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Original article

The “Territorial Self:” Theoretical Propositions for a Phenomenological Understanding of Schizophrenia[☆]



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ABSTRACT

Objectives. – This theoretical paper discusses the integration of a “territorial self” alongside the minimal and narrative selves most commonly described by contemporary phenomenology and used by phenomenological psychopathology.

Methods. – We start from the schizophrenic experience and the tools for understanding it, in order to highlight some limitations in the use of vocal communication within the clinical system to evoke phenomena that are a priori pre-linguistic.

Results. – This theoretical path, which requires an openness to clinical observation and intersubjectivity, leads to nosographic and therapeutic implications that seem useful to us from a phenomenological perspective.

Discussion. – From a nosographic standpoint, we discuss the (non-systematic) crossovers between the schizophrenic experience and the psychotic experience; whereas, from a therapeutic standpoint, the proposal of the territorial self allows us to insist on the fact that the clinical relationship is characterized as much by an analysis of experience and a discussion about it as it is by a joint practice and an experiential experience requiring a common ground.

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Conclusions. – The “territorial self” proves to be a fruitful and heuristic theoretical proposal, enriching nosographic debates in the field of psychosis, and contributing to a reflection on the practice of psychotherapy.

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1. Introduction

Taking as its starting point a phenomenological understanding of schizophrenia, this paper aims to initiate a theoretical discussion of the articulation of a minimal self/narrative self and to propose the integration of a “territorial self,” for which I will propose a definition and demonstrate in what ways the latter cannot be dissolved in the two extreme dimensions of the *ego*. Finally, I will evoke the nosographical and therapeutical implications of these propositions, asking the fundamental question: is the clinical relationship characterized by an analysis of experience and discourse on experience and/or by a conjoined practice and experience that would require the sharing of a common space?

2. Contributions and limits of the EASE and EAWE scales

For those clinicians who engage with schizophrenic patients using a phenomenological framework, the Examination of Anomalous Self-Experience (EASE) [1] and Examination of Anomalous World Experience (EAWE) [2] scales are recognized as being of great interest. Centered on a first-person perspective, EASE and EAWE are tools that make use of the narratives produced by subjects about their own experiences (I will not go into any greater detail about these well-known tools; readers can consult, in addition to the original articles, [3,4]). The scoring and the interpretation of different items (separated and organized in various domains) are based on subjects' descriptions of their experiences. While these tools are precious, and while the narrative dimension plays a fundamental role in our understanding of subjects' functioning, it is clear that these scales do not represent the only source of information on the concrete ways in which a person enters in contact with their interlocutor and with their environment. The non-verbal dimension, bodily interactions, various modalities of relational exchanges – which, in other publications [5,6], I have referred to, following Deleuze, as *territorialization* – are also decisive keys to understanding subjectivity and experience. Clinical practice is, indeed, enriched by a meticulous analysis of this essential dimension of a subject's experience, which can reveal information that has at least as much value (while apparently of a different degree) as a first-person discourse.

The key contribution of the EASE and EAWE scales goes hand in hand with their methodological difficulty, in that both scales focus on the narrative dimension of a subject's discourse. These two scales are based on the implicit hypothesis that there is a sufficiently elevated correlation between a person's lived experience and what they think about, and how they express, this experience. (These two dimensions cannot, by the way, be superimposed.) It seems reasonable to think that people never verbalize the results of their ideational activity with absolute fidelity; moreover, their reflective activity cannot be perfectly superimposed on the complexity of their lived experiences. In addition, these scales are also based on the convincing hypothesis that verbalizing is beneficial for the patient, or that the interaction between the patient and the clinician is likely to encourage treatment (if only because many patients have few opportunities to engage with an interlocutor in a shared discourse on their experiences).

In a recent study [7], I exposed and discussed the contributions of the EASE and EAWE scales, but also the inherent limitations of the first-person perspective. I suggested that adding an “observed” dimension to the items on these scales could allow for an improved overall understanding of the

person, offering a thumbnail-sized version of the patient's narration of their experiences, but also of their lived experience of space and of social-behavioral interactions.

In this context, it seems reasonable to think that one of the future challenges of phenomenological psychopathology will be the integration of clinical (ethological) observation into studies that focus on the first-person perspective [5,8–10]. The experience of a “loss of common sense” (a key item on the EASE scale) is particularly relevant to this reflection. This experience is frequently (even systematically) said to occupy a central place in the life of schizophrenic subjects. This experience can be articulated and described by the patient (“It's hard for me to understand other people, I don't know how to act around them;” “Social rules are a problem for me because, if they're not explicit, I can't guess what they are;” “I never know how to carry myself when I'm with someone, I don't know what the right distance is”), but the loss of common sense is often experienced in an acute way in the clinician–patient relationship. If this loss isn't present in the content of the discourse, it often appears in the discourse's form. Furthermore, when subjects are questioned about a loss of common sense, they often deny having experienced it, whereas the clinician often observes the presence of this type of disorder in the form and the (in)coherence of patients' discourse and in their difficulties in attuning themselves relationally with their interlocutor.

Likewise, the literature reveals certain difficulties in using these scales [3,11–15], since the experiences that they target are difficult to articulate and have never, or rarely, been expressed verbally: “One reason for this is that many of these experiences possess a prereflective quality. They are not explicit in the focus of thematic attention but constitute more the over-all background of awareness” ([1], p. 122). We can also highlight the fact that numerous clinicians and researchers may not be familiar with these types of anomalies in self-experience before using the EASE and EAWE scales.

The verbal expression of these nearly “unspeakable” experiences thus requires a certain capacity to use language and to link one's discourse with one's experience. In her research on anomalous experiences of the world in schizophrenia, Elisabeth Pienkos observes an underlying schizophrenic *Gestalt* that she calls “the unmooring of the world” [13,15], the loss of an “anchor.” Pienkos suggests that this “unmooring” can be identified in the form, as well as in the content, of subjects' responses. She explains the phenomenon thusly: “Without an implicit, common-sense awareness of what counts as typical experience and what might be unusual or strange, a research subject may be unable to catalogue or speak about particularly unusual experiences” ([13], p. 31).

This observation supports my hypothesis of a difficulty in identifying experiences that are, by their nature, reflective and, as such, not particularly adapted to a formulation in the first person. This doesn't call the first-person perspective into question, nor the essential dimension of tools that can help describe anomalous experiences that are a central part of schizophrenia. My objective is to remind readers of the unspeakable dimension of this complex semiology and the *gaps* between language, observation, and experiences (those of the schizophrenic subject and those of the clinician). In this context, a fully phenomenological approach should include this ethological and preverbal dimension that, while important, escapes discourse and auto-description of experiences.

3. Theoretical proposition of an intermediate “territorial self”

This reflection on the tacit dimension of experience leads to an interrogation of the theoretical statute of this ethical and ecological aspect of the relational experience of the self (in general and in the schizophrenic experience, in particular). Here, I propose the observation that between the experience of an irreducible and *princeps* self – the “minimal self” described by Zahavi – and a biographical and communicable self – Ricœur's “narrative self” –, we can set aside a place for the self's ethical and ecological dimension: which I propose to call the “territorial self.” The reference to Deleuze and Guattari [16] to qualify this relational, experiential, and environmental dimension of the self might be somewhat disconcerting to a reader who expects a more direct link to the history of the phenomenological current. However, the Deleuzian geophilosophical project offers many fecund contributions, particularly in its capacity to integrate the ethological facet, but also in its capacity to propose a reflection that is, paradoxically, less directly invested in subjectivity and in first-person experiences. This ethical dimension of the self leads to an apprehension of “man in situation;” a study thereof would

aim for an identification of the concrete dimension of the experience of the self in situation, forged in the practice of living.

Contemporary reflections and debates on the notion of *self* – principally in the fields of phenomenology, hermeneutics, and embodied cognition – are polarized around two specific forms of self: the minimal self and the narrative self, which we can define as follows [17–21]:

- The minimal self corresponds to a feeling of self in its implicit, non-conceptual, and primitive dimensions. The minimal self is said to be an agent, thus allowing the subject to experience itself as the subject of its actions; the minimal self feels ownership, or a sense of mineness, that points to its capacity to conceive of experiences as belonging to it [21,22]. This dimension of the self is prereflective and embodied; indeed, the body is at the origin of this *princeps* experience that makes the subject conscious of its status as a “conscious subject.” Precognitively, prereflectively, and prethematically, but also with a certain immediateness, the minimal self gives the subject the intuition of what it is, in the most fundamental and originary way, allowing for the premises and conditions of a first-person experience;
- the narrative self is the actualized capacity to refer to oneself and to direct one’s reflective attention towards certain aspects of one’s own mental life and subjectivity. It is an explicit experience, integrating a conceptual and discursive dimension. It is the part of subjective experience that involves the person’s autobiography and rests, following Ricœur’s work, on the idea that biographical consciousness simultaneously creates, invents, and diffuses identity (while Ricœur’s oeuvre contains numerous reflections on narrative identity, I am referring here most specifically to *Time and Narrative* [Vol. 3] and *Oneself as Another*) [23,24]. Thanks to the narrative self, the individual inscribes her/himself in history and constitutes her/himself through engagement in a variety of personal and interpersonal forms of narrative activity. Gallagher and Zahavi point out that the cardinal point of the narrative self is its capacity to reflectively recognize certain experiences and values, and to integrate them into a conception of the self [19–21]. Regarding the cognitive consideration of the narrative dimension of the self, the reader can refer to Fabrice Berna’s work [25].

Between this self that corresponds to the most primitive, prereflective self-consciousness, and that which allows for discourse and for the cognitive elaboration of reflective self-consciousness, we can note a *gap*: there is no perfect attunement between lived experience and discourse about lived experience. A gap, and doubtless a kind of *delay*, in that the linguistic and narrative appropriation of experience suggests an act of meditation, implying a temporal distance from the prereflective experience, which we can reasonably suppose to be more instantaneous. The minimal and narrative dimensions are distinct facets of the same self, and present a degree of organized complementarity. The presence of a minimal level of self-awareness should be considered a condition of the possibility of the emergence of a narrative self; the latter is, in other words, founded on the former, even though, in ordinary experience, they are generally mutually integrated.

My hypothesis consists in thinking that the experience of the self, if we are to give a complete description of it, should integrate a territorial dimension – that is, an ethical and ecological dimension. In effect, it would be reductive to think that the subjective experience could be reduced to two extremes: a prereflective pole (the minimal dimension of conscious experience) and a reflective pole (that of a subject who contemplates and comments upon her/his lived experiences, though their discursive and linguistic capacities). It seems – if we follow Wykretowicz’s propositions [26,27] – that our thought must include a third polarity: that which creates itself through its experiences, in the encounter with places and with others, indeed, through that which Deleuze and Guattari call territorialization. Directly linked to the body, this facet of the self is also preconceptual, but, unlike the minimal self, it is not primitive. This facet is pre narrative, but inscribes the subject in social history. The “territorial self” is the self of lived experience. It is fundamentally ethical (Deleuze and Guattari already underscored the double meaning of *ethos*: “both abode and manner, homeland and style”) ([16], p. 320). This “ethical self” corresponds to an individual’s way of being, their styles of existence, their character and habits. This practice of the ethical is fundamentally linked to our way of inhabiting a space and interacting with the other territorial selves that we meet throughout our subjective experience. Remember: one territorializes as one is, but one *is* in their territorializing. My way of interacting

with others in a common space, while it may be a unique self-experience, cannot be reduced to the minimal and narrative dimensions of this self.

I must insist on the fact that this hypothesis was greatly influenced and clarified by my numerous exchanges with Hubert Wykretowicz in the context of what we might call the “dispositional self” [26,27]. Furthermore, as concerns the affective dimension of the practical and relational experience of the self, the reader can consult the works of Anna Bortolan [28], and can consult the “concept of life” as developed by Thomas Fuchs [29]. The notion of the territorial self proposed in this article also resonates with the concept of Enaction, which comes from Embodied Cognition, developed by authors such as Varela [30] and Noë [31], which studies the interactions between cognition, the bodily experience thereof, and the environment.

Let us bear in mind that the territorial self is the concept through which we can try to grasp the being that reveals itself thanks to its experience of the world, and through its practice of life, through its behavior and its actions in a given milieu. In this perspective, the environment shapes the subject at least as much as the subject transforms the environment. The territorial self is the ethical way of being oneself, through one's style and ways of moving, of expressing oneself, of acting and reacting, of feeling emotion. This is an experiential, practical, and relational creation of form, which follows upon the minimal experience of the self and which precedes the narrative identity's expression of discourse. The territorial subject is not so much a subject that speaks its being, but instead a subject that is engaged in existence and in social and inter-bodily exchange; the territorial subject is that which acts, lives, and territorializes with enthusiasm and innocence, or with passion.

4. The experience of the self in schizophrenia

Within this article's focus on schizophrenia, I will limit myself to a theoretical consideration of three dimensions of the self: minimal self, territorial self, narrative self. Contemporary scholarship considers schizophrenia as a disorder of the self, and the most commonly accepted model is Sass and Parnas's *Ipsity-Disturbance Model (IDM)*, which suggests that the schizophrenic person presents a disorder of the minimal self [32,33]. The *ipseity disorder* described by these authors, which brings together clinical data and sophisticated theoretical arguments, is based on anomalies in subjects' experiences of self and is described as three interdependent facets:

- *hyper-reflectivity*, which refers to an exaggerated self-awareness, a tendency (fundamentally involuntary) to direct one's attentions towards phenomena or processes that are habitually *inhabited* or experienced (at least tacitly) as being implicitly part of the self. The schizophrenic interrogates *a priori* implicit/prereflective phenomena, such as self-awareness, bodily sensations, and interactions with the environment in an explicit/reflective mode;
- *diminished sense of self*, which refers to a (passive and automatic) decline in the experience of the feeling of existing as a conscious subject or as an agent of one's actions. In the schizophrenic experience, feelings of ownership and agency – central characteristics of the minimal self – are disturbed. The deepest prereflective subjective structure of experience, the intimate connection of the subject to itself, is diminished in schizophrenia; those subjects who are the most gravely disturbed may report that these primordial attributes have disappeared from their experiences. The schizophrenic subject might say that her/his mind is controlled by an extraterrestrial force, for example. The experience of “alien control” demonstrates a radical loss of the capacities of ownership and agency [34];
- *a disturbance in the subject's adherence to and grip on the social world*. Among the three facets of the basic self-disorder, schizophrenic subjects doubtless find this one to be the most difficult to objectivate and to articulate verbally. As we saw in the preceding section of this article, the identification of experiences that are, by nature, prereflective and that are difficult to place outside of the realm of common sense presents obvious discursive paradoxes that must be considered as factors that contribute to, or at least reinforce, the social and relational ruptures experienced by the schizophrenic person.

It is interesting to consider how these three modalities of self-disorder in schizophrenia are present in the experience of the three forms of self (see Table 1). We can observe that: 1) hyper-reflectivity

Table 1
Presence of the Three Forms of Self in the Three Facets of the *Ipsity-Disturbance Model*.

Three facets of the <i>Ipsity-Disturbance Model</i>	1/ Hyper-reflectivity	2/ Diminished Sense of self	3/ Disturbance in Adherence to and Grip on the World
Respective Presence of the Three Forms of Self	The narrative self interrogates: minimal self, territorial self	Minimal Self (can be verbalized via the narrative self)	Territorial Self (can be verbalized via the narrative self)

probably consists in the reflective and narrative interrogation of prereflective phenomena borne of the minimal self, but also of the territorial self – this first modality thus convokes all three facets of the self; 2) while the diminished feeling of selfhood essentially relates to the minimal self, we should bear in mind that these difficulties are verbalized and, as such, they convoke the narrative self; 3) the disturbance of the subject’s adherence to and grip on the social world is present in disorders of the territorial self, while being verbalized and thus convoking the narrative self in a secondary fashion.

It is, moreover, interesting to note that the most easily verbalizable phenomenon (and one that is often expressed) is that of *hyper-reflectivity* (while interrogating generally prereflective phenomena, hyper-reflectivity is situated in the reflective register). The *diminished sense of self* is situated at an intermediate level, since it correlates with prereflective phenomena, but the schizophrenic subject often has a great deal of difficulty in finding the right words to express this experience. Finally, the *disturbance in adherence to the world*, in the prereflective dimension of the subject’s connection to the world, is doubtless the facet that is the most difficult to express, situated as it is at the limit of the possibilities offered by language to express an anomalous experience that remains, overall, unspeakable. One could suggest that this third facet is the most difficult to put into words since it is experienced by the subject as dependent on the outside world, whereas the first two facets, while related to the prereflective, concern an experience that is internal to the subject and, even if the subject feels deprived of it, s/he probably has a more precise memory of these more personal and internal modalities of experience.

5. Nosographical and theoretical contributions

The theoretical proposition of the territorial self has much to contribute to the field of schizophrenia; I will evoke two of these contributions in more detail in this article: 1) its utilization in the diagnostic process and 2) its consequences for therapeutical practice.

5.1. Nosographical contribution

A consideration of the territorial self in the nosographical and diagnostic process allows us to rectify an apparent lack in the domain of phenomenological psychopathology: a discussion of the differences and similarities between psychosis and schizophrenia. Indeed, if schizophrenia is a psychosis, not every psychosis is a schizophrenia. From this perspective, psychoanalysis proposes a much deeper reflection on patients who present a psychotic being-in-the-world, while not presenting a complete tableau of one of the major psychotic psychopathologies. Here, one can think of the diagnosis of “white psychosis” proposed by André Green [35].

I suggest that the differentiation between two prereflective forms of self – minimal and territorial – allows us to furnish a clinically and psychopathologically relevant diagnostic hypothesis. If one follows the reasoning laid out in this article, it is reasonable to say that the common denominator between all the different forms of psychosis (schizophrenia, paranoid delusional disorder, mania, melancholy, but also numerous unspecified psychotic disorders) is the presence of a disorder of the territorial self. That is, the psychotic subject’s ethical, relational, and ecological experience of self could be said to be disordered. This would be, then, the fundamental clinical sign of the psychotic experience. This pathognomic sign of the psychotic experience recalls the psychopathology of common sense as

Table 2
Forms of Self Present in Schizophrenia and in Other Psychoses.

Psychotic Disorders	Schizophrenia (and certain profound melancholic states)	Other Psychoses (paranoid delusional disorder, manic state, melancholic state, unspecified psychotic disorders)
Forms of Self Present	Disorder of the Territorial Self and Disorder of the Minimal Self-Experience	Disorder of the Territorial Self but not Disorder of the Minimal Self

described, notably, by Giovanni Stanghellini (even though Stanghellini limits these experiences to schizophrenia and melancholy) [36].

However, a disorder of the minimal self seems to be found only in the schizophrenic experience (and in certain profound melancholic states – for example, during experiences of melancholic depersonalization or disorders in bodily experience; the extreme example would be Cotard’s delusion, which clearly involves a disorder of the minimal self). The diminished sense of self, expressed in the loss of agency and mineness, seems to be a unique and pathognomic experience found, more precisely, in schizophrenia (with an exception made for certain cases of melancholy). To put it another way: what makes individuals who suffer from paranoia, mania, melancholy (in general), and psychosis (in its a-specific forms) psychotic but not schizophrenic – independently of the symptoms listed, for example, in the DSM-5 – is that they do not present a disorder of the minimal self, but, indeed, a disorder of the territorial self. As concerns hyper-reflectivity, for schizophrenic subjects, this is present in the reflective interrogation of phenomena that are generally considered to be prereflective, linked to the minimal and territorial selves. For other forms of psychosis, this accentuated reflectivity concerns the prereflective aspects that only touch on the territorial dimension of the self (the subject’s relationships with others, with objects, with the temporal dimension of the territorial). Note that manic individuals do not, *a priori*, present hyper-reflective symptoms, as they are too busy to invest a territorial self and have no time to interrogate this experience (these distinctive elements are schematized in Table 2).

5.2. Therapeutic contribution

The question of the clinical and therapeutic encounter also merits to be discussed in the light of this reflection on the territorial self. The narrative dimension – that is, inviting the subject to verbalize about their experience and helping them integrate this perception into their biography – remains, evidently, one of the pillars of a phenomenological therapeutics. An intersubjective encounter in which a profound experience is carefully unpacked can be a decisive moment for schizophrenic persons who often feel misunderstood.

These therapeutic dimensions call upon the narrative self and contribute to a construction of the subject’s experience, thanks to the mediation of narrativity. This aspect of therapy aims at *understanding* the subject and at exploring in detail the world in which they express themselves. This world, thus unpacked, becomes more livable. One could reasonably think that, if the subject was better understood, and if this understanding was the result of a bond with the other (in this case, the therapist), that the subject would be less perturbed by the anomalies of their experiences. This is, at least, the implicit wager of these therapeutic propositions: understanding existence allows one to exist better. While it is possible to question the systemic applicability of this proposition, it is, however, impossible to reject it outright. On the one hand, increased intelligibility is a source of evolution and of creation for the subject her/himself. This is, at heart, the central thesis of Ricoeur’s notion of narrative identity (for a subtle application of the narrative dimension of the self in psychotherapy, readers can refer to [37]). On the other hand, one can also affirm that the characteristic of the clinical encounter is that this increase is acquired through a relational and collective act, a discourse pronounced by multiple voices (a co-construction). There is an added value in terms of meaning, of course, but its profundity comes from the affinity between those who are responsible for it.

Beyond these crucial clinical contributions, it is interesting to attempt to highlight the ways in which the notion of the territorial self can contribute to the practice of therapy with schizophrenic patients (while I can’t develop the point here, I believe that this holds true for any form of clinical encounter,

whether it involves schizophrenic patients or not). Within the limits of this article, I will evoke two reasons that justify the use of the territorial paradigm: the first being that a principal symptom of the schizophrenic experience is, as mentioned earlier, hyper-reflectivity, that is, an excessive use of the narrative part of the self to make sense of prereflective experiences. The second reason is that if the territorial experience and its potential difficulties are particularly prominent in schizophrenia, it is coherent to seek them out in the clinical dynamic.

Indeed, it appears paradoxical that, if hyper-reflectivity is a characteristic sign of the schizophrenic experience, the first-person perspective consists in provoking an introspection that recalls this very hyper-reflectivity. Of course, the fact that this activity occurs in the framework of a relationship with the therapist and that it is markedly different than the hyper-reflective act (characterized by its solipsistic dimension) should not be minimized. It is, however, troubling to observe that the principal therapeutic solution proposed by phenomenology – that is, discourse on prereflective phenomena – can be superimposed on the cardinal symptom of the schizophrenic disorder: that is, the tendency to interrogate implicit and *a priori* tacit phenomena in a reflective mode. Once again, the fact that this questioning happens in dialogue (and not in a monologue, as is the case with hyper-reflectivity) is decisive. It is, however, relevant to suggest that a coherent therapeutic path for patients who interrogate life instead of living it would consist in helping them participate in this technical understanding of experience, and in helping them reconnect with the prereflective – again, in the framework of a relationship –, by proposing sequences that could allow them to rediscover a more carefree life, or the naiveté of an experience in the first person that quiets their constant self-questioning.

For a large number of therapists, invoking the territorial self in clinical practice with schizophrenia is, in fact, self-evident. It is, however, perhaps less obvious for researchers who do not, in general, “live” with their patients on a daily basis. Therapists know that before any form of dialogue, an essential aspect of the therapeutic process is to construct an interaction, a capacity to share common meaning, to stroll together through a shared territory. Moreover, it would be erroneous to think that this would constitute a simple first step that would allow for the later exploration of subtler and more essential modalities. The encounter with the prereflective, without the mediation of language, is without a doubt a foundational act of any therapy. This encounter naturally occurs in and with the body, and can involve either the territorial or the minimal self. The particularity of these acts is that, while being intrinsically therapeutic, they “target” (or encounter) the prereflective dimension of the self. Paradoxically, they should be produced without any stated therapeutic objective. This is the paradoxical condition of a therapeutic address to the territorial self and to the relational and carefree dimension of subject's experience of self. The clinician, in these cases, doesn't know why s/he is doing what s/he does. With the patient, the clinician *practices* life instead of *thinking* it. In the category of prereflective mediations, let us list: artistic practices (dance [38,39], movement therapy [40]); therapies with animals [41]; but also the numerous informal moments between therapist and patient: those moments where a casual observer might think that the therapist isn't doing anything, but where, instead, s/he might very well be in a place of deep therapeutic work, in a place of the most subtle ethical engagement.

Disclosure of interest

The author declares that he has no competing interest.

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