Consciousness and Cognition 74 (2019) 102770

Contents lists available at ScienceDirect

Consciousness and Cognition

journal homepage: www.elsevier.com/locate/concog

Thought insertion and disturbed for-me-ness (minimal selfhood) in schizophrenia

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ARTICLE INFO

Keywords:
Minimal self
For-me-ness
Self-disorders
Thought insertion
Schizophrenia
First-rank symptoms
Consciousness

ABSTRACT

In contemporary consciousness research, we have defended a position of experiential minimalism, arguing that for-me-ness (or minimal selfhood) is a necessary, universal feature of phenomenal consciousness. The concept of for-me-ness refers to the fact that experiences are given first-personally to the subject of experience. To challenge the universality of for-me-ness, several authors have referred to the case of thought insertion as a clear counter example. In this study, we address and refute the claim that episodes of thought insertion represent examples of experiences lacking for-me-ness. We highlight certain unaddressed methodological and psychopathological problems that tend to hamper philosophical discussions of thought insertion. Although thought insertion does not involve a lack of for-me-ness, we do argue that thought insertion involves a disturbed for-me-ness. Finally, we offer a novel account of how for-me-ness is disturbed in schizophrenia spectrum disorders and we discuss how a disturbed for-me-ness may be involved in the formation of thought insertion.

1. Introduction

During the last decades, the self has attracted considerable attention in a variety of disciplines such as philosophy, psychology, psychiatry, cognitive science, and neuroscience. Especially the attempt to define the most primitive or fundamental form of selfhood has proven theoretically fruitful, opened up new avenues of research, and fertilized the ground for a scientific debate about the nature of the self. Drawing on resources from, e.g., German idealism, phenomenology, and analytic philosophy of mind, one of us has defended a form of experiential minimalism, arguing that phenomenal consciousness necessarily entails reflexive (pre-reflective) self-consciousness in the sense that there is something it-is-like *for me* to have or live through experiences (Zahavi, 1999, 2005, 2014). In other words, all experiences are first-personally manifest; they are always given to the subject of that experience in a manner in which they are not given to anyone else (e.g., the pain I experience is given to me in a manner that is significantly different from how everybody else may experience my pain). This first-personal or subjective character of experience has been identified as the 'minimal self' (cf. Zahavi & Kriegel, 2016). The idea is not that consciousness is populated by some kind of 'self-object' or that it contains some pervasive 'I-qualia'. Rather, experience, in virtue of its very subjective givenness, necessarily involves a fundamental for-me-ness (viz. minimal selfhood).

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https://doi.org/10.1016/j.concog.2019.102770
Received 10 May 2019; Received in revised form 18 June 2019; Accepted 19 June 2019

This way of thinking about self has had a profound impact on psychiatric research, where something like a 'renaissance' of phenomenological psychopathology has taken place within the last two decades. Especially Sass and Parnas (2003) initial conceptualization of the basic disturbance in schizophrenia as a disorder of 'ipseity' or 'minimal self', which offered a unifying account of otherwise seemingly heterogeneous symptoms and signs, became an impetus to phenomenological research in psychopathology (cf. Cermolacce, Naudin, & Parnas, 2007; Nelson, Parnas, & Sass, 2014; Parnas & Henriksen, 2019). The subsequent publication of the *EASE: Examination of Anomalous Self-Experience* scale (Parnas et al., 2005) allowed clinicians and researchers to systematically investigate a range of pervasive and persistent changes in the very structure of experience, which to some extent can be considered manifestations of a disturbed minimal self. Empirical studies have found that such anomalous self-experiences hyper-aggregate in schizophrenia spectrum disorders (Parnas & Henriksen, 2014). However, clinical and empirical research on anomalous self-experiences also provides insights that can allow for a refinement of the philosophical concept of minimal self.

As for all popular research topics, the minimal self and its alleged frailty in schizophrenia spectrum conditions is up for scientific scrutiny and discussion. Recently, a series of critical papers have been published, targeting different aspects of our philosophical and psychopathological analysis (e.g., Lane, 2012; Billon, 2013; Dainton, 2016; Howell & Thompson, 2017; Guillot, 2017; Farrell & McClelland, 2017; López-Silva, 2017; Carruthers & Musholt, 2018). Much of this critique has already been explicitly addressed elsewhere (Zahavi, 2017, 2018, 2019), but one central and recurrent theme in much of the critical literature has so far not been thoroughly addressed, namely the use of psychopathological cases, especially the case of thought insertion, as alleged counter examples to the claim that for-me-ness (or minimal selfhood) is a necessary and universal feature of phenomenal consciousness.

The purpose of this article is twofold. First, we address the claim that episodes of thought insertion represent examples of experiences lacking for-me-ness (Section 2), and then offer some critical reflections on the philosophical use of the psychopathological phenomenon of thought insertion (Section 3). Second, we provide a new account of how for-me-ness (minimal selfhood) is affected in schizophrenia spectrum disorders, and we then discuss the relation between a disturbed for-me-ness and thought insertion (Section 4).

2. Thought insertion – Examples of experiences lacking for-me-ness?

The standard way to challenge universality claims is to find putative counter examples. Recently, several authors have presented examples of experiences that they claim lack for-me-ness, thus seemingly rebutting our claim that this feature is a necessary, universal feature of phenomenal consciousness. These examples are usually collected from psychopathology, drug-induced altered states of consciousness, and mystical, enlightenment experiences. The key issue here concerns exactly how we are to understand such experiences.[1]

One of the most discussed psychopathological phenomena in philosophy of psychiatry is thought insertion. Below, we offer a more substantial description of thought insertion but for now it suffices to say that thought insertion is a phenomenon in which patients experience some of their thoughts as not belonging to themselves, and furthermore ascribe the source of these thoughts to someone or something else. To explain how the phenomenon of thought insertion is possible, philosophers have generally argued that we must distinguish different features of consciousness, and that, in the case of thought insertion, some features are lacking, while others are preserved. Such a binary approach, which considers singular features as present or absent, is a recurrent theme in philosophical accounts of thought insertion. For example, Stephens and Graham (1994) propose a distinction between what they call the sense of being the subject of mental activity (sense of subjectivity) and the sense of being the agent of mental activity (sense of agency), and then proceed to argue that, in thought insertion, the sense of agency is lost, whereas the sense of subjectivity is retained. In an influential article, Gallagher (2004) criticises Stephens and Graham's conceptualization of 'sense of agency' for relying on second-order, reflective capacities that is then applied to first-order, phenomenal experiences. Gallagher recasts the concept of 'sense of agency' at a first-order, pre-reflective level of experience and argues that thought insertion involves a loss of (pre-reflective) sense of agency but not of ownership. For Gallagher, the patients' denial of agency of inserted thoughts is therefore "not a mistake or misinterpretation (…) but a report of what the subject actually experiences" (2004, 17).

Just like Gallagher, Metzinger also argues that it is necessary to take the phenomenology of the patients' experiences seriously. For Metzinger, however, this involves taking the patients' reports at face value. This is, e.g., vivid, when he claims that patients with Cotard's Syndrome "truthfully" describe their experience of being dead or somehow nonexistent (Metzinger, 2003, 456ff.). Metzinger further claims that when it comes to cases of thought insertion, they constitute examples "where patients are confronted with conscious, cognitive contents for which they have no sense of agency or ownership" (Metzinger, 2003, 445).

A few years later, Lane made similar claims and argued that the existence of thought insertion as well as certain other psychopathological cases demonstrates that self and consciousness, although normally tightly interwoven, are in fact not necessarily linked (Lane, 2012, 281). According to Lane, it is crucial not to conflate "hosting" a thought with "owning" a thought, and in his view "hosting" does not imply "ownership" (Lane, 2012, 260) or, as he also puts it, "perspective does not determine mineness" (Lane, 2012, 258). Like Metzinger, Lane too embraces a literal interpretation of the patients' description of their experiences (Lane, 2015, 116). If a patient states that some of his thoughts are not his, this proves that a subject can undergo experiences without these experiences being lived through as the subject's own. As Lane concludes, "Phenomenal consciousness does not entail self-awareness;

[1] We have elsewhere addressed the claim that certain mystical experiences and drug-induced altered states of consciousness represent counter examples of for-me-ness or minimal selfhood (Zahavi, 2011; Parnas & Henriksen, 2016; Henriksen and Parnas, in press). In this article, we focus solely on experiences of thought insertion.

it is not stamped with a meish quality; and, for-me-ness does not play a determining role in its constitution" (Lane, 2012, 281).

Most recently, López-Silva (2017) has also argued that the absence of a sense of ownership, or as he calls it 'mineness', in thought insertion demonstrates the fallaciousness of the claim that any conscious experience necessarily involves a minimal experiential self. More specifically, López-Silva claims that the case of thought insertion, which, on his account, involves a loss of mineness but not of for-me-ness, provides "prima facie evidence" for the claim that an experiential sense of mineness (or ownership) is of little significance for phenomenal consciousness as such (2017, 7).

As pointed out in detail by Zahavi (2018), often the critics are using the concepts of 'for-me-ness' and 'mineness' differently than the authors they are criticizing, which simply adds to the confusion. However, one initial reply to the various criticisms described above concerns the notion of ownership in question. Is ownership a univocal notion, or might it be necessary to distinguish different kinds of ownership? If the latter happens to be the case, is it then plausible to claim that all types of ownership are absent in episodes of thought insertion? Consider, for instance, the distinction between 'personal ownership' and 'perspectival ownership' proposed by Albahari (2006, 53–54). Personal ownership is a question of identifying oneself as the personal owner of an experience, thought or action; it is a question of appropriating and being thematically aware of owning certain experiences, thoughts or actions. By contrast, for a subject to own something in a perspectival sense is simply for the experience, thought or action in question to present itself in a distinctive manner to the subject whose experience, thought or action it is. So, the reason I can be said to own my thoughts or perceptions perspectivally is that they appear to me in a manner that is different from how they can appear to anybody else. Do episodes of thought insertion also lack perspectival ownership? When a subject who experiences thought insertion reports that certain thoughts are not his own thoughts, that someone else is generating these thoughts, he is also indicating that these thoughts are present to him, not 'over there' in someone else's head, but in his own mind. This is precisely why they are so troubling and unsettling. By contrast, alien thoughts in alien minds are typically harmless (cf. Zahavi, 2005, 144). Irrespective of the degree of felt alienation, the experiences do not manifest themselves in the public domain; they are not intersubjectively accessible in the same way tables and chairs are. This is what most fundamentally makes the experiences first-personal, and this is why even these pathological experiences retain perspectival ownership and thus for-me-ness as we define it. Saying that is not to deny that thought insertion testifies to a deeply disturbed mind; nor does claiming that for-me-ness is 'retained' necessarily imply that it is entirely unaffected (see Section 4). However, in order to get to the core of the disturbance, we need to investigate it more carefully.

3. A critique of the philosophical use of examples of thought insertion

Philosophical accounts of thought insertion are often hampered by various unaddressed methodological and psychopathological complications. Let us in what follows highlight some of these problems and offer some critical reflections on the ways in which philosophers tend to engage with examples of thought insertion; an engagement which often impedes rather than promotes scientific exploration of this particular psychopathological phenomenon.

In the philosophical literature on thought insertion, it is frequently ignored or forgotten that an example is precisely an example of something, i.e., an example depicts only certain, preferably characteristic, aspects of the phenomenon it is exemplifying (cf. Lat. *eximere*, 'take out'). Accounting for a phenomenon on the sole basis of a few examples consequently harbours an inherent risk of misrepresenting the phenomenon. Differently put, the original phenomenon may fade away and the accounts end up explaining something different than the phenomenon they were supposed to explain. In our view, this is precisely the case with many of the accounts of thought insertion found in contemporary philosophy of psychiatry. Rather than first obtaining a solid, clinical grasp of the phenomenon of thought insertion, and then offering an account of it, it appears that many authors simply skip the first step and start with the second. Based typically only on a few examples of thought insertion found in the literature, accounts of thought insertion are readily offered and their implications for theories of phenomenal consciousness eagerly discussed. Indeed, it is often difficult not to get the impression that the primary concern of several of these authors is not, in fact, to offer a substantial account of thought insertion but rather to construe thought insertion as an invalidating counter example to whatever theory of consciousness they are out to criticize.

Two of the most used and recycled examples of thought insertion in philosophy of psychiatry are those provided by Mellor (1970) and Frith (1992). The point is not that these examples are particularly misleading but rather that they are just *two* examples, depicting certain aspects of some manifestations of thought insertion, while missing other aspects. Let us take a brief look at these examples and then express some of our concerns:

> I look out of the window and I think the garden looks nice and the grass looks cool, but the thoughts of Eamonn Andrews come into my mind. There are no other thoughts there, only his.… He treats my mind like a screen and flashes his thoughts on to it like you flash a picture (Mellor, 1970, 17)
>
> Thoughts are put into my mind like "Kill God". It's just like my mind working, but it isn't. They come from this chap, Chris. They're his thoughts (Frith, 1992, 66)

From these examples, at least three aspects of the two patients' experience of thought insertion can be disentangled: (i) the phrases that foreign thoughts "come into my mind" and "are put into my mind" seem to indicate that these thoughts somehow *enter* the mind from the outside[2]; (ii) both patients claim that the source of these thoughts are foreign agents, namely Eamonn Andrews and

[2] Similarly, López-Silva (2018), who also draws on another example ("One of our patients reported physically feeling the alien thoughts as they

Chris, respectively; (iii) the patient, quoted by Mellor, further describes that there "are no other thoughts there, only his" and that they are flashed onto her mind like onto a screen.

As the clinical literature (e.g., Koehler, 1979; Klosterkötter, 1988) documents, other patients might, however, experience thought insertion quite differently:

(i*) Some patients complain of thoughts, which are not of their own making, simply being there, in their mind, without "entering" it from the outside. For example, when a patient with schizophrenia was asked if he sometimes experienced that alien thoughts were being inserted into his head, he immediately denied having this experience (i.e. thought insertion). However, upon further interviewing, it became evident that the patient did in fact experience thought insertion (Jansson & Nordgaard, 2016, 37). Most likely, the patient initially denied the question because he did not experience the alien thoughts as being "inserted" in his head; rather, the alien thoughts were simply there.

(ii*) Some patients may also not ascribe the source of these thoughts to a specific person but more vaguely to someone or something else. For example, one of our patients described her experience of thought insertion in the following way: "Sometimes, I get thoughts about death that are not my own thoughts. But I can't say that they are yours or someone else's. I can't figure out, whose thoughts it is that I get into my head… I can never figure out who gives me these thoughts." Another patient experiencing thought insertion was also not able to pin-point the source of these thoughts. He said,

> There are two worlds. There is the unreal world, which is the world I am in and we are in. And then there is the real world. The only thing that is real in the unreal world is my own self. Everything else – buildings, trees, houses – is unreal. All other humans are extras. My body is part of the charade. There is a real world somewhere and from there someone or something is trying to control me by putting thoughts into my head or by creating (…) screaming voices inside my head (Parnas & Henriksen, 2016, 83).

Thought insertion is a cognitive experience of a thought content that the patient claims is not his own. For this reason, there is a close affinity and clinical overlap between thought insertion and auditory verbal hallucinations in schizophrenia as our example above illustrates (Parnas & Urfer-Parnas, 2017). Moreover, thought insertion belongs to a generic group of so-called "passivity phenomena", which also comprises thought withdrawal (a phenomenon sometimes described as the reverse of thought insertion, typically following thought block), thought broadcast (an experience of others being able to hear or having access to one's thoughts), and "made" volitions, impulses, feelings, motor acts, and other bodily phenomena.

(iii*) It is also quite rare that patients, experiencing thought insertion, have the experience that there are "no other thoughts" during episodes of thought insertion. The delusional conviction that alien thoughts occupy one's mind may, as other symptomatologies, fluctuate in intensity and duration, and it may last from minutes to years. Some patients may, in an almost revelatory sense, immediately know the source of the alien thoughts, whereas other patients wonder about the source of these thoughts, where they come from, what they mean, and why they are experiencing them, etc. Patients can tell apart the alien thoughts from their own thoughts. As one patient experiencing thought insertion put it, "They are very different from my usual thoughts and are thoughts that other people don't think". This patient considered them "solemn thoughts" and believed they were sent to him from God (Jansson & Nordgaard, 2016, 37). Another highly intelligent and reflective patient of ours was unable to determine if the sense of alienation related to his inserted thoughts stemmed from the nature of the thought content or their mode of presentation in his consciousness. To a person without clinical knowledge of thought insertion, the third aspect of Mellor's example may be taken to imply that inserted thoughts are experienced in a sort of mental vacuum, in a complete absence of other thoughts, which, however, rarely is the case. Finally, the patient's description of her mind being treated like a screen onto which Eamonn Andrews flashes his thoughts is open to interpretation. Perhaps it is simply a metaphor used to further describe the experience of a mental vacuum. Or it can be a more concrete experience of somehow seeing 'his' thoughts before her eyes, perhaps reminiscent of a form of perceptualization of inner speech in which she perceives her thoughts like subtitles on a film and needs to read them in order to know what she is thinking (Parnas & Sass, 2011). Ultimately, it is impossible to know exactly what the patient meant with this description of her experience, and this is really our point. Without any comprehensive familiarity with clinical psychopathology and when relying only on a few examples that are constantly recycled in the literature, philosophers tend to overemphasize particular aspects and overlook other relevant aspects, thereby offering accounts of thought insertion that are clinically irrelevant and psychopathologically as well as philosophically confusing.

To enable a more comprehensive description of thought insertion, some authors suggest that more clinical examples are needed (e.g., López-Silva, 2018). However, the problem runs deeper than that of quantity. In brief, it has to do with how such examples are used and interpreted. In an effort to take patients' descriptions of their own experiences seriously – "patient phenomenology" as it sometimes is termed – philosophers sometimes slip and mistakenly take this to involve taking patients' descriptions literally. We already noticed how a literal interpretation was central to both Metzinger's and Lane's account of thought insertion in Section 2. For some, such an approach even acquires the character of a dictum: "the patient's reports should be taken at face-value" (Billon, 2013, 299; cf. Lane, 2015). Billon goes so far as to formulate, what he calls, a 'phenomenological constraint' to accounts of thought insertion: "If the patient says that an occurrent thought is not his, then it is not subjective. If the patient says that an occurrent thought feels his, then it is subjective" (Billon, 2013, 299).

(*footnote continued*)
entered his head and claimed that he could pin-point the point of entry!" [Cahill & Frith, 1996, 278]), suggests that this particular aspect, i.e., thoughts entering the mind from the outside, is central to the phenomenology of thought insertion.

Taking patients' reports at face value and equating a phenomenological approach to thought insertion specifically and psychopathology more generally with a *literal* interpretation of patients' report is, however, methodologically problematic and it ignores substantial contributions of major phenomenological psychopathologists such as Minkowski, Binswanger, and Tatossian, etc. (cf. Zahavi, 2005, 145f.). As a first, necessary step, we have to acknowledge that sincerely listening to a patient or striving to understand a patient's experiences does not imply that we accept what the patient describes at face value. Some observations may help elucidate why this should not be the case.

First, one patient firmly denied hearing voices, because she was convinced that the voices, which she vividly described hearing, were not hallucinations but voices of real people, whom she believed lived on the other side of the globe. Similarly, another patient vehemently denied hearing voices, asserting that he was not insane. However, the patient's main complaint was that he, round-the-clock, heard conversations of his neighbours, talking negatively about him. In both cases, the patients did in fact "hear voices" in the sense of having hallucinations, despite explicitly denying this. Crucially, mental terms such as "hearing voices", "feeling depressed", "being anxious", "having low self-esteem", etc. are polysemic and, as the two examples illustrate, what a patient means with a given mental term does not necessarily correspond to its clinical meaning. Similarly, what a patient means with a given description (e.g., that some of his thoughts are not his) does not necessarily correspond to a loss of certain features of phenomenal consciousness (e.g., 'for-me-ness', 'sense of ownership', 'sense of agency') as these features are defined in the philosophical literature. In short, clinicians should not take patients' reports at face value but must always faithfully explore the patients' experiences, their structure and quality, in the *context* of other experiences, behaviour, and life history. In other words, only a contextual assessment can clarify if a certain complaint is in fact a symptom at all and what kind of symptom it may be.

Second, psychiatric symptoms are not "natural objects" in the sense of discrete, independently existing entities (Parnas & Urfer-Parnas, 2017). Since psychiatric symptoms are not "objects", accessible to scrutiny from a third-person perspective, but rather fragments of experience disclosed in a second-person situation, examining psychopathology and gathering psychiatric "data" requires an adequate approach, viz. a semi-structured, psychiatric interview (Jansson & Nordgaard, 2016; Nordgaard, Sass, & Parnas, 2013). For example, one cannot obtain a valid answer to a question of whether a patient has transitivistic experiences (i.e. experiences of permeability of the boundary between self and other/world) by asking directly 'do you have loose ego-boundaries?' Rather, a positive assessment can be made, if a certain experiential 'structure', reflecting transitivism, manifests itself in various formulations and examples offered by the patient throughout the interview. By asking for clarifications, further examples, and by proposing alternative examples of pathological experiences to the patient, the clinician performs a kind of psychopathological "eidetic reduction" in the sense of peeling off accidental properties of the experience in question and laying bare its essential features (Parnas & Zahavi, 2002, 157).

Third, psychiatric symptoms are also not "ready-made", simply waiting in the patient's consciousness for an adequate prompting to come into a full view (Nordgaard et al., 2013). Patients' reports of their experiences are usually a result of a process of conceptualization, where initially felt anomalies in the experiential field, e.g., sensations or feelings of alienation, evoke reflective efforts to conceptualize and grasp these experiences. Patients often take recourse to metaphors and use the 'as-if' qualification to express anomalous experiences that may seem to defy natural certitudes of space, time, and causality or fall outside ordinary linguistic categories (Parnas & Henriksen, 2016). For example, a patient may report that it feels like some of her thoughts do not belong to her, as if another generated them. The 'as if' qualification here suggests that the patient retains a reflective distance to her experience, i.e. her grasp of reality has not slipped and she is not delusional. However, a further concretization of the metaphor, away from its ordinary intersubjective meaning, could make the patient's report closer to a delusion. It is consequently important to remember that metaphors are not just metaphors. They always convey certain lived aspects of pre-linguistic experience, and, not infrequently, patients use metaphors in somewhat more concrete ways than one might be inclined to expect, reflecting the lived anomalous experiences they are meant to articulate (Henriksen & Parnas, 2015, 195; Nordgaard et al., 2013; Parnas et al., 2005, 237). Unfortunately, awareness of the 'distance' between the originally lived anomalous experience and its conceptual formulation as well as of the role of metaphor in language and psychopathology, which always has been an important theme in phenomenological psychopathology, are frequently ignored in recent philosophical accounts on thought insertion; this is especially so when patients' reports are simply taken at face value.

Another frequent problem in the philosophical discussion of thought insertion concerns a tendency to decontextualize this experience from the psychopathological Gestalt in which it is embedded. Psychiatric symptoms lose their clinical significance if they are severed from the psychopathological Gestalt they are part of and from which they receive their meaning (Jansson & Nordgaard, 2016, 98). This decontextualization is particularly conspicuous in contemporary literature, where patients, who experience thought insertion, often simply are referred to as "TI patients" (see, e.g., López-Silva, 2018). Putting it bluntly, there are no TI patients. There are, however, patients with schizophrenia and some of them occasionally experience thought insertion (Nordgaard, Arnfred, Handest, & Parnas, 2008). In psychopathological literature, thought insertion refers to a specific form of experience that Schneider (1959) famously included in his list of 'first-rank symptoms', which he considered of strong diagnostic importance for schizophrenia. Although the diagnostic weight of first-rank symptoms has been deemphasized in *DSM-5: Diagnostic and statistical manual of mental disorders, 5th edition* (American Psychiatric Association, 2013), the presence of one first-rank symptom remains a sufficient criterion to render a schizophrenia diagnosis in *The ICD-10 classification of mental and behavioural disorders* (World Health Organization, 1992), if the duration criterion is fulfilled and the exclusion criteria are not. For Schneider, several of the first-rank symptoms of schizophrenia, including thought insertion, fundamentally involves "a 'lowering' of the 'barrier' between self and the surrounding world, the loss of the very contours of the self" (1959, 134)[3]—what he, in the German original, called '*Ichstörung*' (1971, 136) and which may be translated as 'ego'- or 'self-disorders'. What Schneider alludes to here may be described as the core of the psychopathological Gestalt of schizophrenia in its synchronic and diachronic pathogenetic unfolding, i.e., a characteristic pattern that transpires through,

shapes, and to some extent unifies the different symptoms and signs that may emerge (e.g., Sass & Parnas, 2003; Parnas, 2011, 2012). Schneider touches here upon something that many classical psychopathologists (e.g., Kraepelin, Bleuler, Jaspers, Berze, Gruhle, Minkowski) had also recognized, though described in different ways and with varying clarity, namely that patients with schizophrenia often suffer from a diminished sense of self or self-presence, which is reflected in an altered subjective life that is manifest already prior to the articulation of psychosis.

4. Phenomenology of thought insertion and disturbed for-me-ness in schizophrenia

Since the inception of the concept of schizophrenia, it has been consistently argued that schizophrenia as a psychotic disorder is preceded by a whole range of anomalies of experience (e.g., de Clérambault, 1920; Huber, Gross, & Schüttler, 1979; Gross et al., 1987; Klosterkötter, 1988; Parnas, 1999). In the last two decades, phenomenologically informed empirical studies, using the EASE scale, have consistently demonstrated the presence of certain trait-like, non-psychotic, anomalous self-experiences in schizophrenia spectrum disorders. In general terms, children or adolescents, who later suffer from schizophrenia spectrum disorders, describe a certain type of solitude that must be differentiated from social isolation. It is a feeling of being different from others, a phenomenon termed '*Anderssein*' in German psychopathology, and which has been nicely conceptualized by the Japanese psychiatrist Mari Nagai (2016). In essence, it is a feeling of being 'ontologically different' from others, often without being able to verbalise precisely what this difference amounts to (Parnas & Henriksen, 2014, 253). Importantly, this sense of 'difference', this global sense of inner and existential alienation, precedes thematization – i.e. the feeling of difference precedes finding out "what" is different – and it is often associated with specific disturbances of self- and world-experience. The experiential field may become increasingly anonymized and thoughts may appear somehow at a distance from the thinking subject. The patients might report that their thoughts are not experienced in the usually silent manner but rather heard spoken aloud with the patient's own voice ('*Gedankenlautwerden*') or seen as subtitles in a movie, requiring the patient to listen to or read his thoughts in order to know what he is thinking. Patients also often report that certain thoughts may feel as if they weren't generated by the patients themselves (*'Gedankenenteignung'*) or that apparently disconnected thoughts, often trivial or emotionally neutral thoughts, break into and interfere with the patients' main line of thoughts. Patients may further describe that they have too many thoughts, e.g., rapidly changing thoughts or parallel trains of thoughts occurring with a loss of control, coherence, and meaning. Such instances of thought pressure are often associated with the experience that the thoughts or feelings have acquired spatial qualities, e.g., they are experienced as if they are located in a particular part of the brain or as if they are moving in a certain way. Patients also often describe experiences of bodily estrangement, e.g., unusual bodily sensations (cenesthesias) and feelings as if the body does not really fit or as if the body and mind are somehow disconnected. They often have non-psychotic demarcation problems (e.g., feelings of being 'too open' or 'transparent', as if others, merely by looking at them would know what they are thinking [transitivism]). They might have experiences of not being fully present in the world (e.g., manifested in feelings of being ephemeral, not fully existing, "lacking a core", decreased emotional resonance and responsivity, and in a pervasively felt distance to the world) or quasi-solipsistic experiences (e.g., fleeting feelings of being the very centre of the world or feelings of having unique responsibilities or special insights into hidden dimensions of reality). Such anomalous self- and world-experiences reflect an experiential framework characterized by a diminished sense of self-presence and an increased self-alienation. We have elsewhere described the formation of psychotic symptoms as an expression of increasing self-alienation or "alterization" in which a part of oneself come to be experienced as a persecuting, influencing or hallucinatory Other (Parnas & Henriksen, 2016, 85).

From a phenomenological perspective, psychotic phenomena such as thought insertion are thus not only embedded in but usually arise from an altered experiential framework, which empirical studies have found to be specific for schizophrenia spectrum disorders (Parnas & Henriksen, 2014). In other words, such psychotic phenomena are often the outcome of a profound sense of self-alienation that already exists prior to the onset of psychosis. The self-alienation in question is fundamentally speaking a pervasively *felt distance* between the experiencer and his experiences. When reaching its full potentiation in psychosis, this felt distance becomes unbridgeable, as it were, allowing some of the patient's own thoughts to appear so strange and unfamiliar that they no longer are recognized as his own thoughts. From this perspective, thought insertion may be considered an 'end phenomenon' (Klosterkötter, 1988), resulting from a process of increasing self-alienation. In a very simplified manner, this process can be described as follows: initially, a patient experiences a 'distance' to his own thoughts; then certain thoughts appear not to be generated by the patient; then the patient becomes increasingly convinced that the thoughts are in fact not his own; and finally, he believes that the alien thoughts are generated by someone or something else.

How best to conceive of the initial state and subsequent development of thought insertion? In our view, the pervasively felt distance between the experiencer and his experiences is best described as involving a frail or disturbed for-me-ness. This is also why we think that thought insertion points to the presence of a fundamental self-disorder. But what precisely does this amount to? Let us first reject two interpretations, and then present our own.

1. According to the first misinterpretation, what we find in thought insertion is a dissolution of the first-person perspective. There is no for-me-ness. It is completely absent.

[3] The phrase about the lowering of the barrier between self and world in the English translation does not adequately capture what is at stake in the German original. Here, Schneider speaks of a "'Durchlässigkeit' der 'Ich-Umwelt-Schranke'" (1971, 136), which emphasises an alarming "permeability" of the very boundary between the self and the surrounding world.

To speak of anomalous self-experiences or of a disturbed self is, however, still to speak of self-experiences and of selfhood. Indeed, regardless of how alienated or distanced the patient feels vis-à-vis the experiences, the experiences never manifest themselves in the public domain. They are never intersubjectively accessible in the same sense as tables and chairs. The experiences are given differently to the patient than to anybody else. The epistemic asymmetry is preserved. This is what most fundamentally make the experiences first-personal, and this is why even these pathological experiences retain their for-me-ness.

2. According to the second misinterpretation, for-me-ness is so fundamental and formal a feature of consciousness that it is never affected in pathology. Strictly speaking, there is no difference between the for-me-ness of a healthy subject and the for-me-ness of a patient with schizophrenia. When speaking of self-disorders or of disturbed self-experiences, it is, on this interpretation, consequently important to realize that the disturbances all pertain to higher and more robust layers of selfhood and self-experience. They do not affect the most minimal level. To use an artichoke analogy, although the petals have been affected, the heart remains intact and unchanged.

Although this second interpretation isn't as erroneous as the first, we still find it unsatisfactory. We think it underestimates how pervasive and fundamental a disorder of consciousness we are actually dealing with. Consider the following three examples that specifically target what in psychopathological terms is called a 'distorted first-person perspective' (EASE item 2.2).

One patient reported, "I look out through my eyes from a retracted point, and I see my skull in my visual periphery" (Henriksen & Nordgaard 2014, 437). Another patient described how everything inside his head was covered in darkness except a 'light spot' at a slanted left position through and from which he perceived his thoughts and the world. The patient further described how, through this light spot, he saw his thoughts as images or subtitles on a film, "it's like watching a television from a distance of 2 m" (Henriksen & Parnas, 2017, 180). Finally, Nagai offers the following example from a patient describing an experience from the very onset of her illness:

> when I'm with others, there are two *Is*: the *I* who is among them, and the *I* who objectively looks at this I. No matter how much absorbed I am in something, there is always an *I* that looks on it from the outside dispassionately. This latter, outer self is always managing and controlling me. Even when I talk with others, the outer self listens to their words and tells them to the inner self. After listening to this, the inner self starts to talk. The inner self speaks what the outer self commands it to do (Nagai, 2016, 497; italics in original).

The first two examples exemplify a spatialization of the perspectival origo (i.e., the elusive zero-point, pole or source of one's perspective) with ensuing self-alienation. In the first example, the perspectival origo has acquired a concrete, physical extension, which it normally never has. In the second example, the patients' thoughts have also acquired spatial qualities. Here, the *felt distance* between the experiencer and his experiences is vivid, requiring the patient to see or read his own thoughts to know what he is thinking. In the last example, Nagai's patient reports an experience of profound self-monitoring, which Nagai herself terms 'simultaneous introspection' (2016, 497), but which perhaps is better designated as 'involuntary self-witnessing' (Stephensen and Parnas, 2018, 635). Crucially, this involuntary self-witnessing is quite different from normal kinds of self-observation or introspection where one takes oneself as an object of reflection. In involuntary self-witnessing, there is no clear-cut subject-object structure and the fundamental unity of experience, which normally ties together the 'reflecting' and 'reflected upon' ego, is replaced with a fundamental self-fragmentation or duplication occurring within the experiential stream itself. As the patient explains, there are "two *Is*", "the inner self" and "the outer self", and they ceaselessly and at the same time observe each other. In other words, the act of observing and being observed apparently occurs simultaneously within one and the same experience (Nagai, 2016, 497).

We don't think examples like these support the view that there is something like an innermost core of for-me-ness that remains intact and unchanged. Fruit syrup might consequently be a better analogy than an artichoke. When you mix red fruit syrup with water, the syrup colours all the water red, it doesn't leave a bottom layer untouched and untainted. And contra the first interpretation, even when coloured, the water remains water. It doesn't disappear.

William James famously argued that our own present thoughts are characterized by a quality of "warmth and intimacy" (James, 1890, 239). Although anomalous and psychotic experiences do remain characterized by for-me-ness in the sense of being given to the experiencer first-personally, i.e., in a manner that is not available to anybody else, the for-me-ness in question seems to lack the very features James was referring to. Already at the pre-reflective level, the self-presence, the for-me-ness, is impaired and disturbed. This is also why the reflective self-ascription of the psychotic experiences can be so challenging.

Referring back to Albahari's distinction between 'personal ownership' and 'perspectival ownership', our proposal is that the psychopathological phenomena that we have been discussing are not merely restricted to and located on the level of personal ownership. They also affect the level of perspectival ownership. In short, we maintain that for-me-ness (minimal selfhood) is neither lacking nor unaffected but disturbed in schizophrenia spectrum disorders.

5. Conclusion

In this article, we have (i) presented our position on experiential minimalism, considering for-me-ness (or minimal selfhood) as a necessary, universal feature of phenomenal consciousness; (ii) discussed and refuted alleged counter examples that construe thought insertions as cases of experiences lacking for-me-mess; (iii) offered critical reflections on the philosophical use of thought insertion; and (iv) clarified how we believe for-me-ness may be disturbed in schizophrenia and involved in the development of thought insertion.

Let us conclude by reiterating one of our main messages. If one wants to understand and offer an account of thought insertion, it is crucial to first obtain a solid, clinical grasp of the phenomenon. This requires taking into consideration the altered experiential framework in which the experience of thought insertion articulates itself. More specifically, one has to consider the psychopathological Gestalt of schizophrenia, its pathogenetic unfolding, and, not least, the psychological dynamics at work (which we have not even touched upon here). Unfortunately, these aspects of thought insertion have frequently been ignored in current philosophy of psychiatry, where the experience is often carved out, decontextualized, and studied in complete isolation from the altered experiential framework in which it occurs. The prevailing binary approach to thought insertion, i.e., to reiterate, the idea that some features of consciousness are simply lacking while others are perfectly preserved, is a foreseeable product of an approach that does not rely on any clinical knowledge of thought insertion but only on a few recycled examples.

Declaration of Competing Interest

The authors declare no conflicts of interest.

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