Self and Other in Schizophrenia:
A Structural Analysis of Delusion

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Abstract: This article draws from phenomenological authors such as Sartre to investigate pathogenetic issues in psychopathology from a first-person perspective. Psychosis is a "total experience" that points to orientating changes in subjectivity, supported by evidence regarding self-disorders in the schizophrenia spectrum. This article proposes that schizophrenia is essentially characterized (and therefore distinguished) by specific structural alterations of (inter)subjectivity around the relationship between self and Other, which all its seemingly disparate signs and symptoms eventually point to. Two reciprocal distortions are present in psychotic schizophrenia patients: (A) an encroaching and substantialized Other, and (B) a self transformed into being-for-the-Other. Under the altered conditions of (A & B), delusional mood is the presence but inaccessibility of the Other; a delusional perception is an eruption or surfacing of objectification of self by Other; a delusion is an experience of the Other, which fulfills certainty, incorrigibility, and potentially falsehood. Theoretical arguments show how (A & B) leads to delusions as meeting Jaspers' criteria, and clinical examples throughout show the phenomenological accuracy of the theory.

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(1) Introduction

Both current and historical research in the phenomenological psychopathology tradition point to the origin of the schizophrenia spectrum, including non-psychotic variants, in anomalies in the patients' first-person perspective or core experiential configuration (self-disorders) (Nordgaard et al. 2021). A body of empirical studies also establishes this claim (Henriksen et al. 2021). However, self-disorders as currently formulated are mostly non-psychotic, and despite suggestions (Sass & Parnas 2003), it is still unclear how they can lead to the spectrum's psychotic epitome. The task I take up in this article is to find some alteration in the structures of consciousness, analogous to self-disorders, that not only is associated with but necessarily and sufficiently precipitate the transition to schizophrenia psychosis.

Psychosis is a "total experience": patients describe an ontological transformation ("I found myself in an entirely different world"; "It was as if I suddenly gained a new form of consciousness") resistant to linguistic expression, coupled with intense emotions and hypo- and hyper-reality (Feyaerts et al. 2021, Ritunnano et al. 2022, van Duppen 2015). Such profound reorganizing changes in the fabric of experience, which seem to be global not only in effect but also in origin, suggest a corresponding change in subjectivity, the zero-point of orientation. Based on this characterization, the approach in this article is in contrast with current modular accounts of psychosis, often in terms of unusual experiences or faulty inferences (Maher 1974, Coltheart et al. 2011, Fletcher & Frith 2009).

Further, I argue that the change in subjectivity is not a total dissolution (cf. the debate in nineteenth-century psychiatry about madness, totality, and partiality, Parnas et al. 2021) but is *expressible* in ordered ways. Describing this change will facilitate the dialogue between philosophy and psychiatry for mutual enrichment, as phenomenology can provide the conceptual tools for understanding madness while madness can in turn serve as a limit-testing case for theories of consciousness (Stephensen & Parnas 2018), in addition to potentially guiding biological research into the disease's pathogenesis and treatment.

This article proposes that schizophrenia psychosis is *essentially* characterized by alterations of (inter)subjectivity around the relationship between self and Other.

Specifically, two reciprocal distortions are present in psychotic schizophrenia patients: (A) an emergent, substantialized Other, and (B) a self transformed into being-for-the-Other. (For simplicity, other peculiarities in self–Other dynamics, especially a paradoxical independence of the self from foreign influences, captured, e.g., by Minkowski's 1987 "loss of vital contact with reality," are not discussed but do not subtract from the thesis.) These structural alterations, in their specific forms described later, are unique to this pathology and are shared by seemingly disparate signs and symptoms. This kind of core to schizophrenia should therefore become more widely known. The primary focus of this article is how the twin distortions, posited as a generating factor (Minkowski 1970), lead to delusions, a cardinal symptom.

As an instance of (A & B: distortion of self and Other), a delusion in schizophrenia is always an *experience* of an increasingly definite and dominating Other. That psychotic symptoms reflect an emerging otherness in the patient's subjectivity was already well-voiced by Ey (1973) in his volumes on hallucination more than 50 years ago, which the present contribution seeks to consolidate with more structural detail. To make this claim concrete by two generalizable examples (the correspondence will be apparent later), in the case where the patient believes that his son has jug ears when it is medically false, it is because it seems so (e.g., by sight) to the patient's Other (perhaps conjured up when considering the perspective of one who has *true* expertise); in the case where the patient wrongly believes that a gang is pursuing her maliciously, the gang is her Other whom she experiences too much so as to make her wrong. Under these altered conditions, such experiences acquire certainty, incorrigibility, and often falsehood. Playing critical roles in my deduction to these clinical features is the experience's being both *hers* and *not hers*, its transcendentality, and its arising from a substantialized presence.

Since the remaining article deals with Other-perception, I preface it now with how he is to be understood. The Other is a perspective distinct from and relative to the self. Two interlocking senses, meant to be atheoretical, can be set apart. Noteworthily, I do not assert that this is the most correct way to understand this notion, and the thesis to be developed does not necessarily depend on it over another understanding, but it is useful to outline at least *a way* for the benefit of the reader. (The intra-Other:) He can be considered as seen and constructed by the patient, as a moment "inside" the patient's

consciousness that indicates and refers to an alien subjectivity ("Frank as Nancy perceives him"). (The inter-Other:) Alternatively, if he is real (his personal identity, not the thoughts, acts, or other modifications attributed to him by the patient; otherwise, all Others featured in delusions are fictional), he can be considered as an independent consciousness, by itself and "outside" the patient, to whom the intra-Other refers ("Frank actually"). (This is *not* the distinction between the truthful Other and the delusional or "imaginary" Other: the inter-Other, being the original, cannot be false, but the intra-Other can be faithful *or* unfaithful.)

Although sometimes useful, this distinction can be misleading. It is wrong to think of the intra-Other as an intra-mental plenitude. Experientially to the patient, the intra-Other reaches out and *is* the inter-Other. Although the thoughts we form of the inter-Other constitute the intra-Other, we nevertheless *think of* the inter-Other. Importantly, *the patient's altered structure (that I propose) is an altered intra-Other* (it is not the disease of another subjectivity), but this quasi-subject is always in his capacity to refer to the subject, and the patient considers the *inter*-Other to be the one bothering her. It is the same when, anxious, we think other people are judging us: it is properly the intra-Other who is at first judgmental, by virtue of which we are convinced of our hypothesis, but we think it is the inter-Other who is judging us. (In this case, the inter-Other is a *projection* displaced from the intra-Other. The qualification of projection allows a non-real Other to be an inter-Other.) Consequently, when I say that an Other encroaches on the patient, for example, I usually do not mark out which Other he is, because he is them both but in different senses; I only label and explain when the distinction is truly helpful or there is a true risk of equivocation.

After this (1) Introduction, this article is organized as follows. (2) I briefly motivate my conception of delusion from current views. (3) I present the Other and objectification as normally experienced, drawing from authors in the phenomenological movement. (4) I state the self–Other model of schizophrenia in more detail. (5) I examine, in preparation, delusional mood and delusional perception. (6) I examine how delusions, with their distinctive, absolute characteristics, are possible given the proposed mechanism. The reflections leading to this theory derived from literature review and my own psychosis while being a philosophy student and received further confirmation in discussions with

clinicians. For clarity and consistency, throughout the article, I use "she" pronouns to refer to the patient and "he" pronouns to the Other, except in cases where I appropriate examples from elsewhere, in which case the gender of the patient is preserved.

(2) Motivation

We start with the question: what *is* a delusion? Unfortunately, defining delusions has been almost intractable. Definitions based on the false belief paradigm have been criticized intensely (Spitzer 1990, Coltheart et al. 2011). One such formulation found in the ICD-11 can be reconstructed as follows: delusions are (a) untrue (b) beliefs (c) not shared by others, usually (d) based on incorrect inference (e) about external reality, (f) held with conviction, (g) not modifiable by contradicting evidence, and (h) not accepted by other group members (World Health Organization 2022). These criteria can perhaps assist one in picturing the phenomenon, but strictly speaking, they do not capture clinical judgment. All of them have been challenged. One criticism is that contrary to (a), delusions can be true: a delusion of jealousy still counts when the spouse turns out to be unfaithful (Jaspers 1963, p. 106); during my first psychotic episode, in addition to thinking I was sick, I was convinced that I was not treated properly, which was true for almost as long as I believed it. For doctors, the demarcation perhaps lies not in a checklist but in the *form* of the experience, in how the patient is concerned about or argues for her belief. Regardless, faced with these difficulties when dealing with external indicators like (a–h), we might wonder whether we engaged ourselves with a much more difficult task; perhaps it is easier to proceed from *how* delusions are experienced inside the patient (accessible enough by, e.g., testimony or behavior), not least because delusions first appear as experiences.

Before we follow this suggestion, we note that these criteria can be traced back to Jaspers (1963, pp. 95–6): according to him, delusions (I) are held with extraordinary conviction (certainty), (II) are impervious to counterargument or other experiences (incorrigibility), and (III) have impossible contents. Since many delusions are in fact possible, (III) has evolved in the literature to falsehood. For Jaspers, however, he recognized that these external indicators are superficial and even incorrect as a *definition* (p. 93). (If we keep in mind their limitations, we can use these criteria to check if the phenomenon we arrive at manifests in the ways delusions do, and this I will do in the

Section 6.) Spitzer (1990) finds that later criteria tend to put much emphasis on (III), which is also the problematic one, with specifications made to accommodate its shortfalls. From (I) and (II), he makes a move that goes beyond considering delusions by their contents to *how* they are stated.

First, Spitzer observes that (I) and (II) alone cannot define delusions. In fact, we make statements like these all the time, albeit about our mental states. I say with certainty and incorrigibility that I have a pain in my leg, that I am feeling good today, or that I am thinking about having trout for dinner. No one else can question me about these statements. (The controversy around privileged access rests on a confusion about what exactly the subject cannot be wrong about. She, of course, can, e.g., have wrong memories or make wrong inferences about her hidden motivations. However, there is nonetheless something nuclear that, if it is truly to be her first-person experience, must be exactly as it manifests, is given, or is accessible to her; otherwise, it is not her experience.) Delusions, however, Spitzer then observes, are stated with the same conviction about things, persons, and states of affairs that lie *outside* the privileged access one has to one's own mind. The patient may have the sudden notion that "I could be King Ludwig's son" or that "I am the victim of a gang of murderers," facts that connect him to the external world (Jaspers 1963, Bleuler 1950). This epistemological extension is inadmissible. In this way, Spitzer arrives at a definition of delusions as statements uttered about the external world that are uttered like statements about one's own mental states. How might someone subsume states of affairs other than her mental state into her privileged experiential domain?

I suggest that she does this through the Other, a transcendence intimately experienced. I will explore this in detail in Section 6. I will first describe the Other and objectification in normal consciousness.

(3) The Other and Objectification

In this section, I will examine the following in turn: whether and how I experience the Other; what is my primal relation with the Other; and what is fear, shame, and pride, emotions that constitute the core of many delusions.

The foundation from which the pathology of schizophrenia emerges, I claim, is that we experience the (inter-)Other such that the (intra-)Other is within us. An

examination of Scheler's work leads to the existence of this immanent transcendence and preludes its deformation in schizophrenia. The claim of an Other within self seems counterintuitive: it is a tautology that my experiences are mine and that your experiences are yours. However, to Scheler, the matter resists this simple analysis (1954, p. 244). In one sense, this saying is self-evident: if we posit two substrata, maybe two soul-substances or brains, then they cannot enter each other. But in the phenomenological sense, Scheler argues, it is far from self-evident. Not only my own experiences but the (inter-)Other's experiences are *intersubjectively* given to me in perception (*not* originally, in the way inter-his experiences are given to inter-himself, but through the intra-Other, who takes much from me; however, this still counts as being given), and just as and not after how his physical appearances are given to me (p. 244). This is a phenomenological *fact* that we should understand just by appealing to our everyday acquaintance with others:

> we certainly believe ourselves to be directly acquainted with another person's joy in his laughter, with his sorrow and pain in his tears, with his shame in his blushing, with his entreaty in his outstretched hands, with his love in his look of affection, with his rage in the gnashing of his teeth, with his threats in the clenching of his fist, and with the tenor of his thoughts in the sound of his words. If anyone tells me that this is not "perception," for it cannot be so, in view of the fact that a perception is simply a "complex of physical sensations," and that there is certainly no sensation of another person's mind nor any stimulus from such a source, I would beg him to turn aside from such questionable theories and address himself to the phenomenological facts (p. 260).

We encounter the Other first in his expressive unity, containing both mental and physical aspects (p. 261), e.g., a laughter manifests not just a facial movement but also a felt emotion. We do not encounter him only in his expressionless body, unless we are engaging in a medical examination. In fact, we can tell the love or hate in a person's eyes long before we notice the color of his irises (p. 244). We can distinguish between inner perception, which deals with mental phenomena, to outer perception, which deals with physical phenomena. However, they cannot be defined by a supposed distinction between whether their objects are myself or others: I can touch and see myself (or better,

sense myself by interoception and proprioception) just as I can touch and see others, and in the same way, I can perceive others as well as myself inwardly (p. 249). (This does not conflict with the Other's purported radical alterity: this perception is not original, so he originally transcends my grasp, no matter how much I perceive him unoriginally.)

What is this inner perception of the (inter-)Other? It is not his experience of himself , though it refers to it, for he is an Other to me (Husserl 1960, p. 109), nor are they of the same magnitude—I can understand the terror of someone drowning without undergoing the terror myself—but they have a connection: the Other's original experience and my perception of it are *similar*, Scheler says, for then this perception provides a bridge to the distinct experiences of how I can imitate or be infected by the Other (in joy, sadness, reflection, etc.) or be reminded of a similar personal experience (Scheler 1954, p. 11). No other relation seems plausible. To see some candidates, suppose someone is in pain: I do not perceive his pain first through *pity* since it requires his pain to be given to me in some form already if I am to notice it, nor does any other derivative emotion work; I do not perceive his pain through a *proposition*, "he is in pain," since I more properly am told of it than perceive it (pp. 8–9). This perception of the Other, being *like* the Other's original experience, *must also be an experience*, just in another mode. Observing people on the streets, I am immediately inundated by the myriad perspectives and intuit within my consciousness at least the shell of what it is like to be them: noticing someone rushing to catch a bus, I too am briefly stimulated by a sense of urgency; facing someone's mockery, I replay his insensitivity; seeing a wounded soldier, I am vaguely but viscerally aware of *his* distress and disintegrating flesh. (These are purely in my capacity as a dative of experience. Although the language may be prone to hint otherwise, this is not "emotional contagion" or even "affective sharing" but strictly *perceptual experience*—*I* am not in a hurry or in pain—because in another, "proper" sense of *I*, these experiences are *not* mine, see below.) I will argue that this experience of the Other (or its structure) is altered in schizophrenia (see Section 4.A: distortion of the Other, and Section 6.III: falsehood).

So (some of) the (inter-)Other's experiences are "copied," however imperfectly, within my experience. There are, consequently, also two senses of *I*. Within my experience, what *properly* belongs to me (*my* theses, opinions, preferences, etc.; e.g., "I

like trout") and not to my intra-Other (e.g., "(I am aware that) he likes snappers"), then, is a *proper* part of what manifests or is given to me, the latter including the intra-Other. If I meaning the experiential self (the self to whom experiences are given, i.e., my consciousness, defended in Zahavi 2011) is the dative of the experience (*to* whom it manifests), then I meaning the proper self (the self not including the intra-Other) can be termed its genitive (*of* whom it belongs or is attributed). This distinction builds layering into selfhood, which Scheler (1954) expresses on p. 246. Experiences of the Other, then, are both *mine* and *not mine* because they are not contained within the proper self but are within the experiential self. This displacement grants them both properties of my experiential self (i.e., experiential truth) and properties of proper selves other than my own (i.e., alterity, intersubjective validity), only the combination of which allows for schizophrenia delusions (see Section 6.I: certainty).

Having arrived, through Scheler, at the phenomenological penetration of Other into self—a prerequisite to the theory to be developed but probably more complex than can be explored here further—I move on now to my primal relation with the Other.

To Sartre (2018), the Other is he *who looks at me* (pp. 353, 375) as he-subject to me-object. (Both senses of the Other are relevant here.) It is in *this* irreducible relation of being that I establish his existence. When I glance at him, he is to me a mere probable object (p. 347). When he glances elsewhere as a human, there are special relations going forth from him to the objects he is concerned about, but he remains a probability to me (p. 349). It is merely probable that he is a human or that he does see what he sees: he can be a robot, or he can be blind. Granted, he causes a regrouping of space superimposed on my space as I am unable to grasp these objects as they appear to him originally, but this "flowing-away" of space to the unknown is confined—it does not go outside of this world—since he is ultimately fixed in place by my relations as I glance at him (p. 351). The dynamic finally inverts when he directs his attention to *me*. My *objectification* reveals the Other's subjecthood: just as an he-object is probable to a certain me-subject, a me-object is probable only to a certain he-subject (p. 352).

Sartre dramatizes this encounter in an example in which I am secretly peeping through a keyhole at a spectacle or to eavesdrop on a conversation (p. 355). The door and the keyhole, to be handled with care, are implements and obstacles to be used by me to

achieve my ends. They offer their *potentialities* (e.g., to be peeped through) to me when I am pre-reflectively aware of my *possibilities* (e.g., to peep). When I am engrossed in this situation, no me-object is present to me in my pre-reflective consciousness (p. 357). But then I hear footsteps in the corridor: someone is *looking* at me. My being is transformed into *being-for-the-Other*.

Immediately, I am *ashamed* of myself. I realize the baseness of my action through this being that is disclosed by the Other (to which we can put mundane adjectives like "base" that strictly identify me despite my transcendence), residing somewhere else—not in me but inside the Other. But, at the same time, I recognize myself in this being, and I *am* her—I admit this in my shame—albeit through an intermediary that is the Other (pp. 308, 392). There I am, half-crouched in that position that should never be seen, my face showing curiosity and vulgar satisfaction. One term in this relation of *being* is my consciousness, and the other term is me as I appear to the Other (p. 366), now present in my pre-reflective awareness. Now this flowing-away is unconfined, and "I flow away out of myself" (p. 358).

Something else happens in this moment: I am *in danger*. I can quickly move to the dark corner, which transmits to me its potentiality, to hide, but the Other can light up the corner with his torch, exposing my hiding-place to plain sight. I am still my possibilities, but they are in turn transcended by the Other's possibilities: at my slightest move, he can show his weapon from his pocket, or he can ring the bell to alert the guardhouse (pp. 360–2). *Fear*, for Sartre, is the feeling of being in danger before the Other's freedom (p. 366).

Shame is the feeling of the self being elsewhere in the Other, but I can take on a new attitude to this dislocation. I can be *responsible* for my objecthood, and this is *pride* (p. 394). Here I try to use my objecthood, which is obtained through the Other, to affect the Other. However, it is still founded on shame, Sartre says, for I must be resigned to being an object first.

Finally, it should be mentioned that counter-objectifying the Other is a possible response for me to my objectification (p. 395). Then I cease to be an object because I cannot be an object for an object (p. 357). I would grasp the entirety of his possibilities and would define him exhaustively as an object once I grasp the totality of the world's implements (pp. 396–7). The flowing-away is confined again as I fix him in place.

Already superficially, analyses of emotions most basic to delusions point to my reactions, according to Sartre, to my objectification.

- I will examine shame in Section 5, where the relation of objectification will become evident.
- Fear corresponds to persecutory delusions. A persecuted patient moves from city to city, unable to settle, because after a while she would feel that her possibilities (moving to a new city) are inevitably transcended by the Other's possibilities (following the patient to the city). If the Other is not always present in her, she would not feel constant danger.
- Pride corresponds to grandiose delusions. When the Other is present as he who looks at me, I become prideful when he happens to apprehend me positively. I cannot be prideful or grandiose when there is truly no one else to witness me (p. 369), though a hypothetical Other suffices.
- Counter-objectification, which does not always happen, in so far as it is my possibilities transcending his possibilities and my fixing him into a degraded, objectified form, manifests externally as aggression.

Due to these correspondences, schizophrenia is plausibly an exaggeration of experiencing the Other.

(4) Self-Other Model

I open with a vignette of Kraepelin's catatonic patient:

> The patient sits with his eyes shut, and pays no attention to his surroundings. He does not look up even when he is spoken to, but he answers, beginning in a low voice, and gradually screaming louder and louder. When asked where he is, he says, "You want to know that too; I tell you who is being measured and is measured and shall be measured." . . . When asked his name, he screams [impersonating Kraepelin], "What is your name? . . . When I tell him to look, he does not look properly. . . . Are you [the patient] getting impudent again? How can you be so impudent? I'm coming! I'll show you! . . . You mustn't be smart either; you're an impudent, lousy fellow. [repetitions omitted]" . . . At the end he scolds in quite inarticulate sounds (Kraepelin 1906).

The patient has an exaggerated awareness of Kraepelin. He complains of Kraepelin's examination ("measur[ing]") and feels strongly, probably inappropriately, that Kraepelin is assessing him negatively ("impudent" and "lousy"). This is what is on his mind: he expresses it spontaneously when prompted with unrelated questions. To him, Kraepelin is the Other dominating his self, the latter now degraded into object form, describable by mundane adjectives. If we *return to the things themselves*, as Husserl says, this alteration in the structure of experience is the conclusion we would reach.

The self–Other model states that in psychotic schizophrenia patients, there are (A) an emergent, substantialized Other, and (B) a self transformed into being-for-the-Other, and that the disease is essentially characterized by these two alterations.

(A) An Other, in the mode of a transcendental subject, encroaches on and stays in the patient's subjectivity. (Here, strictly the intra-Other, which is a structure within the patient's consciousness, is in her, but derivatively concerning the inter-Other, which is the referred-to, independent consciousness. "Transcendental" in the context of Husserl's work describes a power that constitutes—i.e., precedes and makes be or appear—the spatio-temporal world we are usually concerned with. Both the intra- and inter-Other can be transcendental, intra- by being a moment of transcendental self and inter- by being a transcendental transcendence. Opposing "transcendental" is "empirical," meaning part of the constituted world.) She ends up with two quasi-consciousnesses inside her skull: patients complain, e.g., "When I'm with others, there are two *I's*: the *I* who is among them, and the *I* who objectively looks at this *I*"; "What *I* say to myself becomes what *someone* says to me" (Ey 1973, Stephensen & Parnas 2018). Note the transformation and alterization of an "I" in these attestations.

I have characterized the patient's Other as a perspective distinct from and relative to herself that can (in the case of the intra-Other) refer to or (in the case of the inter-Other) be other concrete subjectivities. What the patients experience, then, *is the Other*: he is a subject (another "I"), he and the self refuse and separate from each other (e.g., through a conversation *between* them, "says to"), he "looks at" (i.e., apprehends, evaluates, objectifies) the self, and he can refer to or be other people ("someone"). Note that the Other *can* but does not necessarily refer to or is not necessarily other real people: e.g., the voice in hallucinations, who is an Other in so far as it is separable from the patient's "own

thoughts" (not to mention that it often has characteristics that point to different social groups than the one of the patient, Larøi et al. 2012), is frequently personified but often has no identifiable origin.

Further, here, self and Other are *not interchangeable*: the patient says that the second "I" looks at the first "I," but the first "I" does not look at the second "I" who looks at the first "I." Thus, the Other who is pathologically present in schizophrenia, unlike the self, objectifies and resists being objectified. Hence, the hallucinated "voices" often lack the phenomenological qualities of real voices (e.g., being acoustic or auditory or being given perspectivally with temporal extension, Parnas et al. 2024), the latter being true objects of perception, but appear more like thoughts. The Other here is essentially *transcendental*, prior to the world of objects and a condition of possibility for their appearance (Husserl 1960, p. 21). (This is the purer, p. 3, mode of the Other, so it is allowed that when I say that the Other is substantialized, I mean that it is in this mode, not in the empirical mode, that he is so.) Counter-objectifying the Other does not work well: he comes back with full power, drawing from an endless source as a transcendental subject, always seeing opportunities for counter-counter-objectification. Hence, the patient gets into an altercation with her voices, but she can hardly win—the voices speak back from the very recess of her subjectivity. In short, the patient's look is a looked-at-look (Sartre 2018, p. 364).

What distinguishes the Other in the schizophrenia patient from that in the healthy individual is that in the former, he becomes a substantialized presence in the mind, continually experienced, not mendable by changes in circumstance, whereas in the latter, he comes and goes as appropriate (or, for, e.g., social anxiety patients, he remains socially and contextually dependent). The most important point in this article is that the pathological Other can be likened to an outgrowing transcendental quasi-*substance*: he consolidates into a bare, haunting "something" that now (etymologically) "stands under" his transitory properties, spurring them into sustained appearance. Hence, the patient might say that the voices are "still there" even when she does not hear them (Parnas et al. 2024). The Other dwells there: Schreber, in his memoir of his illness, tells that "for years" and "daily and hourly," he feels the damaging influence of Dr. Flechsig, whose name his voices shout again and again, despite that their personal relations have faded (Schreber

2000, p. 8). Even physically, the Other intrudes and resides in the patient: a cat's semen is in her blood; a police officer is under her skin; someone is eating her brain (Cutting 2007). His alien presence in her mind is given material form, violating her bodily integrity.

(B) The patient experiences herself persistently as an object. To be an object means to be a part of a subject–object dyad, that is, to be the object of the perceiving, thinking, speaking, etc. of an Other. She cannot be an object for herself (Sartre 2018, p. 369): pre-reflective consciousness is immersion in the world, and reflection is either self-coincidence (in reflecting on my acts, I experience myself as the subject of those acts) so that they do not produce objecthood, or self-objectification (e.g., I can categorize the pain in my eye as a case of glaucoma) such that I distance from myself and take on the perspective of an Other (Zahavi 2000). (If I experience myself as an object when I see myself in the mirror or look at my own hands, I am experiencing myself as public, that is, already given to a possible Other.) (There is one exception: I can also be an object of the causal order of nature, e.g., fearing my death by unpreventable illness, but it is a single anomaly.) Translating this into Sartre's terminology, her being is transformed into being-for-the-Other, rigidly, as opposed to being-for-itself, the being of consciousness when it is alone, unlike the normal alternation between the two modes. Moreover, the patient does not become less conscious (that is, turn into being-in-itself), but acquires some characteristics of material things.

Hence, in psychosis, the patient becomes the center around which her world revolves. Everything is linked to her. She is, quite literally, "looked at" (Ritunnano et al. 2022). The voices give a running commentary of whatever she does; TV programs discuss her life story. She becomes like a thing: her uterus feels detached (Parnas et al. 2005); her thoughts are outside her head like a piece of wood; her limbs are replaced by bionic ones; her head becomes a clock, and time stands still (Cutting 2007).

The descriptions of the two distortions do not point to distinct structures but emphasize two aspects of the same structure, which I denote (A & B). The two are reciprocal: one necessarily leads to the other.

(A: distortion of the Other) leads to (B: distortion of the self). The Other as a transcendental subject (A) exists as objectifying the self (B). This act is what first establishes his existence as a subject, as we saw in Section 3: The Other and

Objectification. If he stops looking at the self, he will dissolve into probability because there would be no need to posit him as transcendental—special relations would suffice. Hence, the voices that divide subjectivity in schizophrenia are always self-referential and, further, frequently negative and shaming to the self (Yttri et al. 2022).

(B: distortion of the self) leads to (A: distortion of the Other). The self can only be an object (B) for a pure subject (A) (Sartre 2018, p. 369). Her being-for-the-Other necessitates an Other *for* whom her being is. (This is the only mode in which she can be an object, see B: distortion of the self.) Moreover, when I grasp myself as an object, the Other who is presupposed is transcendental—if he becomes a being within the world, I cease to be an object because I cannot be an object for an object (e.g., a table or a psychophysical human).

Therefore, we can consider (A: distortion of the Other) and (B: distortion of the self) as a whole disturbance. This result not only gives us alternate ways to formulate our observations, by focusing on the two different vantage points, but also reminds us that they closely accompany each other.

(5) Delusional Mood and Perception

In preparation to examining the model's applicability to delusions, I examine delusional mood and delusional perception. They are both instances of (A & B: distortion of self and Other).

Delusional Perception

A *delusional perception* is often described as a sudden, idiosyncratic meaning triggered by a supposedly neutral perceptual stimulus (Nielsen et al. 2022). For example, the patient might insist that someone is looking at her oddly or that the dog scratches oddly at the door (Jaspers 1963, p. 100). It is a *primary delusion*, a type of delusion only found in schizophrenia, (according to Jaspers) along with delusional idea, delusional memory, etc. because the delusional content is there all at once and cannot be traced back to prior mental states. I choose this variant because of the explicit nature of the vehicle (i.e., the perceptual stimulus) on which the delusion rests, which aids analysis. Under this model, it is always *an eruption or surfacing of a relation between self and Other where the self is objectified by the Other*, that is, an instance of (A & B: distortion of self and Other).

I will say two things about how meaning as presented in delusional perception points to its experiential structure. First, Conrad (1958) notes that in this phenomenon, the expressive component of the stimulus dominates its factual component, conferring idiosyncratic meaning. Here the meaning, which plausibly can only belong to the medium of consciousness, comes from the Other in his act of looking, rich in expressive power as a strongly experienced being. This explains why the meaning is always intrusive, forced upon the patient (Jaspers 1963, p. 99): it does not properly belong to her but to her Other. Secondly, this meaning always touches the patient in her being. The clearest example is provided by Blankenburg (1965), where a single delusional perceptual event cuts a patient's life into two and totally defines the latter part: a picture the patient sees suddenly shows him *who* he is henceforth, and he can never get enough of its mysterious hue; he is from now on "bound" to the picture. The objectification of the patient touches her in this endless way.

There are two general types of delusional perception, depending on which term in the relation of objectification is the stimulus: (i) where the thing perceived *is* the self, and (ii) where the thing perceived is the Other. The delusional perception can only be revealed by the appearance of either of these two terms, the solid grounds between which the relation holds. I illustrate this claim with clinical examples.

(i) Recall that shame is a recognition of a relation of being between *my consciousness* and *me as I appear to the Other*: I *am* what the Other objectifies me as. It is this relation of being, within the relation of objectification between self and Other, that is revealed in this type of delusional perception, where the patient-object for the Other is perceived and equated to the patient's consciousness. (Being and identity are different; by "equation" I mean one becoming, not being identical with, the other.) Of course, the patient can only perceive her object-form, not her consciousness, in the ordinary sense of "perception," so the object-form acts as the perceptual vehicle in this case.

Consider a patient's report that on seeing cars on the street, she feels "hard, sharp, and cold" like a car; something metallic leaps from the coachwork and merges with her (Fuchs 2005). There is *no inference* to be found in his experience, like this one: the Other can see the car as metallic, so, similarly, he can see the patient as metallic; whether this inference applies when examining the scenario from the outside, it does not exist as a

reasoning process inside the patient. On the contrary, the patient immediately accepts that she *is* the car; the qualities of the car, its hardness and coldness, are transferred directly onto her. The self immediately feels its equation to something else (by the Other who sees the car as her object-form).

Or consider how patients confuse their identities when a long time ago in the hospital, if their clothing gets dirty or torn, they are put on another's instead (Freeman et al. 1958, p. 53). A patient says, "So I *am* Margaret Provost after all" (italics mine), and the therapist, realizing that the coat is not the patient's usual one, does find the name on the label. The patient feels that it is entirely plausible for the Other to *see* her *as* Margaret Provost, the full name picking out the other patient objectively. Everywhere, we see *presentations of self-object* pre-reflectively, which points to objectification. Otherwise, consciousness escapes strict equation—there is no such object to be found in being-for-itself.

Consider one of my own experiences of shame: once, I found a poster in an office building of an old advert posed by a well-known actor. I saw a smugness in his face; he knows that he is handsome and enjoys showing it. What was more, however, was that I immediately, without any reason, felt that *I was* smug like *him*. It was as if I occupied his body (equating us) when he gazed at me in that repugnant manner. However, *while* I was experiencing this assessment, I thought it was a gross injustice and a distortion of the truth. I felt totally wronged. *I* insisted that I *was not* smug and that we were essentially unlike each other. Even better, *I* did not care whether *he* was in fact smug but, I realized, merely thought that it was possible for someone to see him that way. How could such contradictory attitudes exist? There was an amorphous mass oppressing me, and while trying to avoid further inflictions, I was inhibited to move or see but could hide in no place. My body was frozen in its position, and my mind was fixed in darkness on the apprehension. I smiled awkwardly and subserviently to appease the one who apprehended me thus. The solution is that the delusional perception was *imposed* on me by the Other: the Other saw me as smug; it was Other-, not I-, experience.

(ii) The other type of delusional perception reveals the Other as he who looks at the self. The "eyes" of the look do not need to be the globular organ; it does not need to be any one thing as long as it points to a subjectivity (Sartre 2018, p. 353–4). It can be a

hand, a smell, a gait, or even a bell: a patient misinterprets the gesture of an administrator as an order for him to climb up the wall; an odd smell makes the room toxic (Nielsen et al. 2022); a limping man seems like a devil (Fuchs 2005); the ringing of a bell signifies the fetching-away of dead bodies (Jaspers 1963, p. 102). They refer to acts of transcendental beings. Further, once elaborated, the acts *always* concern the self: the order is *for* the patient, the toxin would *kill* her, the man limps *toward* her, and she simultaneously awaits the fetching *of* herself (ibid.).

The self can be understood loosely here to include family, acquaintances, belongings, or the entire world as a home (hence the apocalyptic and eschatological—or "final *judgment*"—delusions). For this reason, persecutory delusions are often extended to relatives, objectified along with the self: e.g., they are incarcerated, tortured, or pending to have their legs torn off (Bleuler 1950, p. 119). This enlargement of the self is justified: e.g., the child who meets disdain for his parent can become ashamed of himself, an emotion that can only arise if the objectification of his parent is an objectification of him.

However, we cannot apply this enlargement with brute force. Delusional misidentification, where the patient perceives other people as dead or like robots, for example, is a variety of (ii: stimulus is the Other), not (i: stimulus is the self) plus self-enlargement: other people are not objectified (although perhaps this is suggested by descriptions like "dead") as parts of self because they do not become being-for-the-Other; rather, there is a discrepancy between expected and received meaning: note the comparison when a patient says that things at home changed to be "smaller" and therefore unfamiliar because they are "not so homely *as before*" (Jaspers 1963, p. 102, italics mine).

(i & ii) Consider a final example where *both* self and Other are perceived: A Dane on a vacation to Greece drives through Romania and Bulgaria (before they joined the European Union). As a border-control officer (Other-eye) handles her passport (self-object), she thinks that a world war will break out. It is presumably among her country and other countries, and a war is, not coincidentally, a contest of objectification between rivals. Her side (self), of course, is not identical to her passport (being is not identity), but the latter nonetheless becomes an object-form of the former, degraded by the other side

(Other). The passport-handling is a mild, routine, and expected instance of objectification, which is magnified by the patient's altered experiential framework into an event ripe with significance.

Here, I cannot enumerate all possible examples and do not argue *a priori*, but it is evident that when cases of delusional perception are properly examined, their phenomenological features invariably point to the structure proposed.

Delusional Mood

Delusional mood is often described as a state sometimes occurring before delusions where the patient feels in an all-encompassing manner that something that is yet to be defined is impending on her (Henriksen & Parnas 2018). The patient notes that "something is going on" but does not know what exactly. Under this model, it is always *the presence but inaccessibility of the Other*, i.e., that he is unquestionably there but veiled as other subjectivities characteristically are. (Is not the inter-Other is *always* inaccessible? No, because when the intra-Other has content, inter-he is accessible. Can such a diffuse mood be pinpointed to the Other without destroying its vague, atmospheric quality? Yes, because this inaccessible Other is, first, a *bare* subject and, second, *not of this world*.) Or, formulated differently but equivalently, it is *the objecthood of the self when it is not known what that object is*. Conrad designates it as a "peculiar borderland" between normalcy and psychosis, so we can consider it as an *incomplete* instance of (A & B: distortion of self and Other), where the relation holds in form but contains indeterminate matter.

It is a question, and the finding-out of its answer just is the crystallization of the primary delusion. As such, arguments for the relevance of (A & B: distortion of self and Other) for delusional perception apply *mutatis mutandis* for delusional mood. Everything acquires new meaning, which has the same experiential form (i.e., expressivity and relevance) as that in delusional perception. The world is transformed into a strangely unfamiliar one, which suggests a perspective encompassing it that is different from the patient's own.

Emotions that point to objectification, like shame, anxiety, and depression, are already significant in delusional mood, but they are experienced precisely as having contents that are, as of now, out of reach. The patient experiences herself as being elsewhere but does not know that being; she experiences her possibilities as transcended

but does not know in what way; she experiences the evaluation of herself as worthless and her situation as hopeless but does not know why. According to Müller-Suur, delusional mood involves a certain uncertainty: that sense of uncertainty of certain. The Other is certainly (not probably) present, creating these moods in the patient, but his plans, judgments, evaluations, etc. elude the patient. They are somewhere else, not known to her, but she strives to find out. This is a *respect* for the fact that the Other is originally inaccessible to the patient. This respect is soon to be broken. To quote Sartre, who is describing the works of Kafka:

> This painful and elusive atmosphere, this ignorance that is nonetheless lived out as ignorance, this complete opacity that can be sensed only through a complete translucency is nothing but the description of our being-in-the-midst-of-the-world-for-the-Other (Sartre 2018, p. 363).

(6) Delusion

I now generalize the findings in previous sections to all delusions in schizophrenia. Under this model, a delusion is always *an experience of an increasingly definite and dominating Other*. This nature of delusion is rarely discussed but would reveal itself upon a proper examination of any of its instances. This section examines how the phenomenon we arrive at can fulfill Jaspers' criteria: (I) certainty, (II) incorrigibility, and (III) falsehood. I invert the order of the criteria and examine (III), (I), and (II) in turn. After I consider theoretical reasons, I will present a case study of Schreber as corroboration.

(III) Falsehood

Instead of analyzing the notions of truth and falsity, which only apply contingently to delusions, here I examine why delusions have the propensity to deviate and become false. This is a direct result of the substantializing of the Other, who bring them forth.

If we examine some primary delusions, they are nothing but *applications* of inappropriate structures. The patient's experiential structure is that she is objectified, so she experiences herself as objectified, e.g., as a car when she happens to encounter one. Her circumstance is fitted into the preexisting relation. No other explanation is needed. However, this is not always the complete story.

I will make an analogy between delusions in schizophrenia and the substantializing of the Other in everyday life on the one hand and induced pseudo-

hallucinations, continuous sensation, and perceptual deprivation—specifically the *Ganzfeld* (German: "whole field") *effect*—on the other. A participant in a Ganzfeld experiment stares at an undifferentiated and uniform field of color (Wackermann et al. 2008). Already after a few minutes, simple, elementary changes occur. After tens of minutes, more complex percepts take shape. One subject reports something bizarre:

> In the right side of the visual field, a manikin suddenly appeared. He was all in black, had a long narrow head, fairly broad shoulders, very long arms and a relatively small trunk . . . . He approached me, stretching out his hands, very long, very big, like a bowl, and he stayed so for a while, and then he went back to where he came from, slowly (Wackermann et al. 2008).

By a crude analogy between inner perception and outer perception, deviated experiences of the Other are like visual hallucinations in a Ganzfeld experiment. The stipulation on the subject to let her eyes remain open corresponds to the overexerted presence of the Other in the patient. The Other is always felt and experienced, just as the eyes always look out. In each case, perception occurs continuously, although there is nothing or very little to perceive. The color field is empty, and other people are in vagueness and inaccessibility at a distance. Under a poverty of (transcendental) evidence yet an abundance of perception, even a healthy individual *makes up* percepts. This is not without caveats, for delusions and normality are sometimes not as neatly separable as pseudo-hallucinations against a plain background. Nonetheless, the Ganzfeld effect illustrates the consequence of *too much* experience, without the need for a total dissolution of subjectivity. To summarize in Heideggerian terms, the patient loses touch with the ontic (entities) and engages with an "empty ontological [the being of entities] matrix" that inevitably degenerates (Bovet & Parnas 1993).

(I) Certainty

Delusions are certain to the patient (i.e., subjective certainty). I distinguish between (i) *direct* delusions, which concern the Other's transcendental states, and (ii) *indirect* delusions, which concern facts other than the Other but only through his intentionality. These options exhaust delusions in schizophrenia. (ii: indirect delusions) involves an extra step toward intersubjective validity or objectivity.

(i) An example of a direct delusion is that a gang of murderers is pursuing the patient (Bleuler 1950, p. 118), in which case the gang *is the Other* whom she experiences too much. He has a multitude of roles as the Other: he is often the same "voice" that compartmentalizes the patient's subjectivity; he is the one who intrudes her body and causes various sensations; and so on. The location of him as essentially a transcendental subject is hard to pin down, and indeed the pursuer is found to be anywhere: hiding in the walls, in the next room, in the very air. His *cogito* is transcendental: the patient is not interested in and rarely tries to work out how exactly the Other pursues, talks to, influences, etc. her, in ways that conform to empirical laws (e.g., that people must be somewhere and must not be at two places at once), but is satisfied with a transcendental understanding, perhaps using obscure phrases (Bleuler 1950, p. 118). This is what gives a metaphysical taint to delusions in schizophrenia (Bovet & Parnas 1993).

An Other (genitive)-experience is still an experience to the patient (dative). Then, it has *experiential truth* by being *hers*. To quote Descartes:

> I am seeing a light, hearing a noise, feeling heat.—But these things are false, since I am asleep!—But certainly I *seem to* be seeing, hearing, getting hot. This cannot be false (Descartes 2018, p. 21).

The *cogito* as designated by Descartes is my seeing, hearing, feeling, etc. in the broad sense of thinking. The patient's *cogito* as a mode of thinking cannot be false if it is experienced by her. It cannot be false that it *seems* to *the patient* that *the gang* is pursuing her. (Some commentators, e.g., Newman 2025, point out that we can be wrong about our thoughts too, but I take it that ordinary psychological introspection does not qualify as *seeming*.) However, this is not enough. It *can* be false that the gang is *in fact* pursuing her, which, in Descartes' language, is an accompanying judgment of something existing outside her (Descartes 2018, p. 27). If this is all there is, delusions are subject to doubt just like our everyday judgments are. It seems to me that the tower is round, but it is entirely possible that it is square; I will realize only if I walk closer (p. 54). This line of reasoning, as it stands, is not what she is insisting, i.e., that the gang *is*, not merely seemingly, pursuing her.

No, the delusional *cogito* is from the point of view of the Other and not from that of the patient. It *seems* to *the gang*, not her, that it is pursuing her, so it is in fact pursuing

her, which should be understood initially as a mode of thinking. The delusional judgment is not of something existing outside her because the gang is, so to speak, inside her. The thought of the intra-Other is manifest and given to the patient, granting the thought's existence *via* its appearance ("seeming"), but it belongs or is attributed to the Other (see Section 3: The Other and Objectification). The patient essentially plays out the Other's thoughts, and the appearance of these thoughts in their natural progression in the patient's mind (their dative) confirms their existence just like how the thought "I want to eat trout for dinner" would confirm my appetite. The difference is that the genitive of the delusional *cogito* is the Other, who, by substantializing in the patient, has become a locus of experience on par with the proper self. For normal people, Other-experiences are largely responses to externally gathered evidence—my mother smiles, so she is in joy—but the quasi-subject in the patient generates his own activities and, in this way, behaves like the proper self, able to justify himself by the formulation *cogito ergo sum*. Inhering in this congealed locus, which is not available to normal people, it is the Other's *cogito*, or so it seems to the patient, that is intimately experienced. The patient acquires and can apparently experience *from the Other's point of view*—I put this forward as how I experience delusions. (It matters less to whom the thought appears as long as it *appears*—in other words, that it is a thought *of* the Other appearing *to* her does not disqualify its validity as a thought *of* the Other—although, practically, it must appear to the patient herself, in the dative sense, for her to access it.) The intra-Other maps onto the inter-Other, so she believes that the gang experiences pursuing her and therefore is in fact pursuing her. This kind of truth, unlike that of the empirical world, is immune to Descartes' skeptical arguments. The inter-experience is merely a projection from the aberrant intra-experience (see Section 1: Introduction), but such a projection is sufficient for subjective certainty. The Other's transcendental states are certain to the patient, being both *hers* and *not hers*.

(ii) A deluded patient thinks he is Jesus because he "cannot help that *other people*" think that he is Jesus (Parnas et al. 2021, italics mine). According to Husserl, the reality of the world is constituted intersubjectively (Zahavi 1996). This is because the moment I experience objects as experienced by other subjects, they can no longer be reduced to my intentional correlates as subjective plenitude. They acquire real being through the

transcendence of the Other. Subjects can disagree, which permits a distinction. Let us say that only one other reliable subject is necessary for intersubjective validity: it is valid that the actor is smug if at least some reliable people think so, and his shame can testify to it. Objectivity requires that everyone (at least every normal subject) agrees. The patient's Other's *cogito*, through his transcendence, grants intersubjective validity, if not yet objectivity, to the objects of his experience. It appears *to* the patient's Other that her son has jug ears, so she concludes that this is the case, even though it is medically false. After all, the Other testifies so; it proves it in a way that is not dependent on the patient (even though it is a projection); it is therefore not "subjective," only in a new sense ("transsubjective"). In this way, indirect facts become certain and real to the patient as objects of the Other's intentionality.

The patient experiences the Other in ways that are deviated (see III: falsehood, above), so by (i: direct delusions) and (ii: indirect delusions), the corresponding delusion is certain for her.

(II) Incorrigibility

Since delusions in schizophrenia are transcendental, they are not correctible by empirical evidence. The basis of delusions is the Other as transcendental subject, including his transcendental states (*cogito*). These belong to the transcendental realm, strictly prior to the natural or empirical realm; the former is not even a tag-end of the latter (Husserl 1960, p. 21). My performing Husserl's transcendental-phenomenological reduction leads me to the transcendental realm. The I- and Other-life remain untouched by the *epoché*, which is simply a refraining from positing the world as existing. I can set my thinking, feeling, sensing, etc. apart from the world "out there." Therefore, these two realms are separate from each other: the former exists regardless of whether the latter exists. Moreover, this world as revealed by my *cogito* is the only one I can ever access—I have no way of reaching it except *through* my transcendental experience—so it continually presupposes transcendental (inter)subjectivity (p. 21). The transcendental is the condition of possibility of the empirical, and not the other way around. Therefore, the former cannot be falsified by the latter.

The transcendental *constitutes* (makes be or appear) the empirical. This is why delusions do not admit science as counterevidence but instead revise science for the

patient (Schreber 2000, pp. 245–7): they as constitutive power is strictly prior to science, which only provides empirical laws. Ordinarily, this separation is not a problem because our transcendental experiences are intact: we can revise our previous belief that someone lied, for example, when we have a *new*, stronger experience that he was not lying. No matter how much empirical evidence (including those about his psychology) we find, if we cannot have a different experience of him, the evidence can only reinforce our previous judgment. In schizophrenia, however, transcendental experience itself is deviated (see III: falsehood, above), and no empirical fact, which comes after it, has the hope of correcting it.

A related but different point pertains to *double bookkeeping*, exhibited especially by patients in non-acute phases of illness who hold strong convictions about their delusions but nonetheless do not act on them (Sass 2013). Schreber gives a reason for this phenomenon: "my so-called delusions are concerned solely with God and the beyond, they can therefore never in any way influence my behavior in any worldly matter." For these patients, there are two disjoint realms: the transcendental, Other, and delusional on the one hand and the empirical, mundane, and shared on the other (Parnas et al. 2021). The pathological Other in the patient exists as transcendental and resists becoming empirical, so he and his *cogito* are *outside* of the world as to lack any real consequences for action *in* the world. He may indeed be co-constitutive (see I.ii: certainty, indirect delusions), but action only heeds what is empirically efficacious, which he, by his segregation, is not. A patient insists that he is Napoleon (Sass 2013), but this status is only according to one with no significance in this world, so he willingly sweeps the floor. In acute phases where the patient is, e.g., violent, the Other always take on the form of a real target to whom she attacks, and the realms crash together.

Schreber Case

Schreber was a German judge who wrote a memoir of his schizophrenia. I take him as an example because his writing is remarkably meticulous and informative regarding his experiential framework. His delusional system is "an enormous architecture of nerves, dominated by a predatory God" (Schreber 2000, back-cover), where he defines "every single nerve of intellect" to represent "the total mental individuality of a human being" (p. 20). Put differently, his world is controlled by a vast number of other subjectivities.

Further, he defines God who is on top of all these as "only nerve, not body" (p. 20). Here, God is the Other pushed to the limit of infinity (Sartre 2018, pp. 363, 382). His inventions fit quite well with (A & B: distortion of self and Other).

Since detailed experiential accounts are scarcely available, the following passage will exemplify how delusions unfold, corroborating the process outlined theoretically above. This vignette is usually described to be Schreber's delusion of turning from a man to a woman, but note how the Other mediates this experience too:

> When the rays approach, my breast gives the impression of a pretty well-developed female bosom; this phenomenon can be *seen* by anybody who wants to observe me *with his own eyes*. I am therefore in a position to offer objective evidence by observation of my body. A brief glance however would not suffice, the observer would have to go to the trouble of spending 10 or 15 minutes near me. . . . Naturally hairs remain under my arms and on my chest; these are by the way sparse in my case; my nipples also remain small as in the male sex. Notwithstanding, I venture to assert flatly that anybody who sees me standing in front of a mirror with the upper part of my body naked would get the undoubted impression of a female trunk (Schreber 2000, p. 248).

"Rays" are divine creations; they have "the faculty of transforming themselves into all things of the created world" (p. 21), that is, they can exist both in the mode of the transcendental and in the mode of the empirical; in this and in that they are other than him, they are the Other. So, Schreber's *being* a woman (see Section 5, delusional perception, i: stimulus is self) is a result of apprehensions by the Other, either symbolically ("rays") or hypothetically ("anybody"). Not just any such apprehension, though: it is a requirement for the Other to spend a remarkable "10 or 15 minutes" just staring at Schreber before he can judge "correctly," corresponding to a presence deviated through overexertion (fulfilling III: falsehood). Moreover, by repeated (intra)intersubjective apprehensions by "anybody," which have experiential truth *from (literally) the point of view of his Other* ("seen . . . *with* [*anybody's*] *own eyes*"; not from his own point of view), his appearance as a woman gains "objectiv[ity]," an ideal of certainty for an object of intentionality (fulfilling I: certainty). Finally, some world-positing empirical facts oppose the delusion ("Naturally hairs remain . . ."; note the assertion of

the hairs' actuality), but they cannot overcome ("Notwithstanding . . .") the transcendental apprehension (fulfilling II: incorrigibility).

(7) Conclusion

In conclusion, this article proposes the self–Other model of schizophrenia, where the Other pathologically dominates the self. Delusional mood and delusional perception are both instances of this alteration. The patient's delusion is an experience of her Other, which by being both *hers* and *not hers*, is certain; by being transcendental, is empirically incorrigible; and by arising from a substantialized presence, is frequently false. Common delusional themes point to basic existentialist emotions when self encounters Other (fear, shame, pride, etc.). Delusions in schizophrenia are more specific and more interesting than the customary assertion than "she holds a false belief." I have shown that some psychopathological phenomena are in the scope of transcendental phenomenology and are expressible by alterations in the structures of (inter)subjectivity.

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