal alterations of selfhood. He said that he sometimes felt as if the world affected him too much, which lead him to say the following:

> When I am flying, a billion years ahead and I fall and want to stop with my feet, but I do not have where to put my feet and stop because it is an abyss, and then I fly up again. This will take billions of years, and I am walking up, up, up and wanting to stop to get my feet right, but I can't..I need to get my feet right… I am afraid of feeling small… this feeling of being small before

> the time that has always existed and will always exist, I have a… strange sensation…
>
> At night, I am lying in my bed and start having this sensation. It is a sensation; I do not move, I am asleep, laying still, I feel as if the feet, as if I had to bend the toes of my feet, but it does not bend and so I stop and continue feeling.

Regarding Bodily Experiences (EASE Domain 3). F. displayed three intriguing experiences. The first relates to bowel movements, which he described as follows:

> Yes… the belly is hurting, you know. There are some twinges on this side. I do not feel the desire because to evacuate, you need to use force. It is also now **** (makes noise with the mouth). And I do not feel the desire of using force. When the blow is on this side, and I then feel like using force. The impression I have is that I have two sides. One that stores and one that expels.

One more interesting phenomenon is that F. said he sometimes felt as if his "essence flows through his feet". He would sometimes be laying down, and not keeping his "essence" inside, so he needed to bend his feet to keep it inside. F. said the essence would also flow out of his fingers, back when he was an adolescent. When I interviewed him, he felt as if he only has to say "go out", that the essence would indeed flow out.

F.'s case is an interesting comparison to the other patients interviewed, given the focus on one EASE domain (Bodily Experiences), and the fact that his experiences also vary in intensity and frequency. While he used to have to "force" his essence to stay inside by bending his feet, he could, at the time I interviewed him, "let go" of it.

Table 8 – EASE (Patient F.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference	X	
1.1.1. Loss of thought ipseity	X	
1.2. Thought pressure	X	
1.4.1. Thought block	X	
1.6.1. Ruminations/obsessions (pure rumination	X	
1.6.4. Ruminations/obsessions (pseudo-obsessions)	X	

1.6.5. Ruminations/obsessions (rituals/compulsions)	X	
1.7. Perceptualization of inner speech or thought (internal as the first-rank symptom)	X	
1.9. Perceptualization of inner speech or thought (external)	X	
1.10. Inability to discriminate modalities of intentionality	X	
1.11. Disturbance of thought initiative/intentionality	X	
1.12. Attentional disturbances (inability to split attention)	X	
1.13. Disorder of short-term memory	X	
1.14. Disturbance of time experience (disturbance in subjective time)	X	
1.15. Discontinuous awareness of own action	X	
1.17. Disturbance of expressive language function	X	
2. Self-awareness and presence		
2.3.2. Psychic depersonalization (unspecified depersonalization)	X	
2.5.1. Fluid global derealization	X	
2.13.5. Diffuse, free-floating pervasive anxiety	X	
2.16. Diminished initiative	X	
2.17. Hypohedonia	X	
2.18. Diminished vitality (state-like and trait-like)	X	
3. Bodily Experiences		
3.1.1. Morphological change (sensation of change)	X	
3.1.2. Morphological change (perception of change)	X	
4. Demarcation/transtivism		
4.5. Other transitivistic phenomena	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena	X	
5.4. “As if” feelings of extraordinary creative power	X	
5.6. Magical ideas linked to the subject’s way of experiencing	X	

Source: Author, 2021

Case Synopsis:

F.'s case is curious, given the fact that his altered experiences and subjective and worldly configuration is focused on bodily aspects. His narrative was highly sexualized in many places. His answers often referred to how he positions himself toward women, for instance. F. had a history of substance abuse, which lessened over the years. However, he still had a somewhat rigid sense of selfhood, even if it is not that fragmented as H.'s, for example. Instead, F.'s overall sense of self would not allow him to be functional on a deeper level, both concerning his contact with himself and others and the world. He sometimes still felt as if his "essence would flow out of his body, more specifically his feet. Regarding the intensity of altered self and world experiences, F.'s have also changed, throughout his illness. His altered experiences' interrelation points to a feeling of selfhood that cannot fluidly find a more rooted and functional engagement in the world. F.'s sociality was, at the time of the interview, in general also poor, given that he had lost a rather significant amount of social capacities, which lead to poor intersubjective possibilities.

PATIENT G.

Clinic history/anamnesis:

G. was, when I interviewed him, a 55-year-old male, diagnosed with schizophrenia, who was then living with his wife and four daughters. G. used to work at a tire manufacturing company for a long time, then in telemarketing. He had also worked in two other informal jobs, having retired afterwards. Over the course of two years, he also received psychological care, apart from the psychopharmacological treatment. G. refers that when he was a young adult old, he went to a catholic church, and when the priest said his name, he would begin laughing. He then felt as if he was committing sin and stopped going to church. When he was 18, he started frequenting an evangelic congregation and believed the priest knew what he was thinking. When he is a young adult, G. refers that everything was going wrong with his family. His brother in law was murdered, and his sister separated from her husband. From this moment on, G. says that his life became even more of "living hell". G.'s hallucinatory and delusional experiences would revolve mostly around mystic-religious phenomena; however, these experiences were also felt in his body, through the insertion of holy spirits that took command of his thought and agency. One day, the priest told him that his life was a mess and that he should leave that particular church.

G. then started to drown in debts, which he was still able to pay off. Then, G. began visiting an Adventist church, where he heard that "God would not forgive you". G. then started hearing voices and feeling "God's spirit" in his body and brain. He also believed that God put "wrong words" in his mouth and that a particular voice told him that his wife was cheating on him. G. began feeling wrath toward God and stopped trusting in Him. G. then went to an emergency unit and was medicated with risperidone, afterwards being sent to the outpatient clinic. In November of this same year, G. is given the diagnostic hypothesis of schizophrenia is given, and G.'s risperidone dose is increased.

In March of the next year, G. was treated with risperidone, biperiden and sertraline, given that he was displaying obsessive symptoms. Also, G. would say that God would enter his body and insert terrible thoughts, especially in happy times, but even when

things were not that well. For instance, he said that his daughter had to stay at the hospital's ICU for one week, given complications that arose from bariatric surgery, and that, when he visited her, God inserted a thought that "it would be better if she were dead". By the end of this year, Clozapine is introduced because of the patient's side effects, such as excessive drowsiness. G. continued having delirious experiences that God and other spirits are influencing him.

When I interviewed G., his delusional activities and hallucinations were, almost all of them, of religious nature. During the interviews, G. maintained a more or less coherent stream of thought and speech. However, apart from the alterations of the self and a fragile sense of identity, G. told me that he felt as if he would indeed "get completely" mad, that he felt as if his head would explode. When I interviewed him, G. said that, when he talked to others, he would sometimes still feel a "spirit" involving his body, but not so strongly, anymore. This "spirit" G. would talk about taking control of some of his bodily functions; it would accelerate his heartbeat, and "shut" his mouth so that he would not be able to speak.

At the time of the interviews, G. maintained a relatively normal thought process. His wrath about God remained, and he continues believing that God is the "devil" and that these two entities are frequently "acting" in and through him. G. is otherwise relatively well preserved and able to function well, also in the scope of his social relations. When I interviewed him, he was being treated with Clozapine.

While his contact with me was satisfactory and he could narrate some of his experience in some detail, when I interviewed him, his delirious religious activity did not seem to allow for more profound and meaningful relations with others and his family. G. still seemed somewhat disconnected from a meaningful intersubjective world. His connections were restricted to close family and not much more, since he would usually withdraw from social situations, have little desire to contact the world, and others. Social activities were, at the time of the interviews, almost nonexistent.

Phenomenological and dynamic analysis:

When I interviewed him, G. showed significant alterations in EASE Domain 1 (Cognition and Stream of Consciousness). His would present vivid descriptions of thoughts being inserted into his head and controlling his entire "self". For instance, he said: "God put a spirit in my body, and then he put me in the direction toward that lady, and I felt the need to grab her, the need for grabbing her. Then I started yelling at him to stop that…"

He also said that the priest would know his every thought, and expose these to everyone in the church:

> … and, to harm me even more, when I went to church… the preacher would say all the things I was thinking about. He would expose all my thoughts for all the church to hear. He would know everything that I thought about, but always in a pejorative manner.

G. would also spatially experience his hallucinations. He said that,

> That was real; it was real. The guy materialized in front of me, he did. Of the same green colour, with those things to scratch heads. In front of me, he materialized and wrote on my forehead. Also, I saw a thing on the floor, that would stand up and turn into a serpent; it would turn to my head. My head is al hurt, it used to be all hurt, and no medication would make it better. It was a pain in my head, all up and down.

G. *felt* and *heard* God everywhere, which influenced his entire lifeworld, given that he would begin to act and exist because an *external* force would enter his mind. As he said, "… it was me and that force making me act. Making me think… voices talking inside my heart, inside my head, inside my chest…I felt, like this, the spirit beside me, sometimes I feel a spirit around me…"

Regarding EASE Domain 3 (Bodily Experiences), G. would experience synesthetic alterations, such as when he said that: "It was a pressure on the head, I would clench my teeth…

I felt my body on fire. I lived in a hellfire, my body burned just like fire… my face deformed, everything changed."

Physical pain would also be present,

> They were pains that were not natural; my back hurt, I felt the pain that made me fall to the floor. I passed in front of a church, looked at the cross and from there a spirit would leave, enter my back and I would fall on the ground with so much pain.

G. also said that he would still be afraid of bodily contact with others, as described in EASE Domain 4 (Demarcation/Transitivism). He said that,

> I am afraid of saying hello to people. Because I am afraid of what God might do to me… I feel panic of these things, I feel panic, because every time that I would talk to someone and make contact with someone, God would put the spirit in me.

In G.'s case, it is interesting to note that the content of his anomalous self was mostly mono-thematic (religious and mystic). He says that he felt much better overall when I interviewed him and that he was trying to get his life back on track by having and informal job. However, he would still feel bouts of anger toward God.

Table 9 – EASE (Patient G.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference		X
1.2. Loss of thought ipseity		X
1.3. Thought pressure		X
1.5. Silent thought echo	X	
1.6.1. Ruminations/obsessions (pure rumination)	X	
1.6.5. Ruminations/obsessions (rituals/compulsions)	X	
1.10. Inability to discriminate modalities of intentionality	X	

1.11. Disturbance of thought initiative/intentionality	X	
1.12.2. Attentional disturbances (inability to split attention)	X	
2. Self-awareness and presence		
2.13.2. Anxiety (psychic-mental)		
3. Bodily Experiences		
3.1.1. Morphological change (perception of change)	X	
3.6. Spatialization (Objectification) of bodily experiences	X	
3.7. Cenesthetic experiences	X	
3.8.4. Motor disturbances (desautomation of movement)		
4. Demarcation/transitivism		
4.1. Confusion with the other	X	
4.3.1. Threatening bodily contact and fusion (Feeling unpleasant/anxiety-provoking)		
4.4. Passivity mood	X	

Source: Author, 2021

Case Synopsis:

G. is a patient whose experiences also have lessened in intensity throughout his illness. His alterations of self and world were similar to C.'s, given that they were mostly of religious content, in nature. G. used to attend church, where he began having various delusional and hallucinatory experiences, that directly influenced his sense of self. Most parts of G.'s narrative revolved around the fact that God would possess him entirely so that he would lose all or most autonomy over his thoughts, agency and so forth. A fear still permeated G.'s contact with others and reality that this might once more happen violently and his being in the world would be very much impregnated with a fragile and unstable connection toward the world, as it were. Thus, his basal feeling of self had also suffered significant alterations, specifically regarding how he understood and perceived his surroundings and others. At the time of the interview, he said that he felt much better in general; however, a feeling of widespread anger toward God would persist.

PATIENT H.

Clinical history and anamnesis:

H. was, when I interviewed him, a 31 years old male patient, currently participating in several support programmes of an association linked to the Schizophrenia Program of a research university. Besides participating in this group's activities with other patients, H.'s pharmacological treatment was made as an outpatient, with a private psychiatrist. He was living with his mother, when I interviewed him. H. had a brother, who passed away. He also managed to finish his high school studies. H. began developing symptoms in early youth. He was hospitalized twice. He attempted suicide once and also had a nephew who was diagnosed with schizophrenia. H. started his psychiatric treatment during adolescence, having been diagnosed with schizoaffective disorder when he was in Europe with his family. His brother passed away from cancer. H. would then stop studying, already showing a tendency to isolate himself and display a "distanced gaze".

H. was then hospitalized and began his treatment with Invega, returning to Brazil with his mother. H. would say that his parents "made up" the illness and then stops taking his medication because he says they "cause hurricanes". He would continue being aggressive with his mother, saying that she "was having an affair" with a "technician". H. would then start taking risperidone but continue to be socially retracted and with a distanced gaze. H. was also continuously aggressive with his mother, would be "disgusted" by her and thus a variety of delusional experiences continued. H. was, at this point, not functional and eating and sleeping, all day long. New delusional discourses appeared, and olanzapine is associated with his treatment, impacting the positive symptoms he displayed. His mother says he would now seem "possessed" and he would begin laughing uncontrollably.

While his delusional activity diminished, the laughter continued, his thinking became more disorganized. His father then said he would like H. to come to Europe, that his mother wanted him here. H. then he began a course of computer graphics course. During that time, his facial expression would become "frozen". He stopped a course he was doing, and would only stay on the internet, all day long. In July of this year, he has a relapse and would

say that the “T.V. is humiliating” him. He had sensations throughout his body, an “orgastic spot” that makes him anxious. He begins his soliloquies again. His dose of risperidone is lowered. H. almost finished another course but stopped it before finishing it. He then goes back to Europe, where he promised not to stop his medications and then returns to Brazil, once more. In that same year, he was hospitalized for the second time, and his diagnosis is changed to paranoid schizophrenia. He abuses alcohol during this time and is aggressive with his parents.

His parents’ relations deteriorate during this time, and he says that “his parents made him fragile”. He is apathetic and lacks initiative. His life in Europe does not go well, and he decides that it would be best to return to Brazil. He has a sedentary lifestyle and usually sleeps quite a bit. H. would then continue developing thoughts of auto-reference and thought interference. He is once more treated with Clozapine and begins saying that he “absorbs” the feelings of others. After returning to Brazil, H. stayed with his father. His father’s coexistence is now tranquil, yet he continues displaying delusional thought and continues his treatment with Clozapine. H.’s overall cognitive and social functionality is relatively low, and daily, he mostly at home, other than participating in support groups.

H.’s constancy of positive symptoms is relatable to B.’s, even though the contents differ. However, H. presents a more disorganized configuration of delusions and hallucinations. It is sometimes challenging to distinguish which experience occurred at which point over the years. When not hallucinating or having delusions, H. logical discourse is also disorganized and very puerile.

H. had, when I interviewed him, a good supporting network: he would participate in discussion groups with other patients, thus feeling supported by treatment networks. However, a similarity would arise, regarding work, study and other social relations: while H. seemed to have difficulties engaging in meaningful and deep ties with others; yet, he still maintained a few intersubjective relations. This contributes, I believe, to a better outcome regarding his overall clinical picture. His speech, however, when I interviewed him, was quite disorganized and permeated with positive symptomatology. H. was one of the patients on which the EAWE “Other Person” domain was utilized, and the patient showed much difficulty in describing his intersubjective relations to me.

Phenomenological and dynamic analysis:

The interviews with H. were difficult because he would often enter a delusional stream of thought, which made it difficult to investigate the anomalous self-experiences present more thoroughly. However, even so, H.'s experiences presented themselves as an interesting challenge to be taken on. H. was also the first patient I utilized the "Other Persons" section of EAWE (Examination of Anomalous Self Experience) on, EASE's sister instrument, which focuses on anomalous experiences of the world.

Concerning Domain 1 (Cognition and Stream of Consciousness), H.'s stream of thought was still quite disorganized, a mixture between hallucinatory and delusional phenomena, where thought insertion did occur. He would say, for instance, that,

> No, what happens is that for many years I have had these involuntary thoughts. I explain to them; I have made it a habit of silencing my mind. So, nowadays, I think in silence. And, this is it. But why? So that I can contain them and avoid involuntary thoughts to enter my mind.

When asked about these involuntary thoughts and where they are generated, H. said that,

> Where they are generated? I can tell where my thought is. It all starts with my emotions. But the external thought I capture it with something that enters my mind on a superficial level. I am thinking about my thought processes, and then the involuntary thinking also comes, at the same time.

The excerpt also points to another phenomenon present in EASE, which belongs to Domain 2 (Self Awareness and Presence), namely sub-item 2.6., *Hyperreflexivity*. The patient used to think about his thoughts, thus over-reflecting on what was being considered and objectifying the contents of his stream of consciousness.

Shortly after the question of where these involuntary thoughts are generated, H. said that,

> Let's say that God gives the orders of these thoughts. I don't know if it is the Demon our the Guardian angel that makes me have these thoughts. Even so, it is a Demon, right… I think this is it; it is God teaching me to… I don't know, transforming me from within, you know? Emotionally and spiritually.

Item 1.3, *thought pressure*, is also present. H. said that,

> Yes, when I was **** or **** years old. What happened is that thoughts would come very quickly, a lot of information on a mental level would come to me… what happened, is that I had to read everything. I read, read and read uncontrollably… but then, you know, the purpose of this is that we need to learn to silence ourselves, and self-control.

H. says he was able to, when I interviewed him, "energize feelings. I can cool it down and soothe it. I am capable of cooling my feelings. Yes, more like this. But, for instance, if I hold on to them, I may freeze them, and they might go back to their place, you know?"

Regarding EASE item 2 (Self Awareness and Presence), H. used to feel distanced from himself and the world. He would say that that,

> In Europe, when I was an adolescent, it is even written like this in the bible, the valley of shadows. On an emotional level, this is how it felt. It was all sad, obscure. Everything was somber… that was sad, like a black prism on my sight, you know?... Today I feel… today is very different. Today my vision of the world is like a white prism, you know? The colours are not bright, but my God, it is all less despair ridden than what it used to be…

In EASE Domain 3, H. also talked about anomalous experiences he has had, related to his face. He said that,

> You know, my eyes are now much brighter. Like, happier. But this does not necessarily mean that they are happy. That is, they became happier and…. I like looking in the mirror because they are now so pretty! Before they were sad, you know?

EAWE ("OTHER PERSONS")

Regarding EAWE, H. reports that he used to feel quite detached and isolated from others, socially. This phenomenon can be found in EAWE (item 3.2), which relates to a *Sense of Remoteness from Others*. He said that, "I felt distant from everyone. Except my mother. But from people, in general, I felt distant. I felt sad because it was like I felt very lonely. I was surrounded by people but felt lonely". He says that "Nowadays, I am almost normal regarding interpersonal situations, I talk with others, with some people I make jokes…"

However, H. when I interviewed him, still had difficulties participating in social situations, because of the "projections" he says he has (thought insertions). He would say "Involuntary sensations…they make me feel ashamed". Such experiences are found in EAWE (sub item 3.6.), *Interference by Voices*.

H. also said that he used to communicate with others when he worked at a fast-food restaurant. This refers to EAWE sub-item 3.13.; People *Seem as if Communicating Something*. He said that, "I knew what people were thinking; I had the remote perception, or, I knew when their people in another geography were talking about me, I could listen to that. It was nice."

Table 10 – EASE (Patient H.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference	X	
1.2. Loss of thought ipseity	X	
1.3. Thought pressure	X	
1.4.1. Thought block	X	
1.6.5. Ruminations (rituals/compulsions)	X	
1.13. Disorder of short-term memory	X	

1.14.1. Disturbance of time experience (disturbance in subjective time)		
1.14.2. Disturbance of time experience (disturbance in existential time)	X	
2. Self-awareness and presence		
2.2.1. Distorted first-person perspective (mineness/subjecthood)	X	
2.2.2. Distorted first-person perspective (experiential distance)	X	
2.5.1. Derealization (fluid global derealization)	X	
2.6. Hyperreflexivity	X	
2.7.1. I-split (delusional elaboration)	X	
2.8.1. Dissociative depersonalization (“as if” phenomenon)	X	
2.8.2. Dissociative depersonalization (dissociative visual hallucination)	X	
2.10. Sense of change in relation to chronological age	X	
2.13.2. Anxiety (phobic anxiety)	X	
2.16. Diminished initiative	X	
2.18. Diminished vitality (state-like/trait-like)	X	
3. Bodily Experiences		
3.2.1. Mirror-related phenomena (search for a change)	X	
3.2.2. Mirror-related phenomena (perception of change)	X	
3.6. Spatialization (objectification) of bodily experiences	X	
3.7. Cenesthetic experiences	X	
4. Demarcation/transitivism		
4.1. Confusion with the other	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena	X	
5.4. “As if feelings” of extraordinary creative power	X	
5.6. Magical ideas linked to the subject’s way of experiencing	X	

Source: Author, 2021

Table 11 – EAWE (Patient H.)

Domains/Severity	(2) Mild
3.2. Sense of Remoteness from others	X
3.6. Interference by voices	X
3.13. People Seem if communicating something special or unusual	X

Source: Author, 2021

Case Synopsis:

H.'s case is, in some aspects, similar to B.'s. His own subjective and worldly configuration and dynamics were still profoundly impregnated with positive symptomatology and a wide variety of anomalous experiences. When I interviewed him, H.'s sense of self was still intensely infused with a wide variety of altered perceptual experiences that shape his entire way of being in the world. Interestingly, however, H.'s alterations from the self are of a different kind, since they do not necessarily have such clear-cut characteristics, such as B.'s. They are also not always of a grandiose and metaphysical nature, but rather embedded in the social and intersubjective world. H. remembers having been bullied at school, and how this began distancing from the world, and others. While he says that was, when I interviewed him, able to participate in social encounters, he still could not develop meaningful and more profound encounters with others. Aside from the fact that many of his positive symptomatology was also imbued with mystical and religious experiences, his entire self seemed to have never been able to fix himself in the social and shared world. H. also displayed a very childish way of being in the world and relating to others. Thus, his sense of self also seemed as if it had not found a more concrete anchor in the world, always being permeated by a sort of inverted and "subjectified" feeling that did not allow H. to more fluidly contact his surroundings, be that via interpersonal relations, or meaningful activities of sorts.

PATIENT I.

Clinical history/anamnesis:

I. was, when I interviewed him, a 49-year-old male patient, currently participating (and leading) in some support groups. I. was also seen by a private psychiatrist. I.'s symptoms began when he was a young adult. He had been, when I interviewed him, hospitalized 4 times, one hospitalization having occurred voluntarily. Back then, he was living with his younger brother, father and mother. His older brother lived alone, on the same street. At home, he would help out with tasks such as cleaning the house and cooking. Apart from this, he would give speeches about his illness, lead two groups for patients at the support groups, and teach English at an English school. I. used to get along well with his father, but suddenly he felt like his father did not like him, anymore.

During his adolescent years, I. would often ask him what was happening, but he never directly responded. He would say that his father and mother would only respond "dubiously" and in a divergent manner, never saying what had happened. Following this, I. would begin developing "phantasies" on why his father did not like him, and never indeed got an answer. When he was an adolescent, I. began developing feelings about a girl during his high school years. These feelings also occurred "platonically", since he would make up that she also liked him, but this would never be substantiated, given that she never really told him this. I. was going through a process of analysis, and he would ask his analyst whether she knew this girl he was falling in love with. The analyst did not respond, but "left the question" open. Thus, I. began to delusionally believe that his analyst indeed knew about the girl he liked and that they were both in contact with each other.

I. then started calling his analyst's office, asking to talk to ****, that was the name of the girl he liked. Coincidentally, his analyst's daughter had the same name, and I. was told that **** had just left, that she was not there. From this day on, I.'s delusional activity grew even more potent, and he would be sure that his analyst knew the girl he was in love with and that they were talking about him. Following this, I. was hospitalized, and his delusional activity grew, he would believe that radios were transmitting him secret information about the wars. He

would think that he was being spied on. I. then began treatment with his first private psychiatrist, who would treat him for about 20 years. During this time, I. would start growing angry at this psychiatrist, because she would confide in the psychiatrist, which made I. uncomfortable. He was by that time already taking Clozapine. As an adult, I. began being treated at the outpatient clinic of a university hospital initially and then continued his treatment with another private psychiatrist, with whom he remains until today. Slowly, I.'s symptoms began to ease, and he would once more begin a psychotherapeutic process.

During this process, I. began to more critically discuss the relationship with his father which gradually got better, since he would understand that his parents are now older and that it would be essential to care for them. When I interviewed him, I.'s thought process was relatively is organized, and he would be able to begin and end an idea or argument rationally. While his delusional and hallucinatory symptoms had, at the time of the interviews, improved, I felt that I. still had difficulties with affectively engaging with others. However, even so, I. could function daily. He had even sent out some C.V.'s, written a book and would engage with some friends. He was then, at that point, being treated with Clozapine.

Regarding his social life and overall intersubjective relations, the patient participated in various support groups and gave speeches about his own experiences. However, difficulties in *integrating* his own life and social experiences arose, given that I. has challenges in engaging with the world and others on a deeper level. His illness has lead him to a sort of superficial and repetitive mode of being in the world. While I. would have some meaningful intersubjective relations, he would have difficulties maintaining them over a more extended period of time.

Phenomenological and dynamic analysis:

I.'s interview began with him saying that he would still experience thought pressure (EASE sub item 1.3.) on quite a regular basis. He would say that,

> there are moments of anxiety, there are moments of fear when a lot of thoughts pass through my head, one after the other, and this is generally out of control. Because a series of thoughts come, a series of anxiety, of discomfort. I believe that many times some side effect of the medication might bring this on…

An interesting example that I. talked about related to the fact that he had difficulties relating to the world and others through affection. He often experienced what in EASE has been coined a discordance between expression and expressed (sub item 1.16.). He would say that,

> this exact example of the smile. I think that… I think that sometimes I regret a smile that I give. Sometimes this comes immediately and then I regret it. Because I know that I am angry at someone… I think this goes far, I will try telling you a bit about it… the thing is… ot really the smile that should be there.do not really know if this is it… it happens, but at the same time I think that I should not bring this smile back. But then I speculate that, in the long term, this might actually be good to me.

Regarding EASE Domain 2 (Self Awareness and Presence), I. has experienced feelings of a pervasive sense of "I", which he only acknowledges as a more "concrete" sense of selfhood much later on, in his life. He said that,

> … when I was an adolescent, I read ***. And that already modified my sense of self… I think that at that time I started considering my deeper sense of "I". During that time, it was not so clear, but with the passing of time it became clearer. I began considering this sense of a deeper "I" that you ask about… I did not have a "we", I lost a bit the identification that people have. For instance, people belong to a variety of things in life. You belong to the university you study at, so your "I" is connected to the many activities that you do… many people ask themselves…and this feeling of "I believe" in this, this and that, I lost it when I read a philosopher, when I was young. I started thinking about the following- I do not believe in anything… my interior "I" does not depend on opinions…it was not that, anymore… I began thinking that my deeper sense of "I" identified itself with logic.

I. then goes on narrating feelings of depersonalization and self-alienation (EASE sub item 2.3.). He said that,

> with the evolution of my life, this conception of "I" changed. And then yes, when I meditate at home, sometimes I do this, what happens… first I acquired a bodily consciousness, and when I travel beyond this as if my "I" was not included in my body. My "I" is not in my body, it is in the universe. I have a brain like everyone, but this brain is more… between my "I" and my body. This "I" is a more mystical thing, a thing that is in space. A more mystical thing, really and then I start getting in contact with this body.

I. also said that during these states of depersonalization, he also felt "less affected" by things; however, he could not express how and why exactly this happened. But he found it crucial to feel as if he belonged to something *more*, namely, the cosmos:

> It is so difficult to belong to humankind. But belonging to the cosmos, this is more profound and stronger. I gave a speech there at…, and most of those in the audience were illiterate. They were not able to fill out the questionnaire that I gave them after the speech. So I thought to myself and said, taking a risk: I belong to the cosmos. They interrupted what they were doing and clapped their hands (laughs).

Regarding EASE Dimension 3 (Bodily Experiences), I. described a specific division or dualistic experience concerning his "I" and the body, which relates to EASE sub-item 3.3., *psychophysical misfit and psychophysical split*. He said that,

> I see, once more… and I feel… according to some Indian thinkers, it (the body, my insertion), is an organ of contact. Between your "I" and what is up there, and you're body. So "I" am behind the body, I believe in this.

I. also presented altered experiences related to the Demarcation/Transitivism Domain, of EASE. He said that, "I am here, a part of me is in you, and a part of you in me. It is inevitable that this exchange occurs. It is inevitable".

He also talked about a feeling of being fragile, as if things and others would frequently "pass-through" him. He said that,

> I feel fragile. But to diminish this feeling of fragility, it is the connection with others and the universe. This seems to be the answer. I feel fragile, I feel vulnerable, but then I think about the contact with humankind, let's say, with the universe.

Table 12 – EASE (Patient I.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1. Thought interference	X	
1.3. Thought pressure	X	
1.4.1. Thought block	X	
1.5. Silent thought echo	X	
1.6.1. Ruminations/obsessions (pure rumination)	X	
2. Self-awareness and presence		
2.1.1/2. Diminished sense of basic sense of self (early in life/adolescence)	X	
2.2.2. Distorted first-person perspective (experiential distance)	X	
2.3.2. Psychic depersonalization (self-alienation	X	
2.4.2. Diminished presence (distance to the world)	X	
2.6. Hyperreflexivity	X	
2.8.1. Dissociative depersonalization ("as if phenomenon)	X	
2.13.5. Diffuse, free-floating pervasive anxiety	X	
2.18.1. Diminished vitality (state-like)	X	
3. Bodily Experiences		
3.1.1. Morphological change (sensation of change)	X	
3.3. Psychophysical misfit and psychophysical split	X	
3.6. Spatialization (Objectification) of bodily experiences	X	
4. Demarcation/transitivism		
4.1. Confusion with the other	X	
4.3.1. Threatening bodily contact and fusion (feeling unpleasant)	X	
4.4. Passivity Mood	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena	X	
5.7. Existential or intellectual changes	X	
5.8. Solipsistic grandiosity	X	

Source: Author, 2021

Case Synopsis:

Patient I. represents another intriguing group of patients that were interviewed for this project. I. was, in comparison to most other patients, quite functional when I interviewed him, both regarding how he dealt with his illness, as well as to his surroundings and others. I. would still present, at the time of the interviews, subtle experiential alterations of self, world and others, but managed to deal well with them, daily. However, it seemed as if I. was still not able to experience his illness more meaningfully. He still seemed distanced from himself in the world, and it was possible to identify, in his narrative, gaps of his personal history. It was as if I. had not really integrated his own experiences, but somehow created a third-person perspective narrative about it, which did not allow him to engage with the world and others more fluidly. However, I. was still able to give speeches about his struggle with schizophrenia, and he has also published a book. His self-world-others configuration allows him to function differently compared to most other patients interviewed in the project. When I interviewed him, his symptoms were mostly residual, tending more toward a lack of volition and energy, rather than more basal alterations in the feeling of self.

PATIENT J.

Clinical history/anamnesis:

J. was a 41-year-old female patient, who was, when I interviewed her, being treated at a schizophrenia programme of a university hospital. J. lived with her mother, who was retired, and a younger brother who worked at an auto repair shop. J. also had an older brother, who possibly had traces of autism, but who was never really diagnosed. Another brother was diagnosed with bipolar disorder, and he committed suicide while hospitalized. Her father lived in a different state but sometimes came to visit. J. had no children and had never married when I interviewed her. She had finished high school. J. had her first psychotic episode when she was a young adult. Since then, she has been in psychiatric treatment. J. was hospitalized four times, all voluntarily. She was undergoing psychotherapeutic treatment, at the moment. J. says her paternal grandfather had schizophrenia. Over the next three years, J. says she had many more serious psychotic episodes, where she thought she was being filmed, she would talk to the T.V., hear voices and many other things (SIC).

However, J. says she had been stable for quite some time, when I interviewed her. She says she would help with domestic activities and helps at home, sometimes going to the market. J. was also interested in reading about schizophrenia, which she often does and discusses in her psychotherapy sessions. She also liked going to the park sometimes, where she would walk around. J. has never tried committing suicide, and she was, at the time of the interviews, being treated with risperidone. J. told me that she would start to "dissociate" things when she was quite young and that many things that she says "do not make sense". She refers that she liked being alone as a child and that she used to have "autistic behaviors": she would rock back and forth with a cloth, not paying attention to the world around her. She also said that she would, from very early on, "jump" when listening to music.

For J., this is a kind of *euphoria* that continued until she was in her mid-ages. She also says this was a kind of *bizarre behavior*. J. also says that she never had friends; she would never participate in activities in school. During her adolescence, she would sit on her bed for hours, and look at the ceiling, *just thinking nothing*. She sometimes would just look ahead, also

staring into the nothing. J. says that this same behavior would continue when she got old: she'll continue just staring at the walls, sometimes going out but then returning home. When she read something, J. also said that she would continuously re-read the same book or text repeatedly.

J. said that she does not have so many topics to talk about, because she re-reads everything. When I asked her if she had any plans for her life, she would say that she just "wants to get old and die". J. would always repeat that she is not "smart" because she has schizophrenia and thus "acts out of influence". She said she does not do things because she is capable, but because she likes that things are "organized". J. also said that if she began working somewhere, people would find that "strange", because she would start doing things on her own, independently. So, for her, it made "no sense find a job". To her mother, J. would say that she has a divided mind because it sometimes wants to do things, sometimes not. She would say that her "thought process" would always lead her in the wrong direction. Also, she referred to the fact that her mind has too much "dopamine'', which makes her say things she would not like to say. For J., her mind is would always set traps for her to be constantly afraid of doing things inappropriately. J. said that she needed to control her mind, because she is not a "natural person", given her illness and the fact that her mind does not help her.

J. was one of the patients I interviewed who would almost have no social contact at all. Her concrete and objective worldview would not allow her to interact with others or to have a meaningful job. While J. is an intelligent patient, she has enormous difficulties in engaging affectively with the world and others.

Phenomenological and dynamic analysis:

J.'s speech was relatively organized; however, she would be exceptionally *concrete* in everything she said. J. would have difficulties in understanding and speaking metaphorically. Regarding affect, J.'s is not entirely flat, but she had problems regulating her affect in the contact withers and the world. J. resembled the patient Blankenburg (31) describes in his essential *Verlust der Natuerlichen Selbstverstaendlichkeit: Ein Beitrag zur Psychopathologie Symptomarmer Schizophrenien*, where he develops an investigation of the so-called symptoms about primary autism in schizophrenia, which then also lead to social withdrawal on higher

levels (secondary autism). For Blankenburg (31), people with schizophrenia often lose what the author coined a loss of "natural self-evidence", which leads to alienation the patient experiences toward the fundamental meaning of things in the world. This will be exemplified by some of J.'s narrative, below.

J. also had what is described in EASE as the spatialization of experience (sub item 1.8.). She would say that,

> I was in the kitchen at home, I would look at the wall, and there was a little painting there, which was a little blurry, like a shadow of the light or so? Like a kind of light? It had like an aura. Then I started seeing mixed up letters on the well. Then I went to the doctors and began seeing letters on the doctor's faces as well. A P and M… then I talked to my psychiatrist, and I read four lines on her forehead which were all mixed up. These were all hallucinations I had.

When she had her first episodic episode, J. would also have difficulties discriminating *modalities of intentionality* (EASE sub item 1.10.). She said that, "I saw some people talking with me through the T.V… when I saw the T.V., I would think that the T.ZV was talking only to me and that everyone else was seeing that messages and no one else was saying anything".

Regarding the item discordance between expression and expressed (sub item 1.16.), J. said that, "There is a discordance. Sometimes I am calm on the inside, but I have a very bad face. It looks as if I am angry, but I am calm".

Now, concerning the "lack of natural evidence" (sub-item 2.1.2.), J. referred that,

> I tried making use of this strategy of giving a meaning to life, of going to college. But then, after three days, a month later, I am already giving up on everything. Because schizophrenia has this, "praecox dementia". The person starts giving up, giving up… So, knowing that this is already my life, I do not even begin… because I know my life is an eternal "giving up"…

> When Dr *** did not psychotherapeutically treat me, it happened that the day made no sense. It seems as if there is no sense in the things I do in my house, it made no sense, I did not want to do it anymore…it loses the meaning. It takes a day, and then on the following day I begin doing things, again. She says that the therapeutic sessions "give me consistency in life''; it seems as if I have more content in the things I experience.

Since sometimes,

> there are times when it all goes away. A wind came, carried it all away, and there is nothing left. All my will to live is gone; I feel like I do not want to do anything, anymore. A feeling of blankness happens, the lights go out. I do not know who I am and who or what the world is.

Also related to EASE Domain 2 (Self Awareness and Cognition), J. experienced a split of her "I" (sub item 2.7.) in the following way:

> If I were just one, I would only think about things peacefully and would be tranquil. I would not have to "flatten" anything, feelings would be neutralized, they would be balanced, and I would not have to flatten feelings, because there would be none.

Regarding senses of change concerning her gender (sub-item 2.11.), J. would say that she felt "androgynous":

> A while ago, they would chase me in school. They made bullying because I was masculinized. I may even be masculine, but I do not care about this anymore. Because the angels are androgynous… God made it like this… If my hand is not feminine, if my hand is thick and hairy, if I have hair on my arms and legs I do not care anymore… I will be an angel; I am not here to be a person…

Concerning EASE Domain 3 (Bodily Experiences), J. referred that she has had a feeling of her head being more prominent than the rest of her body (sub-item 3*., psychophysical*

misfit and psychophysical split). She said that, “I thought that my head was bigger. I thought that my head, my mouth, the cavity of my mouth seemed to be big and my head seemed bigger”.

J. also presented engaging altered experiences related to EASE Domain 4 (Demarcation/transitivism). She said that,

> I do not care too much about the world around me. If I start paying too much attention, there was something that used to happen; it was the colour of the chair, the blue chair was a message for me, a yellow shirt was a message for me, his pants are pink, you know? I used to read colours. I would interpret colour. But I stopped with this thing of interpreting colours. It was too dangerous. If I start interpreting the world,… even if with a silly interpretation, it is a thing of my head, it will dominate me, and I will have a psychotic episode.

In EASE Domain 5 (Existential Reorientation), J. experienced, in her first psychotic episode, “*as if” feelings of extraordinary creative power* (sub-item 5.4.). She said that, “I had the sensation that I was like the mother of Jesus Christ, something like this, as the son of God, I thought I had the power of healing”.

Table 13 – EASE (Patient J.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.6.1. Ruminations/obsessions (pure rumination	X	
1.7.4. Perceptualization of inner speech or thought (external)	X	
1.8. Spatialization of experience	X	
1.12.1. Attentional disturbances	X	
1.16. Discordance between expression and expressed	X	
2. Self-awareness and presence		
2.3.2. Psychic depersonalization (unspecified depersonalization)	X	
2.6. Hyperreflectivity	X	
2.7.1. I-split suspected	X	
2.9. Identity confusion	X	
2.10. Sense of change in relation to chronological age	X	
2.12. Loss of common sense	X	

3. Bodily experiences		
3.3. Psychophysical misfit and psychophysical split	X	
3.6. Spatialization (objectification) of bodily experiences	X	
4. Demarcation/transitivism		
4.5. Other transitivistic phenomena	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena	X	
5.2. Feeling of centrality	X	
5.3. Feeling as if the experiential field is the only reality	X	
5.4. "As if feelings" of extraordinary creative power	X	
5.5. "As if feelings" that the experienced world is not truly real	X	
5.6. Magical ideas linked to the subject's way of experiencing	X	
5.7. Existential or intellectual change	X	

Source: Author, 2021

Case Synopsis:

J. is a fascinating patient whose particular self-world-others configuration arises out of a concrete and very *crystallized* way of being in the world. J. was, such as I., also an intelligent patient, who believed she could not be more functional *because of her illness*. That is, she attributed her lack of wanting to do things, such as studying, to the incapacity of her *dysfunctional mind* to understand something. So, she continually gave concrete excuses that she would be unable to meaningfully engage with activities, saying she would only be "only waiting to die of old age". While she did not present prominent positive symptoms when I interviewed her, it is as if she consciously chose to remain disengaged from the world through an almost autistic movement in which she felt as if she could not relate to her environment, *even though* she would be capable of doing so. J. says she felt no need for engaging with others and did not wish to engage with any meaningful activities. Every day, she said she would feel pretty much the same, as she also often found herself "staring at the walls" randomly. J. would not be drawn toward the world to act, but her sense of self was permeated by a loss of natural self-evidence (31), which left her disconnected from the world and others.

PATIENT K.

Clinical history/anamnesis

K. was, when I interviewed him, a 39-year-old male patient that also participated in schizophrenia support groups. At that time, K. lived alone, and he was a postgraduate student at a psychoanalytic institute, even participating in several other groups, which were also related to his analytic process. K. had a sister who works in the public sector. His parents were divorced, and his mother would take care of his grandparents. He lived with his mother, and his contact with his father used to be very complicated. K. would say that his father did not believe in his illness, saying that his problems are "religious" in nature. K.'s symptoms began when he was a very young child. He said that he has always had hallucinations and talked to "shadows" and "images".

K. would say that these hallucinations told him that they were spirits and they would tell him about the world in general and life. K. says that since then he stopped talking about the shadows, but then when he was a little older, he saw a girl's spirit, "who became his friend". Then, he says that "things got complicated". He said he would have visions of an old lady with two knives that told him she had made a deal with Belzebu, the Devil. Then he began hearing voices inside his head, of a Demon that possessed him. This Demon, he says, is the only voice "inside" his head that he had.

The other voices, he would say, came from the "outside". After having been influenced by this Devil, he felt he would gain certain powers. He said that he would start being able to "do things that were not normal". K. said that many other spirits began wanting to talk to him after gaining these powers. When K. was an adolescent, he said he met God and began working for him. However, he feels he cannot talk about this, since he made a "confidentiality agreement" with God, and may not disclose the nature of his relationships with him. He says that he has always maintained his "own body", but that this Demon wanted to "train him to become a devil". He was never hospitalized and is currently also being treated undergoing an analytic treatment. K. refers he once attempted suicide when he was a pre-adolescent.

K.'s overall functionality was good, and he could interact with the world and others on a satisfactory level. He would deal well with his remaining symptoms and had a steady girlfriend at the time of the interviews, with whom he participates in various social activities.

K. would be able, to some extent, to have meaningful connections with others. Even if his positive symptomatology still permeated his daily routine, K. said that he has interestingly learned to "live" with some of his hallucinations and delusions, similarly to B. He said that in some situations, he even relies on them, in order not to feel so lonely. K. also had a fiancée when I interviewed him, and seemed happily engaged to her. I also utilized the EAWE "Other Persons" interview with K., where it became clear that K.'s intersubjective difficulties are much more *pervasive* and even short-lived, depending on the situation he finds himself in. I believe this aligns quite well with the primary objective of this project, which aims to understand schizophrenia not just as a descriptive and static disorder, but as one that changes, depending on how alterations of subjectivity, world and symptomatology are, in a specific moment, interconnected and influencing each other.

Phenomenological and dynamic analysis:

Concerning EASE Domain 1 (Cognition and Stream of Consciousness), sub-item 1.1., *thought interference*, K. said that, "Sometimes, a hallucination comes talking to me, when I am tranquil, when I am thinking about something, then I have to interrupt that and talk with the hallucination… this usually always happens".

Concerning sub-item 1.2., *loss of thought ipseity*, K. said that,

> I have some weird ideas that I do not think are mine. I think they were planted, or by the Devil, depending on the ideas….or they are ideas that will take me down a strange path that I think were planted there by fallen angels, demons or anything like this.

Interestingly, K. would also perceptualize his inner thought (sub-item 1.7.). He said that, “I stopped thinking in the format of words, which are easier to read. I think in the format of images, abstract formats”.

K. also experienced a phenomenon present in EASE coined discontinuous awareness of own action (sub-item 1.15.). He would say that,

> This sometimes happens when I am on automatic. When I am too bound to certain ideas, I do things without seeing. Then, when I look, I say: “Oh, how did I get there? I crossed the street and did not remember how I did that. If there were cars, or not…”

An interesting alteration of K.’s experiential life refers to sub-item 1.16., *discordance between expression and expressed*. He said that, “Since my affect is so blunt, I practically have only two feelings: a little bit of anger. Sometimes. And a feeling of constant happiness. So, I feel that I should be seeking some sadness, but I do not feel it. That kind of thing…”

In Domain 2 (Self-awareness and presence), K. would present alterations in sub-item 2.5., *derealization*. He said that, “What I have… the notion, especially because of the hallucinations; when I have many hallucinations related to angels, I feel that everything is a bit of a façade. People are not living an absolute reality which is, really, a simulation.”

Concerning Domain 2 (Self-awareness and presence), K. said that,

> When I have these vivid dreams, I have to act in other forms, different from this one, here. And I… when I am using this heavenly gift, this ability of the angels, my personality also changes. So then, I have a certain variation.

He said his personality was “expandable”: “So, I do not have this notion of… not fragmentation, but of an extension of personality…”

In EASE Domain 3 (Bodily Experiences), K. referred to having felt alterations related to sub-item 3.6., *spatialization (objectification) of bodily experiences*. He would say that,

> Ah, there are… some kinds of sensations of extension, you know? There is the one I told you about where I feel that my body has a bigger area than normal… so, for me, I feel…even a certain distance I can feel the hallucinations when they come closer, you know? So, this distance, I believe it is an extension of my body. These distances. It is like I was expanding to feel what is beyond.

Regarding sub-item 3.2., *mirror-related phenomena*, K. said that, "There is a kind of power I have where I get the impression that my eye looks like the eye of a cat. And, if I look in the mirror with this active power, I get the idea, the impression that I see these cat's eyes…"

K. also had the sensation of having too "tight" of a body, that he seemed not to fit into it. This phenomenon is described in sub-item 3.3., *psychophysical misfit and psychophysical split*: "I have this sensation that my body is tight. It is too small for me. This is very common… especially… and it gets worse when I am tired."

K. also presented transitivistic phenomena, as exemplified in Domain 4 (Demarcation/transitivsm). He would say that,

> When…when, especially, when I am not thinking about anything, without a specific feeling, I… I end up… the feelings of others, if it is something powerful around me, I end up feeling it. Like there is… like there is something that is entering me. That sensation, that feeling of the person, if it is discomfort or happiness.

In Domain 5 (Existential reorientation), K. would have *"as if" feelings of extraordinary creative powers* (sub-item 5.4.). He would say that,

> When I work on my powers of accelerating thought, depending on the level of acceleration, I can have a… I can activate a bigger sensibility, I can perceive the electromagnetic field of others. Then I can also pull other people's feelings; I can perceive thoughts, instincts…

EAWE (Examination of Anomalous World Experiences) Domain 3 "Other Persons"

K., regarding his intersubjective contact with others, experienced an alteration of the experienced described in sub item 3.1.12., *bodily/proprioceptive loss of attunement of other people's behavior or the social encounter*. He said that,

> When I'm more sensible, I cannot interact too well. When I feel suspicious, or so. There is not necessarily a reason for that. I have a certain difficulty that the people closest to me talk about. I have difficulties in understanding gestures. I did a test, one of the four expressions. I got 2 out of 20 right. A certain subtle expression I cannot understand…since I do not have them; it becomes difficult to understand them in others.

K. also felt he needed to come up with specific rules for social interaction, which relates to item 3.3., *alienated/intellectual strategies for understanding others*. He would say that,

> I come up with rules not to be excessive, ethical rules, so as not to abuse of others. I avoid doing things without necessity; I avoid trying to guess things that others cannot or will not avoid in me. Also, I do this so as not to manipulate situations in my favour. For instance, I can influence any woman to like me; it is an influence that makes that they like me.

K. was also inserted continuously into a social realm of *mistrust of others* (sub-item 3.4.3.). He said that,

> Others are judging; I feel exposed. It is constant, but I have learned to "dribble" it. Sometimes, when I am humble, it is better. You can break the paradigm of judgment. I have a pervasive feeling of mistrust that others want to harm me. So, I have difficulties trusting Others. Since I have a perception for potentials, if I show these to Others, they may come to abuse me.

One more experience K. narrated is that of *interference by voices* (sub item 3.6.). Interestingly, however, K. did not perceive the voices that interrupt his intersubjective contact negatively, but as a kind of support: "With hallucinations, it becomes easier to participate in conversations. When they are around… somehow they distract, and I do not get so worried about people."

Concerning sub-item (3.8.1.), the *intrusiveness of the gaze of the other* and *feeling of exposure through one's own eyes* (3.8.2), K. would say that,

> If anything shameful happens regarding my hallucinations, sometimes I feel discomfort in recognizing the gaze of others. Concerning feeling exposed through the eyes, I use a magic trick. I make use of good humour and try distracting the person from taking the focus away from her. The feeling that makes me uncomfortable in others is that I have much more experience and have seen so much more than others…

K. also felt as if *people seem disguised* (sub item 3.12.3.). He said that, "A sensation that people are hiding from themselves; this always happens. As I have this very profound perception of others, I feel they are not there because of their motivations. They were just put there; they are acting out of necessity."

Table 14 – EASE (Patient K.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of Consciousness		
1.1.1. Thought interference	X	
1.1.2. Loss of thought ipseity	X	
1.3. Thought pressure	X	
1.6.1. Ruminations/obsessions (pure rumination	X	
1.7.1. Perceptualization of inner speech of thought	X	
1.12.1. Attentional disturbances (captivation by details)	X	
1.13. Disorder of short-term memory	X	
1.14.1. Disturbance in subjective time	X	
1.15. Discontinuous awareness of own action	X	
1.16. Discordance between Intended Expression and the Expressed	X	
2. Self-awareness and presence		
2.2.1. Distorted first-person perspective (mineness/subjecthood)	X	
2.4.2. Diminished presence (distance from the world)	X	
2.5.1. Derealization (fluid global derealization)	X	
2.7.2. I-split (“as if experience”)	X	
2.8.1 Dissociative depersonalization (“as if phenomenon”)	X	
2.10. Sense of change in relation to chronological age	X	
2.12. Loss of common sense	X	
2.16. Diminished initiative	X	
2.18.1. Diminished vitality (state-like)	X	
3.Bodily experiences		
3.1.1. Morphological change (sensation of change)	X	
3.1.2. Morphological change (perception of change)	X	
3.2.3. Mirror-related phenomena (other phenomena)	X	
3.3. Psychophysical misfit and psychophysical split	X	
3.6. Spatialization (objectification) of bodily experiences	X	
3.7. Cenesthetic experiences		
3.8.1. Motor disturbances (pseudo-movements of the body	X	
3.8.2. Motor disturbances (motor interference)	X	
3.8.3. Motor disturbances (blocking)	X	
4. Demarcation/transitivism		

4.2. Confusion with one's own specular image	X	
4.5. Other transitivistic phenomena	X	
5. Existential reorientation		
5.4. "As if feelings" of extraordinary power	X	
5.6. Magical ideas linked to the X subject's way of experiencing	X	
5.8. Solipsistic grandiosity		

Source: Author, 2021

Table 15 – EAWE (Patient K.)

Domain/intensity	(2) Mild
3.1.2. Bodily/Proprioreceptive loss of Attunement	X
3.3. Alienated/Intellectual Strategies for understanding others	X
3.4.3. Pervasive Mistrust of Others	X
3.6. Interference by Voices	X
3.8.1. Intrusiveness of the Gaze of the Other	X
3.8.2. Feeling of Exposure through One's Own Eyes	X

Source: Author, 2021

Synopsis of the case:

K.'s case also displays an interesting subjective and worldly configuration. K., such as I. or L., can interact with the world and others within his limits. Regarding his feeling of self, he has somehow learned to *lean* on his hallucinations on delusion, saying that they sometimes even help him in social interactions. In other situations, K. has developed *techniques* to diminish the intensity of the presence of some of his voices. In a sense, he has thus learned to live with those in a more or less cooperative manner. His subjective and worldly alterations were sometimes felt in a threatening way. K. maintained a relatively stable and meaningful contact with the world and others, even if this occurs in his singular manner. While K. would still perceive others with uneasiness, such as when he felt invaded by their gaze, he could still maintain meaningful encounters. K. would also be engaged in a post-graduation course and his analytical process, which allowed him to engage critically with issues concerning himself and his surrounding world.

PATIENT L.

Clinical history/anamnesis:

L. was, when I interviewed him, a 50 years old male patient who also participated in support groups, being even inserted in leadership positions there. He was, when I interviewed him, developing his postgraduate activities and busy with the support groups in which he participated. L. also has a sister, who was diagnosed with schizophrenia. His father was diagnosed with schizophrenia as well but is deceased. He was mid-aged years old when his symptoms began and then hospitalized six times throughout his illness. Concerning his medication, L. used to be treated with various medications (also non-psychiatric). When I interviewed him, he told me he had changed his psychiatric treatment and is now treated with a minimal valproic acid and olanzapine dose.

At the time of the interviews, he would continuously discuss his pharmacological treatment with the psychiatrist, and feel open about this, since he felt that was generally well "backed up" by his family, friends and the groups he participated in. For some time, L. has not had positive symptoms, referred that his mood and affectivity, in general, were not too regulated. When I interviewed him, he would say that he still lacked some volition, when it comes to organizing his routine in a more organized manner, he is usually not able to sustain this for too long. However, he would be able to have a more or less systematic routine. When I interviewed him, L. was also engaged in his psychoanalytic treatment, and he also used to participate in therapeutic groups. L. has had suicidal ideations and one suicide attempt.

L. used to work in the exact sciences but then developed a severe illness that he attributes to stress at work. He then went on to live in another country., where he began studying. By the end of the second year, he had a psychotic break. He thus began treatment but had to break up these studies given a severe psychotic episode. At the time of the interview, L. said that he was restructuring his life: he would give speeches, coordinate groups, and begin his postgraduate studies.

L. very much enjoyed studying and the academic world. When I interviewed him, He said that he needed to engage with physical exercise, something he could not do because of his routine. One more project L. was involved in was that of needing a paid job and a relationship. He says the latter was difficult to find because was "picky" with the women he would like to go out will, because he is already a bit older, and having a relationship would demand quite a lot of energy. Besides that, L. would enjoy reading philosophy and literature, and he did usually not watch T.V. He also enjoyed listening to music when he arrived home at night.

When I interviewed him, L. was generally a well-functioning patient, able to have meaningful intersubjective relations, both regarding family and friends. While he had some negative symptomatology remaining, he was able to function well socially, in the speeches he gave and activities he participated, in. One thing he has in common with I. is that he had some difficulties in consequently maintaining his social and professional activities. However, when I interviewed him, L. was also beginning to study for a higher degree, which certainly impacted his life well positively, at that point.

Phenomenological and dynamic analysis:

Concerning EASE Domain 1 (Cognition and Stream of Consciousness), L. said that he did not have, when I interviewed him, acute difficulties in organizing his thought. However, when he was in an acute period with positive symptoms, he said that,

> I started feeling synchronicity with television, for instance, with the internet, my computer. I had the impression that other people that people in chat rooms were not those people… I would communicate with T.V, and the T.V. would answer my questions. When I was "unplugged" from those media, the stream of consciousness, the "telepathic stream" would continue haunting me and I would have an interaction with those entities, during my episode, what happened frequently was great mental confusion.

When I interviewed him, L. still experienced episodes of rumination (sub-item 1.6.) sub-items that,

> For instance, I am a person that usually does the right things, but when something wrong occurs, or I did something wrong, I keep on reenacting things in my mind, so that I do not make the same mistake twice, in the future… I usually think quite a lot. When there is an "end of the year" project going on involving my work, then I already start overthinking, let's do this, let's do that. I begin to imagine what people could already be planning for their year's end, etc.

In the early days of his illness, L. would also have experiences related to sub-item 1.8., spatialization of experience. In his words, he had the feeling as if, "his brain had me transformed into led, and it was hollow on the inside and that inside this structure, there was a kind of led balls. I would begin seeing bizarre structures, forms and drawings in the objects."

Concerning sub-item 1.11., *disturbance of Thought Initiative or thought intentionality*, L. would say that that,

> Think about this. I am already several months wanting to do sports again, and I cannot do it…there is a Tai-Chi association really near my house, about five blocks and even so I cannot do it. I even got a scholarship through this association, and I, even so, cannot go… once or twice a week I would begin doing something, a physical activity. And it is not a physical activity that requires impact; it is something tranquil…

Regarding Domain 2 (Self Awareness and Presence), L. commented that (during his last psychotic episode), he, "Thought about a plot against me, that thinking that my parents are not my parents, that they are traitors, I would think that I was Adam, take off my clothes and get naked, for instance."

During his psychotic episode, L. would have also have experiences of depersonalization (sub-item 2.3.), He would feel that,

> Those people were somehow not from another planet, but other civilizations. This happened frequently. This is why I lived in another country. I had this perception that somehow, people were not what they seemed to be; they would use masks, they wore…

Table 16 – EASE (Patient L.)

Domain/Severity	2 (Mild)	5 (Severe)
1. Cognition and Stream of consciousness		
1.2. Loss of thought ipseity	X	
1.3. Thought pressure	X	
1.6.1. Ruminations/obsessions (pure rumination)	X	
1.6.5. Ruminations/obsessions (rituals/compulsions)	X	
1.8. Spatialization of experience	X	
1.11. Disturbance of thought initiative/intentionality	X	
1.12. Attentional disturbances (inability to split attention)	X	
1.14.2. Disturbance of time experience (disturbance in existential time)	X	
2. Self-awareness and presence		
2.3.2 Psychic depersonalization (unspecified depersonalization)	X	
2.5.1. Derealization (Fluid global derealization)	X	
2.6. Hyperreflectivity	X	
2.13.2. Anxiety (psychic-mental)	X	
2.13.6. Anxiety (Paranoid anxiety)	X	
2.18. Diminished vitality (state-like)	X	
4. Demarcation/transitivism		
4.1. Confusion with the other	X	
4.3.1. Threatening bodily contact and fusion (feeling unpleasant)	X	
4.3.2. Threatening bodily contact and fusion (disappearance)	X	
4.4. Passivity Mood	X	
5. Existential reorientation		
5.1. Primary self-reference phenomena	X	
5.2. Feelings of centrality	X	
5.4. “As if feelings” of extraordinary creative power	X	
5.5. “As if feelings” that the experienced world is not truly real	X	
5.6. Magical ideas linked to the subject’s way of experiencing	X	
5.8. Solipsistic grandiosity	X	

Source: Author, 2021

Case Synopsis:

L. is a patient whose self-world-other configuration demonstrates a quite organized and functional example of how a patient with schizophrenia can meaningfully engage with the world. L., when I interviewed him, did not display any positive symptoms anymore. While he has experienced prominent delusional and hallucinatory experiences at the beginning of his illness, these were controlled at the time of the interviews. However, while L. was impressively able to relate to others, it is still essential to notice how he would have difficulty with some residual symptoms. For instance, he could not maintain regular physical activity since he could not find enough energy to do this. Nonetheless, L.'s sense of selfhood was stable enough to allow him to participate in meaningful activities, both personal and social. In comparison to other patients, his overall cognitive abilities were preserved, thus allowing him to be relatively functional on a daily basis. When he had his psychotic episodes, L. would perceive the world through more profound distorted self-alterations, which would also modify how he would perceive the world. L.'s delusional and hallucinatory experiences would be mostly related to technological content, such as listening to others talking to him through the radio, for instance. So, he could function well in the *shared world* with others, thus also having a relevant and meaningful with the activities he was engaged in. However, he had trouble organizing daily activities and was unable, for instance, to maintain regular physical activity, since he could not find enough energy to do this.

Nonetheless, L.'s sense of selfhood was stable enough to allow him to participate in meaningful activities, both personal and social.

An important thing that distinguishes L. from patients such as F., for instance, is that L. comes from a middle-class socio-cultural background. While this is not a defining fact regarding his case and dynamic configuration, it is still important, given that he can minimally support himself in different settings of his lifeworld.

5. DISCUSSION

To begin the discussion, I would like to point to some of the limitations this study exposes. First, this is, of my knowledge, the first Latin American empirical study utilizing both EASE and EAWE. Therefore, there are not, as of yet, other exact parameters which guided the investigation of the small sample of patients I interviewed. Since the number of patients interviewed was relatively small and primarily comprised of severely chronified patients, I am aware this does not yet suffice for characterizations of unique anomalous self- and world-experience or symptom configurations in a broader grouping of patients. The patients' socio-cultural background also played an essential part in these limitations since I had to adapt some of the interview questions whenever a patient would not understand what was being asked.

A second limitation is that this is the first time utilizing the interviews on a Brazilian population of primarily treatment-refractory patients, which was another significant challenge to take on. Most patients were interviewed three times, with each interview lasting 2 hours. Sometimes, given the patient's condition, I had to diminish the interview time if the patient seemed too tired or cognitively disorganized, at a specific time, during the interview.

The first important positive original feature of this project is that it is the first empirical project I know of, which utilizes the instruments mentioned above in Latin American territory. Hence, I believe this study may open the door to future researchers contemplating utilizing these two phenomenological oriented interviews in Latin American territory. A second important component that highlights this project's original nature is that it is based on robust *empirical and contemporary* theoretical discussions, something not yet so established, in contemporary interdisciplinary research on schizophrenia, in Latin America. This makes this project cross-culturally relevant. Most research, at least in Latin America, focusing on phenomenological psychopathology dealing with schizophrenia either concentrates too much on conceptual discussions or the analysis of single cases. Research focusing on the interconnections between schizophrenia and enactivism are even scarcer. During the research time I spent in Europe, it became clear to me that contemporary empirical and conceptual research is now more necessary than ever, given the different ways in which empirical data and mostly continental philosophical frameworks influence each other. One of the factors that amazed me, regarding the socio-cultural and functional differences of the patients I interviewed

there and in Brazil were the nuanced or more blatant answers I would be given to the questions I asked. In Germany, during my training, patients would sometimes be very concrete when answering specific questions regarding a specific EASE domain, for instance. For instance, they would very directly answer how they felt an alteration in a particular experiential dimension, sometimes having difficulties describing in more depth how this specific experience came about, its frequency and intensity. In Brazil, they would sometimes begin talking about a different topic that was not necessarily related to the question being asked per se.

Regarding *the answers' content*, patients in Germany would sometimes feel a bit cautious or even fearful of answering some of the questions since they seemed to somehow invade their personal space. Even if I tried leaving them as comfortable as possible and would, of course, end the interview immediately if one of them would not want to continue, it was compelling to see how these patients reacted to some of the questions. In Brazil, however, apart from a few patients, the exact opposite occurred: patients would tell me that they felt some of the questions even had *therapeutic qualities*, per se. They would say that since EASE or EAWE would not usually be asked about in psychiatric or psychological consultations, this helped them gain insights into their own experiences and how this would lead them to possibly understand some parts of their subjectivity, world and illness context better.

Let me now enumerate some of the factors I believe directly influenced the results of this project. First, the patients' socio-cultural background in Germany and Brazil was different, directly affecting how the interviews were conducted; both groups of patients enriched this project immensely. This also opens up new perspectives on how EASE and EAWE can be utilized. Instead of simply describing phenomena and looking for core alterations in specific experiential dimensions, it is crucial to describe, in a more interrelated and dynamic way, how symptoms and experiential alterations occur, in each case. So, I believe that researchers utilizing EASE and EAWE would gain much from a perspective that aims to investigate the everchanging interconnectedness between schizophrenic subject and the world in a more refined manner. For instance, as I have shown in the results section, some of the patients did receive formal educational training, some even pursuing, when I interviewed them, Master degrees. Thus, how the subjective, worldly and symptomatological configuration of these patients, such as K. and L., for instance, would be interrelated to each other points to a more *structured* and *possible engagement with the world.* Since these two patients would be able to organize their routines better to a certain extent, this would directly influence their feelings of a more stable sense of selfhood. By this, I do not mean that a complete and fluid

integration between subject and world would be possible, but still, these patients would find a way to produce meaning, even if in their particular ways. K., for instance, did rely on some of his hallucinations to help him in specific intersubjective contexts. They would *help* him deal better with others, which is already different from suffering or feeling invaded by hallucinations and delusions, such as patient G., who felt constantly tormented by his altered experiences.

The second important factors I wish to discuss here relate to the more frequently found altered experiences in the patients I interviewed, to clarify how these contributed to the investigation of the singular dynamic configurations I found in this project. Thirdly, I would like to highlight the content, intensity, frequency and how they appeared in some of those cases.

This project's essential aim is to further illuminate how the phenomenological dimensions of selfhood, embodied perception and sense-making, agency, and intersubjectivity are interrelated. So, it was indeed interesting to witness how each patient narrated and experienced the interconnectedness between these experiential dimensions in different *intensities regarding the presence of their alterations*. They would feel their alterations' intensity varied significantly concerning their symptomatology and other aspects of their personal and social life from their unique perspective. So, even if disentangling the more altered *foundational* phenomena from the others presented was somewhat challenging, given that the connectedness of experiential dimensions and symptoms would appear differently in each patient, it was interesting to see how each unique configuration would influence possibilities of social interaction, for instance. Strikingly, while the interviews were being conducted, it was a very heterogeneous yet *dynamic* and *changing* way of relating to their subjective and worldly alterations that the patients would express.

Intriguingly, while I did rate the interviews according to the EASE and EAWE rating criteria, I also found variations in frequency and intensity. Here, a brief caveat is in order: originally, EASE and EAWE were developed to investigate alterations in the core of the experiences mentioned above. While this certainly is an important objective of these instruments, I found that sometimes even what I understood to be an altered core experience of, say, selfhood, would also be influenced by other alterations, thus being felt by the patient in a different and not necessarily so *acute or fundamental* way. This gave way to quite singular experiential and symptomatological configurations. These differences in the unique configurations also influenced how I rated most interviews, given that I believe that certain patients would have, in specific phases of their illness, acutely and intensely *present* alterations,

which would then, over the years, change in frequency and intensity, what also points to the dynamic factor of the configurations here analyzed. However, I rated most of the patients with either having *present, moderate or mild altered experiences. At which point* in time and life context patients experienced their altered experiences and symptomatology also greatly varied.

Here, I would like to draw to studies made by Raballo and Parnas (48) and Nordgaard et al. (49) to highlight that the patients of these European studies varied greatly from the sample of patients I interviewed in this project. This is due mainly to the fact that most of the patients I interviewed at the Unicamp University infirmary and ambulatory and Unifesp schizophrenia programme were not first-admission patients but already chronified, being treated for a more extended period. For instance, there was, concerning some patients, a significant difference in overall functionality. On the one hand, most patients I interviewed at Unicamp University were refractory, yet still able to narrate their experiences. On the other hand, some of the patients I interviewed at Unifesp University, also being patients with a long period of illness, could function better in the world regarding a job, educational and social possibilities. So, while the sample of patients in Raballo and Parnas' (48) and Nordgaard's (49) studies were less severely ill patients, some of mine were indeed more critically impaired. Yet, I believe this is not a necessarily problematic concern since it reflects the importance of considering *different* socio-cultural backgrounds than those of patients being treated at European psychiatric programmes and facilities.

One other significant difference between this project and both studies mentioned above is something I have already pointed out in the introductory paragraphs of this section: here, considering the absence or presence of altered experience was important; however, I would also like to imply that it is crucial to assess *how* each alteration was present, in each case. For example, I have interviewed patients with more severe positive symptomatology, which would present different configurations regarding their intersubjective possibilities and overall engagement with the world. Thus, the focus on the interrelation between singular symptoms and altered experiences was given here, rather than just the presence or absence of altered experiences.

The groups of alterations that mostly appeared in the interviews were 1) Cognition and Stream of Consciousness, 2) Self-Awareness and presence, and 3) Bodily Experiences. Alterations found in the EAWE "Other Persons" Domain were not that present, given that this instrument was not utilized with all patients.

Keeping in mind the three factors delineated above, what I wish to relate and discuss in this section is that: 1) Specific symptomatological experiences, such as hallucinations, a patient may have influence and interrelate with (2) subjective experiences he may be feeling (alterations in selfhood and bodily experiences, for example). Alterations in this dynamic interrelatedness then may also lead to changes in his (3) social life (worldly experiences), given that the patient might be able to engage with others and the world in more meaningful ways, depending on how severe this interrelatedness might appear at a particular point in the patient's illness.

An overall thought process that permeates this discussion I would like to point to is that the two groups of patients I exemplify may be broadly divided regarding their overall intersubjective social functionality and symptomatology. The first broad group relates to patients who can better maintain some intersubjective relations, professional and personal activities. As I will delineate below, an important characteristic of these patients' configurations is that their sense of selfhood is more or less stable, giving them a more balanced sense of being able to act in the world. The unique configurations derived from these two broader groupings are then investigated in their singularity, concerning the content of their alterations and the particular ways in which each patient accesses his reality, and that of the world and others.

However, it is crucial to point out that these interrelational configurations are not purely static alterations in different dimensions. They also change, depending on the life and illness context the patient finds himself in. Regarding the frequency of the altered experiences and symptoms some patients have narrated in the interviews, these would, for instance, also change from year to year, since at one point an alteration of say, agency would be more present, and then, after some time, one of selfhood. It is also important to highlight that none of these alterations are "hierarchized", concerning their causal influence or primacy over the other. No, they all have the same ontological status; they are equally interrelated, regarding their importance in the overall clinical picture.

The tables in the results section delineate all the dimensions and phenomena that were investigated in this project. For the sake of clarity, I will here focus on the dimensions here investigated, namely selfhood, intersubjectivity and embodied agency and perception (sense-making). I will examine these having in mind the influencing factors of content, intensity and frequency, as highlighted above. So, I would like to discuss six cases in more detail, namely that of patients K., I. and L., B., H., and J., to give a more in-depth picture of what I mean by a dynamic and interrelated framework for schizophrenia.

The first significant grouping of patients I pointed to above, which I would like to flesh out in this section, is, more specifically, patients K., I., and L., who demonstrate better overall social functioning. Regarding their clinical and life contexts, these patients would be better able than the second group to maintain more meaningful and well-lived lives regarding their intersubjective relations and personal projects, all of which are part of their singular interrelated dynamic configurations. Patient K., for instance, presented, when I interviewed him, delusions and hallucinations that were more acute and context-dependent than I. and L. His symptomatology would appear more strongly when he would find himself in a social context, for instance. Yet, this would not necessarily be negatively experienced by him. An interesting connection to be made here, concerning his hallucinations, is that his sense of selfhood would improve when he found himself in certain social situations, given that he told me he could *rely* on his hallucinations to make him feel more tranquil. K. reported that his hallucinations and delusions would revolve around religious content, in which he would make "pacts" with God. Thus, based on the fact that for enactivism, the self is a dynamic phenomenon and also related to agency and the possible creation of meaning, K.'s dynamic configuration, regarding his experiential alterations and symptomatology, is of a relatively balanced nature since he can, *within his limitations*, act in the world in more or less meaningful ways. For instance, he would generally be able to deal with his difficulties while relying either on his positive symptoms or on his girlfriend, which he at the time also had. He would indeed *make use of* some of his hallucinations, such as angels, to help him in different social and intrapsychic contexts, where he would have to make a specific decision about something, for example. This relates to an interesting phenomenon initially coined by Bleuler (53) and phenomenologically appraised by Parnas et al. (54), namely that of "double bookkeeping", which the authors illustrate as follows:

> double bookkeeping as a situation in which the patient simultaneously lives in two different levels of reality. One reality is our shared, social, mundane (ontic) world with its implicit understanding of the laws of nature, mind-independence of the so-called "external world" and the principle of non-contradiction. The other reality involves a private framework that violates spatio-temporal and non-contradiction constrains of the intersubjective world. (54, p. 2)

This phenomena presented by the authors is interesting, given its relevance to what many patients have described, particularly in this first group of patients. So, K. would seem to swing back and forth in his own, more delusional reality and the one of our shared world. Interestingly, K. would manage many of the daily actions he made in the shared world by trying to make sense of some contexts he found himself in, despite being guided by his hallucinatory and delusional activity at the same time. The girlfriend situation exemplifies his singular dynamic configuration well: the girlfriend (social context/factor) would help him to balance out somehow his sense of self (subjectivity), which would then also influence his positive symptomatology, since in a specific situation he would choose, depending on whether he felt safe with her or not, to rely on the help of his hallucinations, or not. However, most of K.s delusional experience is still greatly objectivized since he is not entirely able "to oscillate between one's egocentric perspective and an allocentric or decentered perspective" (36, p.65). I believe K.'s configuration aligns well with Fuchs' (36) argument that the perceptual field inverts in schizophrenia. The flexibility of maintaining the stability of transcendental subjectivity usually allows us to be aware of our meaningful perceptual engagements in the world, and more concrete mundane self-centrality is lost. While K. somehow *exists in* two realities, he cannot *genuinely* find meaning and act in either. However, in comparison to the patients I will discuss in the second part of this section, his configuration still allows him to maintain some kind of meaningful contact with the world and others (his girlfriend).

Patient I. is one more interesting example of a more stable configuration, since his dynamic configuration is less crystalized than K.'s. By less crystalized, I mean that he is more able to fluidly engage with the world and others, and create meaning for whatever activity he might be engaged in. While I. engages relatively well with the world, he cannot continuously do this. I understood how he would make this appear meaningful initially, but would not be grounded in the ordinary shared world. While the frequency and intensity of I.'s positive symptomatology was also rather pervasive, when I interviewed him, it seemed that I.'s contact with the world and himself would repeat itself in specific patterns, since he would always tell

me about the same experience he would have when he was either giving a speech, at home, or with one of his few friends. By this, I mean that I. was not able, when I interviewed him, to root himself in the world via his embodied self, even if he is an intelligent and relatively cognitively preserved patient, compared to the others I interviewed. I.'s configuration would then present a more *crystallized pattern* between his symptomatology, altered sense of self, bodily experience and the world. The enactive possibility of auto-regulation and self-preservation has become less fluid, making it difficult for the patient to act in the world and engage meaningfully with it. While the external world would affect him, it only did so to an extent.

As he would say, "Now, even if I do feel different, I participate in this English course I told you about. I know I am not like the others in the group, I know the difference, but this does not make me feel anxious, anymore. I can have a tranquil posture…"

This excerpt also interestingly relates to the double bookkeeping phenomenon discussed above, albeit differently. While K. tries *acting* in the shared world by using his positive symptomatology, I. remains passive, experiencing himself and the shared world and others more fleetingly. The more crystallized configuration of altered self, world and symptom thus also points to a difficulty in fluidly acting in the world and in making meaningful decisions, since the sense of selfhood that only pervasively engages with the world would many times leave I. in a sort of *limbo of meaning,* where he would not be sure how to exist in the world, and make certain decisions regarding his life, in specific contexts. However, while K. cannot be *fully functional* in the world, he can access our shared world in particular contexts.

It is also interesting to see how *meaning* is generated and appears in diverse ways for most of the patients interviewed. As De Haan (32) points out in her work, psychiatric disorders may be understood as disorders of *sense-making.* She illustrates that this kind of meaningful stance taking toward the world comes in two forms, as I depicted in the introduction. I believe that disorders of sense-making in schizophrenic conditions indeed appear as patterns. Yet, I would add that these patterns are *experienced* and possibly acted upon in different ways by the patients, depending on their relation to possible positive symptomatology that might be present in a specific case, how the patient would experience his alteration and how frequent these altered patterns appear. These patterns appear on whether a general sense of self-stability is possible, and whether alterations in sense-making and agency are also present and how they influence each other, changing the patient's potential access to the world to certain degrees.

The last patient I would like to focus on in this group is L. L. is the most functional patient I have interviewed in this project. His interrelated dynamic configuration of experiential and world alterations is fluid, and he can maintain a certain frequency in whichever activities he chooses to engage in. While L. used to have targeted and quite acute bouts of hallucinatory and delusional experiences, these seemed, when I interviewed him, in complete remission. L.'s experiences would revolve around a variety of auditory hallucinations, as well as feelings of grandeur and superiority, for instance. However, as he told me, he had decided to take his psychiatric and psychological treatment very seriously, making different changes regarding the professionals that would care for him. When I interviewed him, L. told me that he was on a very low dose of antipsychotic medication.

L. would be able to answer the questions regarding his life and altered experiences very precisely. L.'s dynamic and interrelated configuration has also changed throughout his illness, which points to the importance of connecting these contexts in which the disorder alters to gain a more complete clinical picture. L.'s positive symptomatology was, at the beginning of his illness, permeated with delusions of technical control, which would alter his reality and encapsulate him in a world which he found very difficult to escape from. However, with the passing of time and thorough treatment, L.'s positive symptomatology would go into complete remission. When I interviewed him, he would still have moments where he would ruminate quite a bit about certain decisions, but he would then choose between the options and *act*. Also, he would have a specific necessity of organizing things, books, for instance. This would almost have obsessive contours, but did not *freeze* him. I believe that this was more a way of better coping with his routine. Although L. would still have some negative symptomatology reminiscent, which would make it difficult to engage with physical activity, this did not wholly overwhelm him to not being able to engage with other continuously meaningful activities. The stability of his selfhood feeling would directly influence how he would act with others and care for himself, albeit not entirely. When I interviewed him, L. would also participate in groups and individual psychotherapeutic sessions, making him feel more involved in social life and giving him a chance to engage with his feelings more deeply.

Let me now pass on to the second grouping of patients. This group of patients, namely B., H. and J., are, in comparison to the first group, much less organized, both regarding overall cognition and social and intersubjective relations, generally. An important contributing factor to this is that these patients would still present a significant amount of positive (B. and H.) and negative (J.) symptoms when I interviewed them. These would influence their dynamic,

interrelated configurations in different ways, which I will point to, below. Their possibilities of acting in the world and of meaningful engagement with others were also quite severely compromised. A quality I would attribute to their experiential, world, and symptomatological configurations is that of *frailty*, which is, I believe, different from a *crystallized* or *fluid* configuration, such as the ones presented by the first group of patients. These are frail configurations because their anchorage to the world is highly labile since the *selves* of these patients are either so permeated with delusions or hallucinations or extreme concreteness, that they are not even able to create a minimally constant meaningful engagement with the world. Even if a patient like K. lives his life in two different realities, he would still be able to engage with the world meaningfully, in his unique way. For B., H. and J., this presents, I believe, a much more difficult task.

Patient B. presented the most intense and frequent positive symptomatology. The content of his delusional and hallucinatory experiences was quite diverse, ranging from visits to other planets to more *disembodied (out of body)* sensations of being a man trapped in a woman's body. Interestingly, B.'s configuration is very much dynamic in its own way, even if intensely and frequently permeated with positive symptomatology. B. has created a world of his own, and interestingly, when compared to how K. or I. access two realities, B.'s seems as if he has *chosen* to live almost constantly in a world created by himself. Our familiar and shared world is only of secondary importance to him. Also, he seems not to suffer from this. Given that his reality is so constantly permeated with his singular meaningful experiences, he acts according to what he believes to be true, from a double-bookkeeping perspective. The relation he has with his family, especially grandmother, whom I also met when I interviewed him, was difficult since she and other family members would have extreme difficulties understanding and dealing with the reality he lived in. I believe his experiential, worldly and symptomatological configuration is *frail* because he does not find a place in the ordinary, shared world. He cannot enact a shared meaningful world and continuously live in it, which the patients of the first group are partially able to. While this did not seem to affect B., it seems pretty challenging from a clinical perspective, since such a configuration would isolate B. from the rest of the world, thus not offering him opportunities to contact our common and shared world. A look at the complexity of B.'s configuration can be exemplified here:

> I grew up studying the bible, and in there you have Jehova's story, the story of Jehova against the devil... I used to live in this world...I was..., normal… I wanted to get married, to have children, a normal life. Then the accident happened, and in *** things also changed in my head, and I saw that I was not a man on the inside, but a girl. Then I saw that the story between Jehova and the devil was much more complex than I had imagined. Then, there was a moment I started thinking that everyone on earth was an angel, and my world completely changed. It was not mankind anymore, but people were angels. Then some time passed, and I began thinking that humankind was humankind, again.

B.'s reality would thus be constantly shaped by an immense array of different alterations in experience regarding his sense of selfhood and his body. The *meanings* B. would ascribe to his altered experiences were also many, some of which would continue similar in form throughout the temporal framework of his illness, while others would change.

The second patient I would like to discuss here is H., who has essential difficulties with acting in the world and generally. H.'s positive symptomatology was excessively florid, when I interviewed him. He would constantly be talking about specific delusions he would have in certain situations, regarding his mother, for instance. Other feelings that would affect his entire reality, when he was an adolescent, would also appear. For me, a fascinating aspect of H.'s case relates specifically to this: while his feeling of selfhood was, at the time of the interviews, much more fragmented than that of K. or I., for example. H. was also constantly *shifting* from one reality to the other. This is interesting because it shows how sense-making is interconnected with positive symptomatology, in crucial ways, and how this relatedness also changes, depending on the context the patient finds himself in. The dynamic way in which sense-making changes is important, here. His feeling of selfhood would be permeated with different meanings, depending on the kind of hallucinatory or delusional experience he would currently present.

For instance, H. used to feel quite distanced from the world as an adolescent. Here, it is again interesting to see how the relation between subject and world is altered in schizophrenia, and how this permeates how H. would relate to the world and others, and how he experiences these alterations himself. H.'s dynamic configuration's temporal dimension also becomes clear, here: while his disorder has indeed chronified, *how* he perceives the world and others has changed. This way of accessing reality also changed his sense of selfhood. He says that when he was an adolescent, the world seemed as if it was involved by a "black prism", which made things look sad and obscure. When I interviewed him, he said that,

> Nowadays I feel… nowadays it is very different. Nowadays my perception of the world is as if there was a white prism, you know? The colours are not bright, but, my God, it is all much less suffering than what it used to be… this is how it is…I would either see everything in a much happier way or in a sad way… people, places, everything…

This excerpt points to the interrelatedness of subject, world and the meaningful connections of altered experiences when put into context. H. would *make sense* of the world through the prisms he talks about in his singular manner. His feeling of self would be shaped by how he perceived the world and others around him. This feeling of distance and remoteness also appears clearly in the intersubjective relations he used to have during his adolescence. He would say, "I felt distant from everybody, except for my mother. But from people, generally, I felt quite distant… it was very sad… I felt very sad. People surrounded me but I felt very lonely."

When I interviewed him, H. could connect a little better socially, yet these connections were usually still vague or not deep. While his overall motivation and volition to do daily activities lacked, he sometimes felt able to go out and participate in activities, such as support groups, for instance. I believe his dynamic configuration between K. and I.'s, since he also firmly *shifts* between his reality and the shared world. In comparison to B., however, H.'s access to the world and his feeling of selfhood are also fragile since he cannot continuously deal with his routine activities or relationships with others. The shifting between realities is too extreme, too frequent and too intense. All of his activities and relations are permeated with constant changes of meaning, which are linked to his positive symptomatology, and thus, possibilities to act. While he might begin to pursue a specific goal, he soon freezes because of his symptoms' interchangeability, which, from what he told me, would modify both in content and frequency over time.

It is interesting to see how difficulties in intersubjectivity are closely related to intense shifts in meaning (sense-making) as well. While K., for instance, can have intersubjective encounters (with his girlfriend), I had the impression, when I interviewed H., that his access to reality was completely objectified and self-referential. However, it is interesting to see that even if his perceptual (sense-making) activity is inverted, its content has changed, given the contexts he would find himself in. Both K. and H. cases relate to what Henriksen and Nilsson (43) have called *compensatory strategies*, in schizophrenia, where patients might have specific intersubjective relations. Yet, these are adjusted and do not

necessarily occur fluidly. Kyselo's (45) argument of the possibility patients' with schizophrenia may have of regulating one's feeling of selfhood between separation or not from others can also be used as an illustrative argument, especially in K.'s case.

The last patient I would like to discuss is J. In comparison to B. and H., it is quite hard to pinpoint, in this case, the presence of any positive symptomatology. However, J.'s life is permeated with extreme feelings of anhedonia and concreteness regarding her thoughts and actions. When I interviewed her, most of her narrative would revolve around the fact that she had a "split mind", that she was only "waiting for her death", and that life had no other meaning or significance whatsoever. Most of her time, J. would spend at home, helping out with chores such as washing dishes or staring blankly at the walls in her room. Interestingly, J. would be very interested in reading scientific articles and books about schizophrenia, even if she would read the same material over and over again, all the time. I believe J.'s dynamic configuration is frail because she cannot *adapt* her concrete ruminations to meaningful activities with others in the ordinary world. J. hides behind a wall of the *undoable*, which she would integrate as part of her life. Nothing would help her, no treatment, no psychotherapy, and nothing.

As she says, "I tried making use of this strategy of giving a meaning to life, of going to college. But then, after three days, a month later, I am already giving up on everything. Because schizophrenia has this, 'praecox dementia'. The person starts giving up, giving up…"

It is as if J. would somehow completely integrate that people who have schizophrenia cannot do anything anymore. They would simply be left to wither away, which is, as I have shown in the first group of patients, not even remotely true. However, J. has internalized this. Her feeling of self has thus indeed suffered a severe fragmentation, which makes it challenging to engage with the world and other meaningful activities to contextualize the dynamic aspect of J.'s configuration; it is crucial to point to the fact that this concrete outlook on the world she had *used to be different*, at the beginning of her illness.

She would say, for instance, that, "… there was something that used to happen; it was the colour of the chair, the blue chair was a message for me, a yellow shirt was a message for me, his pants are pink, you know?"

Before, there would be some *movement* happening, even if this would be related to the presence of positive symptomatology. Her feeling of self would be in contact with the world and others differently. Also, the interrelatedness of her altered experiences and symptoms

became less intense, having changed throughout her illness, which consequently made her more and more withdrawn. While B. and H.'s configurations were permeated with positive symptomatology, thus making it difficult for them to *root themselves* in our every day and shared reality, J. would withdraw herself entirely into a concrete and isolated state of mind, without any chance of reaching out and finding meaning in the world or interacting in the world, even if just a little.

Finally, in this section, I have shown that schizophrenia is a disorder of a wide array of unique dynamic configurations regarding subjective, worldly alterations and more objective symptoms. While some of the patients of both groups presented here show some similarity regarding their configurations, I find it crucial for contemporary research in schizophrenia to be attentive to how these experiential and symptomatological dimensions influence each other, given each case. While a thorough descriptive analysis of the alterations present is essential, it is not enough. For instance, alterations in specific domains, such as sense-making, which in this project plays a crucial role, experienced by a patient may share similarities with those experienced by another patient, yet *how* these influence each other is quite different regarding their content, intensity and frequency.

In conclusion, I would like to highlight the fact that each configuration is dealt with by the patients differently, thus also having to be assessed differently by the clinician. From my perspective, it is, therefore, crucial to carefully appraise each configuration not only regarding the presence or absence of specific experiential alterations and symptoms but rather as *transitional and interrelated* phenomena emerge uniquely in each case. Each configuration's uniqueness depends on an overall stable sense of selfhood, which is intrinsically linked to the patients' form of accessing reality and making sense of it, even in bizarre, delusional or hallucinatory ways. These two phenomenological and enactive dimensions combined would then lead to how the patient acts in the world. While this sense of agency may be compromised, I wish to point out that schizophrenia is, in contemporary research, not yet seriously approaching each case's singular and dynamic interconnectedness. While more objective similarities may arise in the general clinical picture, the subtle nuances of how the changes in each experiential and symptomatological dimensions occur are crucial and must be investigated, as well. So, while most patients I interviewed here were chronically ill, their modes of accessing and being in the world vastly differed.

6. CONCLUSION

The principal aim of this project was to more thoroughly investigate the various experiential and symptomatological alterations in patients diagnosed with schizophrenia. However, this project aimed to go beyond purely *descriptive* and overly *static* understandings of this disorder. Given the more traditional and objectivist approaches to schizophrenia, it has been shown that a more integrative theoretical framework, encompassing phenomenological psychopathology and enactivism, provides a more *dynamic* approach to schizophrenia, since it highlights the entirety of the self-world experiences and symptomatological configurations in each case, in their *uniqueness and dynamic nature*. The results section pointed out that altered experiences, for instance, sense-making and selfhood, and symptomatology present themselves in very distinct ways, depending on the intensity and frequency of *how* symptoms and altered experiential dimensions would appear in each case, in an interrelated manner. While these configurations did show some similarities, each arrangement would differ, also given the articulation between them and the patients' illness or life context.

The results point to the fact that schizophrenia should be understood as a disorder of everchanging interconnected phenomena, which may change subtly or in a more pronounced manner, depending on the frequency, intensity and content of the interrelatedness between symptomatology and experiential alterations. While a grouping of patients may show alterations in an experiential dimension such as selfhood, for instance, this alteration is to be approached considering the singular *how* of their interrelatedness.

I believe that possible theoretical and clinical repercussions of this project, regarding a more integrated and dynamical understanding of schizophrenia, would be to categorize further and differentiate the domains of EASE and EAWE, to identify whether alterations in one domain are necessary for the appearance of alterations in other domains, and how this would constitute a dynamic array of different configurations which could be integrated into a more comprehensive clinical picture, leading to the fact that psychotherapeutic and pharmacological interventions would thus be more effective if they target changes in the entire dynamic configuration of altered experiences and symptomatology.

For instance, patients showing more *fluid* configurations would be able to establish more meaningful relations with others and the world. The patients in this group would show a

somewhat more stable sense of self, thus allowing better functioning in the shared world. The second group of patients presented more *crystalized*, which would make their engagements with the world and others more difficult. However, it is fundamental to point to the fact that these fluid and crystallized configurations would depend on *how* each patient would experience them and their frequency and intensity. Hence, possible clinical interventions would have to assess the entirety of how the everchanging dynamic interrelatedness of symptoms and experiences could be integrated by the patients, each in their way.

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8. ANNEXES

8.1 – Submitted Article (Receipt of Article)

11-Jan-2021

Dear Mr. Spremberg:

Your manuscript entitled "Towards a more dynamic approach to the psychopathology of schizophrenia" has been successfully submitted online and is presently being given full consideration for publication in the Revista Latinoamericana de Psicopatologia Fundamental.

Your manuscript ID is RLPF-2021-0001.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your street address or e-mail address, please log in to ScholarOne Manuscripts at https://mc04.manuscriptcentral.com/rlpf-scielo and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Center after logging in to https://mc04.manuscriptcentral.com/rlpf-scielo.

Thank you for submitting your manuscript to the Revista Latinoamericana de Psicopatologia Fundamental.

Sincerely,
Revista Latinoamericana de Psicopatologia Fundamental Editorial Office

8.2 – Term of Consent Unicamp

TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

Experiências subjetivas anômalas do "self" e do mundo: perspectivas sobre um estadiamento clínico e psicopatológico em pacientes com psicoses

Adrian Nicholas Spremberg

Número do CAAE: 65223516.3.1001.5404

Você está sendo convidado a participar como voluntário de um estudo. Este documento, chamado Termo de Consentimento Livre e Esclarecido, visa assegurar seus direitos e deveres como participante e é elaborado em duas vias, uma que deverá ficar com você e outra com o pesquisador.

Por favor, leia com atenção e calma, aproveitando para esclarecer suas dúvidas. Se houverem perguntas antes ou mesmo depois de assiná-lo, você poderá esclarecê-las com o pesquisador. Se preferir, pode levar para casa e consultar seus familiares ou outras pessoas antes de decidir participar. Se você não quiser participar ou retirar sua autorização, a qualquer momento, não haverá nenhum tipo de penalização ou prejuízo.

Justificativa e objetivos:

Este projeto têm como objetivo principal investigar experiências subjetivas anômalas do "eu" e do mundo em pacientes com psicoses.

Procedimentos:

Eu gostaria de saber, neste estudo, se você experiencia sensações "estranhas" sobre si mesmo e o mundo ao seu redor. Estas experiências fazem referência a sentimentos e sensações "diferentes" no que diz respeito à sua presença habitual no mundo, à eventuais mudanças que você sente no seu corpo, assim como na sua sensação de "ser você mesmo". Além destas, ainda serão feitas perguntas sobre experiências relacionadas ao tempo, a outras pessoas, etc. Estas podem ter começado a aparecer, por exemplo, como um sentimento de que "eu e o mundo estão diferentes de alguma forma", ou de "nada mais é como era antes". Aos poucos, é possível que estas experiências tenham se tornado mais e mais presentes, dificultando, inclusive, as tarefas do seu dia a dia assim como sua relação com familiares e amigos, por exemplo. Estas entrevistas terão a duração de até três horas, podendo ser divididas em duas ou três vezes. As entrevistas poderão, se você estiver de acordo, ser gravadas. A pesquisa será feita no HC-Unicamp e/ou no ambulatório do Proesq, onde você será entrevistado(a). Estas entrevistas terão duração de duas horas e meia até três horas, podendo ser divididas em duas ou três vezes. As entrevistas poderão, caso você esteja de acordo, ser gravadas.

Desconfortos e riscos:

Você não deve participar deste estudo se apresentar alguma impossibilidade de expressão verbal ou cognitiva. Dado que a entrevista é baseada na coleta de informações subjetivas, é possível que haja algum desconforto subjetivo relacionado a alguma pergunta feita pelo entrevistador. Caso você perceba, de alguma maneira, que as perguntas fazem com que você se sinta ainda mais desconfortável, por conta de outros aspectos relacionados a sua doença, é importante que se atente a isto e relate ao entrevistador.

Ressarcimento e Indenização:
Você terá a garantia ao direito a indenização diante de eventuais danos decorrentes da pesquisa. Não haverá ressarcimento para gastos de viagem que você fizer, para vir às entrevistas.

Benefícios:

Por esta ser esta uma pesquisa exploratória, não haverá ganho de qualquer cunho para você.

Acompanhamento e assistência:

Não haverá acompanhamento direto aos pacientes por parte do entrevistador. Como a maioria dos participantes já deverá se encontrar em algum tipo de acompanhamento médico, psicológico ou de outra natureza no HC da Unicamp e/ou no PROESQ (Unifesp), os encaminhamentos, se necessário, serão feitos de acordo com a exigência de cada participante. Estas medidas serão tomadas com todo cuidado necessário, tendo em conta também o sigilo vigente relacionado a identidade do participante.

Sigilo e privacidade:

Você tem a garantia de que sua identidade será mantida em sigilo e nenhuma informação será dada a outras pessoas que não façam parte da equipe de pesquisadores. Se houver divulgação dos resultados desse estudo, seu nome não será citado, garantindo a você a segurança de que você não poderá ser identificado.

Ressarcimento:

Não haverá ressarcimento de despesas. O estudo poderá ser adaptado a outros eventuais compromissos que o participante possa vir a ter no HC (ou ambulatório), porém, como as entrevistas poderão ser feitas em duas ou três vezes, é possível que o participante também precisará vir para estas em horários que não se encaixem, necessariamente, em suas rotinas no HC (ou ambulatório). Isto será conversado com o participante que se dispor a participar da pesquisa.

Contato:
Em caso de dúvidas sobre o estudo, você poderá entrar em contato com:
Adrian Spremberg
Rua Tessália Vieira de Camargo, 126 - Cidade Universitária Zeferino Vaz
Barão Geraldo, Universidade Estadual de Campinas, Faculdade de Ciências Médicas,
Departamento de Psicologia Medica e Psiquiatria.
Tel: (11) 96059-1205.
Em caso de denúncias ou reclamações sobre sua participação no estudo, você pode entrar em contato com a secretaria do Comitê de Ética em Pesquisa (CEP): Rua: Tessália Vieira de Camargo, 126; CEP 13083-887 Campinas – SP; telefone (19) 3521-8936; fax (19) 3521-7187; e-mail: cep@fcm.unicamp.br

Consentimento livre e esclarecido:

Após ter sido esclarecimento sobre a natureza da pesquisa, seus objetivos, métodos, benefícios previstos, potenciais riscos e o incômodo que esta possa acarretar, aceito participar:

Nome do(a) participante:
_____

_____ Data:
____/_____/_____.
(Assinatura do participante ou nome e assinatura do responsável)

Responsabilidade do Pesquisador:

Asseguro ter cumprido as exigências da resolução 466/2012 CNS/MS e complementares na elaboração do protocolo e na obtenção deste Termo de Consentimento Livre e Esclarecido. Asseguro, também, ter explicado e fornecido uma cópia deste documento ao participante. Informo que o estudo foi aprovado pelo CEP perante o qual o projeto foi apresentado e pela CONEP, quando pertinente. Comprometo-me a utilizar o material e os dados obtidos nesta pesquisa exclusivamente para as finalidades previstas neste documento ou conforme o consentimento dado pelo participante.

_____ Data:
____/_____/_____.
(Assinatura do pesquisador)

8.3 – Term of Consent Unifesp

TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

Experiências subjetivas anômalas do "self" e do mundo: perspectivas sobre um estadiamento clínico e psicopatológico em pacientes com psicoses

Adrian Nicholas Spremberg
Número do CAAE: 65223516.3.3004.5505

Você está sendo convidado a participar como voluntário de um estudo. Este documento, chamado Termo de Consentimento Livre e Esclarecido, visa assegurar seus direitos e deveres como participante e é elaborado em duas vias, uma que deverá ficar com você e outra com o pesquisador.

Por favor, leia com atenção e calma, aproveitando para esclarecer suas dúvidas. Se houverem perguntas antes ou mesmo depois de assiná-lo, você poderá esclarecê-las com o pesquisador. Se preferir, pode levar para casa e consultar seus familiares ou outras pessoas antes de decidir participar. Se você não quiser participar ou retirar sua autorização, a qualquer momento, não haverá nenhum tipo de penalização ou prejuízo.

Justificativa e objetivos:

Este projeto tem como objetivo principal investigar experiências subjetivas anômalas do "eu" e do mundo em pacientes com psicoses.

Procedimentos:

Eu gostaria de saber, neste estudo, se você experiencia sensações "estranhas" sobre si mesmo e o mundo ao seu redor. Estas experiências fazem referência a sentimentos e sensações "diferentes" no que diz respeito à sua presença habitual no mundo, à eventuais mudanças que você sente no seu corpo, assim como na sua sensação de "ser você mesmo". Além destas, ainda serão feitas perguntas sobre experiências relacionadas ao tempo, a outras pessoas, etc. Estas podem ter começado a aparecer, por exemplo, como um sentimento de que "eu e o mundo estão diferentes de alguma forma", ou de "nada mais é como era antes". Aos poucos, é possível que estas experiências tenham se tornado mais e mais presentes, dificultando, inclusive, as tarefas do seu dia a dia assim como sua relação com familiares e amigos, por exemplo. Estas entrevistas terão a duração de até três horas, podendo ser divididas em duas ou três vezes. As entrevistas poderão, se você estiver de acordo, ser gravadas. A pesquisa será feita no HC-Unicamp e/ou no ambulatório do Proesq, onde você será entrevistado(a). Estas entrevistas terão duração de duas horas e meia até três horas, podendo ser divididas em duas ou três vezes. As entrevistas poderão, caso você esteja de acordo, ser gravadas.

Desconfortos e riscos:

Você não deve participar deste estudo se apresentar alguma impossibilidade de expressão verbal ou cognitiva. Dado que a entrevista é baseada na coleta de informações subjetivas, é possível que haja algum desconforto subjetivo relacionado a alguma pergunta feita pelo entrevistador. Caso você perceba, de alguma maneira, que as perguntas fazem com que você se sinta ainda mais desconfortável, por conta de outros aspectos relacionados a sua doença, é importante que se atente a isto e relate ao entrevistador.

Ressarcimento e Indenização:
Você terá a garantia ao direito a indenização diante de eventuais danos decorrentes da pesquisa.

Benefícios:

Por esta ser esta uma pesquisa exploratória, não haverá ganho de qualquer cunho para você.

Acompanhamento e assistência:

Não haverá acompanhamento direto aos pacientes por parte do entrevistador. Como a maioria dos participantes já deverá se encontrar em algum tipo de acompanhamento médico, psicológico ou de outra natureza no HC da Unicamp e/ou no PROESQ (Unifesp), os encaminhamentos, se necessário, serão feitos de acordo com a exigência de cada participante. Estas medidas serão tomadas com todo cuidado necessário, tendo em conta também o sigilo vigente relacionado a identidade do participante.

Sigilo e privacidade:

Você tem a garantia de que sua identidade será mantida em sigilo e nenhuma informação será dada a outras pessoas que não façam parte da equipe de pesquisadores. Se houver divulgação dos resultados desse estudo, seu nome não será citado, garantindo a você a segurança de que você não poderá ser identificado.

Ressarcimento:

Não haverá ressarcimento de despesas. O estudo poderá ser adaptado a outros eventuais compromissos que o participante possa vir a ter no HC (ou ambulatório), porém, como as entrevistas poderão ser feitas em duas ou três vezes, é possível que o participante também precisará vir para estas em horários que não se encaixem, necessariamente, em suas rotinas no HC (ou ambulatório). Isto será conversado com o participante que se dispor a participar da pesquisa.

Contato:
Em caso de dúvidas sobre o estudo, você poderá entrar em contato com:
Adrian Spremberg
Tel: (11) 96059-1205.
Em caso de denúncias ou reclamações sobre sua participação no estudo, você pode entrar em contato com a secretaria do Comitê de Ética em Pesquisa (CEP): Rua Francisco de Castro, nr.55, São Paulo-SP. 04020-050. Tels: 011-55711062/011-5539-7162. Email: cep@unifesp.br

Consentimento livre e esclarecido:

Após ter sido esclarecimento sobre a natureza da pesquisa, seus objetivos, métodos, benefícios previstos, potenciais riscos e o incômodo que esta possa acarretar, aceito participar:

Nome do(a) participante:
_____

_____ Data:
____/_____/_____.
(Assinatura do participante ou nome e assinatura do responsável)

Responsabilidade do Pesquisador:

Asseguro ter cumprido as exigências da resolução 466/2012 CNS/MS e complementares na elaboração do protocolo e na obtenção deste Termo de Consentimento Livre e Esclarecido. Asseguro, também, ter explicado e fornecido uma cópia deste documento ao participante. Informo que o estudo foi aprovado pelo CEP perante o qual o projeto foi apresentado e pela CONEP, quando pertinente. Comprometo-me a utilizar o material e os dados obtidos nesta pesquisa exclusivamente para as finalidades previstas neste documento ou conforme o consentimento dado pelo participante.

_____ Data:
____/_____/_____.
(Assinatura do pesquisador)

8.4 – Unicamp Ethics Committee Approval

UNICAMP - CAMPUS CAMPINAS

PARECER CONSUBSTANCIADO DO CEP

DADOS DA EMENDA

Título da Pesquisa: Experiências subjetivas anômalas do 'self¿ e do mundo: perspectivas sobre um estadiamento clínico e psicopatológico em pacientes com psicoses

Pesquisador: Adrian Nicholas Spremberg

Área Temática:

Versão: 12

CAAE: 65223516.3.1001.5404

Instituição Proponente: Hospital de Clínicas da UNICAMP

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 4.458.379

Apresentação do Projeto:

Solicitação de emenda ao projeto original.

Segundo o documento PB_INFORMAÇÕES_BÁSICAS_1350482_E4.pdf 23/11/2020:

Justificativa da Emenda:

Pedido de Cancelamento da Emenda E4.

Objetivo da Pesquisa:

Inalterado.

Avaliação dos Riscos e Benefícios:

Inalterado.

Comentários e Considerações sobre a Pesquisa:

Pesquisador solicita o cancelamento da ementa E4 de meu projeto, CAAE 65223516.3.1001.5404. A ementa trata de documentos pedidos pelo centro coparticipante de meu projeto, Unifesp, que já foram enviados para o centro, e aprovados.

Considerações sobre os Termos de apresentação obrigatória:

- PB_INFORMAÇÕES_BÁSICAS_1350482_E4.pdf 23/11/2020 : solicita cancelamento da presente emenda.

Endereço: Rua Tessália Vieira de Camargo, 126
Bairro: Barão Geraldo **CEP:** 13.083-887
UF: SP **Município:** CAMPINAS
Telefone: (19)3521-8936 **Fax:** (19)3521-7187 **E-mail:** cep@fcm.unicamp.br

- pedidoementaE4.docx 23/11/2020:solicita cancelamento da presente emenda.

Recomendações:

Enviar relatório parcial de acompanhamento do projeto a cada 6 meses e ao final do estudo(como NOTIFICAÇÃO)

Justificar cronograma , pois estudo terminaria em 2019.

Conclusões ou Pendências e Lista de Inadequações:

Solicitação de retirada de emenda aprovada.

ATENÇÃO AS RECOMENDAÇÕES.

Considerações Finais a critério do CEP:

- O participante da pesquisa deve receber uma via do Termo de Consentimento Livre e Esclarecido, na íntegra, por ele assinado (quando aplicável).
- O participante da pesquisa tem a liberdade de recusar-se a participar ou de retirar seu consentimento em qualquer fase da pesquisa, sem penalização alguma e sem prejuízo ao seu cuidado (quando aplicável).
- O pesquisador deve desenvolver a pesquisa conforme delineada no protocolo aprovado. Se o pesquisador considerar a descontinuação do estudo, esta deve ser justificada e somente ser realizada após análise das razões da descontinuidade pelo CEP que o aprovou. O pesquisador deve aguardar o parecer do CEP quanto à descontinuação, exceto quando perceber risco ou dano não previsto ao participante ou quando constatar a superioridade de uma estratégia diagnóstica ou terapêutica oferecida a um dos grupos da pesquisa, isto é, somente em caso de necessidade de ação imediata com intuito de proteger os participantes.
- O CEP deve ser informado de todos os efeitos adversos ou fatos relevantes que alterem o curso normal do estudo. É papel do pesquisador assegurar medidas imediatas adequadas frente a evento adverso grave ocorrido (mesmo que tenha sido em outro centro) e enviar notificação ao CEP e à Agência Nacional de Vigilância Sanitária – ANVISA – junto com seu posicionamento.
- Eventuais modificações ou emendas ao protocolo devem ser apresentadas ao CEP de forma clara e sucinta, identificando a parte do protocolo a ser modificada e suas justificativas e aguardando a aprovação do CEP para continuidade da pesquisa.
- Em caso de projetos do Grupo I ou II apresentados anteriormente à ANVISA, o pesquisador ou patrocinador deve enviá-las também à mesma, junto com o parecer aprovatório do CEP, para serem juntadas ao protocolo inicial.
- Relatórios parciais semestrais e final devem ser apresentados ao CEP, inicialmente seis meses

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após a data deste parecer de aprovação e ao término do estudo.

-Lembramos que segundo a Resolução 466/2012 , item XI.2 letra e, "cabe ao pesquisador apresentar dados solicitados pelo CEP ou pela CONEP a qualquer momento".

-O pesquisador deve manter os dados da pesquisa em arquivo, físico ou digital, sob sua guarda e responsabilidade, por um período de 5 anos após o término da pesquisa.

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_1350482_E4.pdf	23/11/2020 12:57:12		Aceito
Outros	pedidoementaE4.docx	23/11/2020 12:56:11	Adrian Nicholas Spremberg	Aceito
Outros	cartarespostacepunifesp.docx	03/06/2019 14:25:59	Adrian Nicholas Spremberg	Aceito
Projeto Detalhado / Brochura Investigador	projetofinalmaio2019.docx	03/06/2019 14:24:47	Adrian Nicholas Spremberg	Aceito
Cronograma	cronogramaunifesp.docx	03/06/2019 14:24:09	Adrian Nicholas Spremberg	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	tcleunifesp.docx	06/05/2019 12:48:55	Adrian Nicholas Spremberg	Aceito
Outros	folharostocepunifesp.pdf	06/05/2019 12:47:05	Adrian Nicholas Spremberg	Aceito
Outros	CartarespostaCEPabril2019.docx	11/04/2019 10:59:51	Adrian Nicholas Spremberg	Aceito
Projeto Detalhado / Brochura Investigador	projetofinalabril2019.docx	11/04/2019 10:59:38	Adrian Nicholas Spremberg	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TCLEnovo08012019.pdf	08/01/2019 10:08:57	Adrian Nicholas Spremberg	Aceito
Outros	EAWE.pdf	08/11/2018 19:27:56	Adrian Nicholas Spremberg	Aceito
Outros	relatorioparcial.pdf	02/05/2018 11:19:47	Adrian Nicholas Spremberg	Aceito
Outros	Autorizacaounifesp.pdf	03/04/2018 19:02:50	Adrian Nicholas Spremberg	Aceito

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Outros	Cartarespostafamiliares.pdf	27/06/2017 20:16:28	Adrian Nicholas Spremberg	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TCLEFINAL.pdf	06/04/2017 06:45:54	Adrian Nicholas Spremberg	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TAFINAL.pdf	06/04/2017 06:42:52	Adrian Nicholas Spremberg	Aceito
Outros	declaracaomatricula.pdf	13/02/2017 18:26:38	Adrian Nicholas Spremberg	Aceito
Outros	easeport.pdf	13/02/2017 18:08:16	Adrian Nicholas Spremberg	Aceito
Folha de Rosto	folharosto.pdf	08/01/2017 14:29:32	Adrian Nicholas Spremberg	Aceito
Outros	EAladapt.pdf	19/06/2016 18:32:01	Adrian Nicholas Spremberg	Aceito
Outros	EASE.PDF	18/06/2016 11:33:49	Adrian Nicholas Spremberg	Aceito
Outros	escala_qualidadedevida.pdf	18/06/2016 11:33:09	Adrian Nicholas Spremberg	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

CAMPINAS, 11 de Dezembro de 2020

Assinado por:
Maria Fernanda Ribeiro Bittar
(Coordenador(a))

Endereço: Rua Tessália Vieira de Camargo, 126
Bairro: Barão Geraldo **CEP:** 13.083-887
UF: SP **Município:** CAMPINAS
Telefone: (19)3521-8936 **Fax:** (19)3521-7187 **E-mail:** cep@fcm.unicamp.br

8.5 – Unifesp Ethics Committee Approval

UNIFESP

UNIVERSIDADE FEDERAL DE SÃO PAULO - UNIFESP

Plataforma Brasil

PARECER CONSUBSTANCIADO DO CEP

Elaborado pela Instituição Coparticipante

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: Experiências subjetivas anômalas do `self¿ e do mundo: perspectivas sobre um estadiamento clínico e psicopatológico em pacientes com psicoses

Pesquisador: Adrian Nicholas Spremberg

Área Temática:

Versão: 1

CAAE: 65223516.3.3004.5505

Instituição Proponente: Departamento de Psiquiatria

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 4.504.829

Apresentação do Projeto:

Centro Coordenador: Hospital de Clínicas da UNICAMP

Projeto CEP/UNIFESP: 0575/2019

Trata-se de emenda (Ec1) ao projeto: Pedido de Cancelamento da Emenda E4

As informações elencadas nos campos "Apresentação do Projeto", "Objetivo da Pesquisa" e "Avaliação dos Riscos e Benefícios" foram retiradas do parecer consubstanciado pelo CEP do centro coordenador (PB_PARECER_CONSUBSTANCIADO_CEP_4458379_E4.pdf).

BREVE APRESENTAÇÃO DO PROJETO:

Este projeto tem como principal objetivo desenvolver e caracterizar uma investigação minuciosa de algumas experiências subjetivas anômalas geralmente encontradas em pacientes com o diagnóstico de esquizofrenia.

Objetivo da Pesquisa:

Permanecem inalterados.

-OBJETIVO PRIMÁRIO: Avaliar as experiências anômalas do self e do mundo nos diferentes recortes temporais (curso da doença) da psicose.

Endereço: Rua Botucatu, 740
Bairro: VILA CLEMENTINO **CEP:** 04.023-900
UF: SP **Município:** SAO PAULO
Telefone: (11)5571-1062 **Fax:** (11)5539-7162 **E-mail:** cep@unifesp.br

Avaliação dos Riscos e Benefícios:

sem alteração em decorrência da emenda

Mantidos em relação ao projeto original.

Comentários e Considerações sobre a Pesquisa:

Trata-se de emenda (Ec1) ao projeto.

Justificativa para a emenda:

Pesquisador solicita o cancelamento da ementa E4, CAAE 65223516.3.1001.5404.

A ementa trata de documentos pedidos pelo centro coparticipante de meu projeto, Unifesp, que já foram enviados para o centro, e aprovados.

Considerações sobre os Termos de apresentação obrigatória:

Documentos apresentados para a emenda:

1- Carta justificativa (pedidoementaE4.docx)

Conclusões ou Pendências e Lista de Inadequações:

Emenda aprovada.

Considerações Finais a critério do CEP:

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Outros	pedidoementaE4.docx	23/11/2020 12:56:11	Adrian Nicholas Spremberg	Aceito
Outros	cartarespostacepunifesp.docx	03/06/2019 14:25:59	Adrian Nicholas Spremberg	Aceito
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Outros	CartarespostaCEPabril2019.docx	11/04/2019	Adrian Nicholas	Aceito

Outros	CartarespostaCEPabril2019.docx	10:59:51	Spremberg	Aceito
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Outros	Cartarespostafamiliares.pdf	27/06/2017 20:16:28	Adrian Nicholas Spremberg	Aceito
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Outros	EAladapt.pdf	19/06/2016 18:32:01	Adrian Nicholas Spremberg	Aceito
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Outros	escala_qualidadedevida.pdf	18/06/2016 11:33:09	Adrian Nicholas Spremberg	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

SAO PAULO, 20 de Janeiro de 2021

Assinado por:
Ediléia Bagatin
(Coordenador(a))