

‘There Is a Crack in Everything’. Fragile Normality : Husserl’s Account of Normality Re-Visited

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Abstract

There is a paradox that lies at the heart of every investigation of normality, namely, its dependence on its other (e.g., deviation, break, difference). In this paper, I want to show that this paradox is the reason for the dynamism as well as fragility of normality. In this regard, I will not only argue that every normality is fragile, but also that normality can only be established because it is fragile. In the first part of this paper, I will present and re-visit Husserl’s account of normality as concordant and optimal with regard to its dynamic or fragile aspects. In the second part of this paper, I will apply this account to recent findings in phenomenological pathology regarding schizophrenia and depression to show how Husserl’s account could be helpful for differentiating between different aspects (such as concordance and optimality) as well as genetic levels of (disturbances of) normality.

Keywords: Husserl, phenomenology, normality, pathology, schizophrenia

1. Introduction

A well-known critique of phenomenology, especially with regard to Husserl and Merleau-Ponty, is that its descriptions of experience overly emphasize the ordered, harmonious, or meaningful nature of experience and therefore cannot adequately account for psychopathological phenomena. Phenomenology thus presupposes a meaningful experience of the world that we all (can possibly)

share. Psychopathology and psychoanalysis, however, are confronted with patients who lack such common ground and whose experiences cannot be described within the frames of the normal experience of the psychiatrist.

While Phenomenology begins with the synthesis or unity of experience, psychiatry or psychopathology must start with a radical difference or disruption; while phenomenology understands coherent and meaningful perception as our primary relation to the world, such a perception is merely secondary for psychoanalytic approaches, which considers these perceptions to be imaginary and already symbolically filtered (cf. Lacan, 1961). From the perspective of psychoanalysis, we find thus a reversal: psychopathological experiences, such as hallucinations, are in this regard primary or more real, because they are signs of a resisting (underlying libidinous) reality, i.e., non-symbolized, bare perception (cf. Ayouch, 2009: 19). One could thus state that research in phenomenology understands normality, in the sense of concordant and unified perception, as necessary for every ‘meaningful’ or sharable experience. From the perspective of psychopathology, however, normality must always be secondary, while disruption or difference is primary.

While I will not engage with this specific discussion or problem in this paper, I will argue that, as one can see in this sketched opposition, there is a paradox that lies at the heart of every investigation of normality, namely, how its dependence on its other (e.g., deviation, break, difference) is the reason for its dynamism as well as its fragility. Even though a phenomenological account of normality like Husserl’s does not explicitly emphasize this fragility, it is nonetheless a constitutive factor for an established normality. In this regard, I will revisit Husserl’s account with a slightly different perspective, not only to show that normality is fragile, but also why it necessarily has to be fragile, i.e., that normality can only be established because it is fragile.

In the first part of this paper, I will present and re-visit Husserl’s account of normality as concordant and optimal with regard to its dynamic or fragile aspects. In the second part of this paper, I will apply this account to recent findings in phenomenological pathology regarding schizophrenia and depression to show how Husserl’s account could be helpful for differentiating between different aspects (such as concordance and optimality) as well as genetic levels of (disturbances of) normality.

2. Husserl’s dynamic concept of normality

As a mathematician by profession, Husserl accounts for normality in terms of concordance and coherence. Thus, normality is not just an indicator of usual or habitual behavior, but first of all a necessary criterion for every possible experience. In this sense, normality is characterized by two criteria: the *concordance* of the contents of experience and the inherent relation of every ongoing experience to an ideal or relative *optimum* (Husserl, 2008: 204ff., Text Nr. 55/56/57/58, 637-673; Ms. D 13 XII, XIV; cf. Steinbock, 1995a; 1995b: 123-148; Taipale, 2014: 121-169; Heinämaa, 2013; Heinämaa & Taipale, 2018). Husserl differentiates between normality on an individual level, i.e., concordance (and optimality) with respect to the course of *individual* experiences, and *normality* on an *intersubjective* level, i.e., concordance between the experiences of an individual and those of the whole intersubjective community. Normality, in the strict and stable sense (i.e., a normality that is shared by all), is thus only possible when the latter criterion is fulfilled. Thus, on an intersubjective level, normality permits a coherent and familiar experience while, on an intersubjective level, it establishes a common ground or world as the basis for all social interaction and communication. In the following section, I will explore individual normality and the genetic levels one can, following Husserl, differentiate¹.

a) Individual concordance and optimality

With Husserl, one can argue that normality is a constitutive factor for experience on different levels, beginning with the most passive levels of receptivity to bodily, practical experience, and finally to doxic levels of belief. Within the scope of this paper, I will primarily focus on the first two levels.

Concordance, for Husserl, is a necessary condition of every objectual (German: *gegenständlich*) experience. To have a concordant experience means that what we experience now has to be in accordance with what we have experienced before, and that future experiences fit within this line that stretches between current experiences and the entirety of the subject’s experiential past.

¹ Although Husserl himself did not systematically apply his approach of normality to his genetic phenomenology.

To constitute such a coherent object perception, concordance has to operate already at the level of what Husserl calls the *passive temporal and associative organization of experience* – which Husserl labels the *passive synthesis of consciousness*. In the passive synthesis of consciousness, the formal and temporal continuity of perception is guaranteed by the automatic integration of new sensations in the temporal horizon of consciousness. With his well-known example of the melody, Husserl shows that we would not be able to hear a melody or tune, which is a temporal continuity of tones, if we only experienced the sounds as an unconnected series of sensual input or points (cf. Husserl, 1991). Every incoming tone is retained in consciousness and integrated within the whole of former experiences: the formerly perceived tone is incorporated into a continuity of momentary, gradated retentions, while every new, incoming tone is part of a horizon of upcoming or anticipated tones, a horizon of the protention of tones to come. Another passive synthesis, the synthesis of association, accomplishes a first concordance in terms of content. In the synthesis of association, different perceptions of one object or a plurality of objects are constantly synthesized into one coherent stream of experience. New perceptual input must in this regard

not only be in concordance with what we shortly experienced before, but also with the entire (past and future) experiential horizons of the experiencing subject. This circumstance can also be described in terms of motivation, in the sense that earlier impressions and perceptions motivate later ones, while the former impressions are, in turn, part of the whole experiential history of a subject. (Wehrle, 2015b: 131)²

Perception is considered to be normal when its contents are concordant (*einstimmig*), or “match” with previous contents. This means that every new sensual input has to fit within the larger temporal and thematic context of perception. Perception already inherits implicit assumptions, as it intends or

² See Wehrle (2015b) for a similar description of concordance. Such a temporal continuity and concordance of experienced contents is precisely what is breaking down with regard to pathologies like schizophrenia, as research in phenomenologically inspired psychopathology has shown (Gallagher, 2005: 200; Fuchs, 2013: 229-235; Bovet & Parnas, 1993: 579-597) and will be discussed in part 2 of this paper.

aims at something and thus assumes that this something is the way it appears. But this has to prove itself as concordant in the further course of perception. When one perceives an external object like a house, for example, one intends to see a house, while one actually sees only one side of this house. The sides of the house which are not actually perceived are, in Husserl’s terms, not presented, but merely appresented or emptily intended (anticipated), and have to be actualized or verified in later perceptions. Within such a course of perception, all single perceptions or inputs must belong together and be concordant to form the coherent and stable object perception of a house. Here is another example: Consider when initial appearances are subsequently proven wrong, such as when what appeared to be a human being turns out to be a mannequin. Our anticipations have failed since what we currently perceive is not in accordance with our former experience—it is different than what we expected (cf. Husserl, Ms. D 13, XII, 10-11, 100). In this respect, concordance is necessary to establish a stable reference towards an object and to demonstrate continuity and coherence over time (Wehrle, 2015b: 131).

But such deviations or interruptions to the concordant course of perception are nonetheless important and necessary. This experienced “negation” (cf. Husserl 1973) helps to update our automatic anticipations (perceptual beliefs) and thus verifies them in the negative. In such cases of deviation, we feel irritation or surprise. If something that we automatically anticipate in perception does not show up or suddenly vanishes, we feel irritation and experience this anomaly as a deviation from our normal experience. If the current experience is in conflict with the previous one, we have to solve this conflict in favor of one normality (or reality), while the other will be declared an illusion, dream, or exception. Therefore, to remain a concordant course of perception, one has the following options: if it’s just a minor deviation, the perceptual system can ignore it. This effect, that one normalizes one’s perception by automatically ignoring inconsistent inputs and perceives what one accepts or wants to perceive is demonstrated in many psychological studies, such as studies of inattentional or change blindness (cf. Mack & Rock, 1998; Simons & Chabris, 1999; Simons & Resink, 2005). One can treat the respective deviation as a temporary exception and thereby return to one’s former normality, while the respective implicit assumptions (biases) stay in place. In addition, one can retain one’s overall system of normality, but slightly broaden

and adapt it to the new and changing circumstances. With regard to the previous example of the mannequin, one retains the assumption that an object that looks/behaves like *x* is a human being, but adds to it that, under certain circumstances, a supposed *x* could also be a *y*. Finally, one can be forced to overthrow one's normality, reverse it, or establish a new one. For example, when a person suddenly perceives the world as "upside down", they would first experience this as a disturbing deviation. However, if this new experience lasts for a prolonged or indefinite period of time, a new normality would be established.

On a concrete *bodily-practical level*, normality as a concordance of individual experience manifests itself through *habitual and skilled behavior*.³ In the course of a life that is comprised of returning impressions and interactions, one acquires skills, practical knowledge, and habits that help orientate and familiarize a subject with their environment. This is an aspect which Husserl did not explicitly integrate into his approach to normality, but is nonetheless crucial in that it characterizes and shapes the concrete and practical concordance of individual (as well as intersubjective) experience. In this respect, it is worthwhile to turn to Merleau-Ponty's description of the habitual body or body-schema. On a concrete level, all experiences, especially ones that are repeated daily, leave lasting traces. That means they not only generate

³ The conditions of normality as concordance are thereby a normal structure of consciousness with its passive synthesizing processes and, more concretely, a body with normal kinaesthetic functions and abilities. What and how I experience is thereby concretely dependent on my bodily conditions. Every appearance and course of appearances is thereby strictly correlated to the course of various bodily movements (cf. Husserl, 1966: 214-215; Husserl, 2008: 638, 648ff., 662). This rule-governed [*gesetzmäßig*] interrelation between the moving body and the world has to proceed in a stable way in order to guarantee a unified perception. The normal body thereby serves as a bridge between single-subjective and intersubjective systems of appearances (cf. Husserl, 2008: 651). As every human being (at least potentially) has a body with the same physical organization and more or less the same functions, we are able to automatically retrace the perspectives of others. The bodily perspective of the other is as if my body was not here, but there, in the place of the other. For a similar argumentation, see Wehrle (2015b: 132).

specific skills, but moreover form a body-schema⁴ or body-memory⁵ comprised of the sedimentations of the past experiences of an individual. The repeated performance of capacities and skills and the receptive bodily memory together form the habitual foundation for every further activity and perception of the bodily subject. Normality, on this level, is expressed or manifests itself as an “I can” in the Husserlian sense. It is established by the specific abilities of an individual that match or fit with the respective environment and makes a smooth interaction possible.

The habitual aspect of the body thus enables the actual acting body to orient itself within its environment and thereby guarantees a continuity of its movements and experiences. This *habitual style* of experiencing helps us to automatically and self-evidently orient ourselves within our environments and thus establishes a practical normality. This guarantees a stable way of being-in-the-world, on the one hand, and the establishment of a familiar environment, or “lifeworld”, as Husserl would say, on the other. The operative habits with their implicit rules of daily routines can therefore be understood as the inherent practical normativity of experience. Moreover, if we share a common environment with other individuals, we develop similar skills and habitualities as our fellow subjects, which makes it easier to anticipate their behavior in typical situations. Through repeated interaction and shared practices, an intersubjective normality can be concretely established that, in turn, facilitates cooperation and understanding. Here again, habitual normality can fail. This failure of habitual normality is characterized by deviation. Individually,

⁴ Body schema is a term Merleau-Ponty took over from the psychology of his time (cf. Head, 1926; Schilder, 1923; Gelb & Goldstein, 1920) and re-formulated in the spirit of gestalt-theory. In this sense, the body schema is not a mere sum of information regarding different bodily functions (for example tactile and kinaesthetic sensations), but an holistic form of bodily organization in direct reference to its environment: “I hold my body as an indivisible possession and I know the position of each of my limbs through a body schema (*schéma corporel*)” (Merleau-Ponty, 2012: 100-101). Shaun Gallagher defines the body schema in this regard as a “system of processes that constantly regulate posture and movement – a system of motor-sensory capacities that function below the threshold of awareness, and without the necessity of perceptual monitoring” (Gallagher, 2005: 234).

⁵ The concept of the body memory was introduced by Thomas Fuchs. Cf. Fuchs, 2000: 71-89; Fuchs, 2012: 9-22.

habitual normality fails when a certain habit or behavior does not self-evidently lead to the anticipated goal of action. Intersubjectively, habitual normality fails when an individual habit no longer maps on to respective social anticipations and customs. For example, deviations occur when one enters a different culture from the one in which their habits are socialized (cf. Schutz, 1976), or when the respective social customs and their inherent implicit norms (i.e., the intersubjective community as a whole) have changed, while the individual did not. Such experiences can cause deviations either within the individual's course of experience or between the individual and the intersubjective. This can cause a person to be alienated from their own experience since former habits, practical skills, and knowledge are no longer operative, or no longer function in a self-evident and implicit way. Instead, one becomes aware of these habits or anticipations due to their mismatch with the respective situation, and has to compensate with the explicit learning of new skills and habits, that is, adapt to the new circumstances (cf. Dreyfus, 1972). This special awareness caused by deviations is needed in the long run to keep individual or intersubjective concordance, i.e., establish normality.

While the fragility of the current status of normality is necessary for future normality, every abnormality or anomaly can only be defined as a *modification of (current) normality*. According to Husserl, these phenomena can only be defined or even recognized in relation to an overarching framework of normal experience. Normality is therefore a necessary condition for experience, while abnormality is merely a deviation on the basis of normality. A bodily anomaly, like a burned finger, leads to deviant sensory experience and has to be seen in the context of the overall normal experience of the rest of the sensory system. "In comparison to earlier tactile perceptions, the subject experiences those stemming from the burned finger as abnormal" (Wehrle, 2015b: 133). The subjective body thus necessarily has the desire to re-establish a former normality or to create a new normality (through repeated experiences of another kind), otherwise it no longer experiences itself or the world as concordant and evident, i.e., real. Abnormalities or anomalies are, in this sense, modifications of the (previous) normal, or exceptions. For example, a certain unexpected content of experience, or the sudden change of the circumstances of perception, such as a change in the environmental or bodily conditions of vision, exemplify

such modifications (cf. Husserl, 2008: 640; Husserl, 1966: 215). At least, unless they are persistent, in which case one must establish a new normal.

One may ask: Could anything be normal, so long as we get used to it and keep it concordant? No, Husserl would say, because there is a second criteria in play: optimality. Every perception must not only be concordant, but also optimal with regard to the individual’s practical aims and goals in perception and action, and must match with the circumstances of the current environment. While normality in the sense of *concordance* is thus the *condition of coherent experience*, normality as *optimality* serves as the intentional *aim of perception* (Wehrle, 2015b: 134). Thus, normality must not only be constituted, constantly stabilized, or re-established, but can also be improved as perception and knowledge of the world is never complete and can be enhanced, for example, with technology. Husserl differentiates, in this regard, between a relative and an absolute optimum. While the former is relative to the interests and goals of the individual, the latter refers to the ideal of an optimal (clear and distinctive) perception of a thing or world as such (independent of individual interests). The definition of a relative optimum thereby changes with regard to the interests and professions of its perceivers. “What would count as optimal perception for a pedestrian who just passes by a house would not be optimal enough for an architect interested in the way that house is built, or a real estate agent who has to sell the same house” (Wehrle, 2015b: 134-135). Both the relative and absolute optimums call either for subjective conditions or objective circumstances, which allow for the best, that is, the most differentiated and comprehensive perception of an object. In this sense, one could probably adapt to perceive the world “upside down”, but it is debatable in what sense this would practically be the best possible way to execute one’s actions, or for human beings to perceive and relate to the world in general, regarding their upright position and bodily constitution. Another problem comes into play when one’s perception of the world radically differs from everyone else’s, either all of a sudden or because one is, for example, blind from birth. This might well be experienced as concordant from an individual perspective, but would deviate from an intersubjective concordance and an intersubjectively defined optimality.

b) Intersubjective concordance and optimality

For the constitution of a common world or nature as a basis for joint action and communication, it is necessary to have an inventory of normal bodies [*Bestand an normalen Leibern*], that is, bodies which are functioning in an ortho-aesthetic way (Husserl, Ms. D 13 XII, 90; Wehrle, 2015b: 133). The experience of the blind “deviates in a consistent way from the proven or true world of experience of others” (Husserl, 2008: 657), as Husserl argues. In the same way, Husserl discusses frequent cases of abnormal perceptions as borderline cases; he counts the experience of blind people, “mad” people, children, and animals among these cases. The experience of the blind person is not only discordant with the average perception of a community of subjects. Rather, there is a qualitative argument hidden here, as Husserl argues that the blind person must submit to mainstream intersubjective knowledge because “the better truth, the better law is to be found on the side of the normal human community” (Husserl, 2008: 657)⁶.

Normal bodily as well as mental constitutions and functions (i.e., those that are shared by most) are in this sense the measure for a common experience of the world, which, in turn, serves as a basis for action and communication. In this regard, Husserl would interpret the experience of, for example, a blind subject as “abnormal” only insofar it “deviates in a consistent way from the proven or true world of the experience of others.”⁷ While from an individual level the experience of a blind person is as concordant and stable as that of a

⁶ Perception, especially in the realm of intersubjectivity and science, tends towards a *general optimum*, a normative goal of an adequate perception. For this, a normal bodily constitution is a prerequisite: Husserl speaks in this sense of a “biophysical optimum” or even an “organic teleology” (Husserl, Ms. D13 XIV, 13). The blind person’s perception is in this sense poorer, “his vision is less differentiated, blurred etc. than the normal perceiver’s and both of them know this” (Husserl, 2008: 658).

⁷ Husserl, 2008: 657. In the same way, Husserl discusses constant cases of abnormal perceptions as borderline cases. In fact, he counts the experience of blind people, mad people, children, and animals among these cases. These groups of living creatures are thus excluded from the intersubjective sense-constitution of the world. For a more detailed discussion of Husserl’s transcendental argument, see Heinämaa, 2013.

seeing person, it is discordant with the average perception of a community of (seeing) subjects. Even more importantly, it is discordant with optimal perception as an epistemic norm, which calls for the right subjective-bodily conditions and abilities (free movement, perceptual quality, etc.), as well as for the best “objective” circumstances (such as lighting conditions and perceptual distance). Normality is therefore not only to be defined as intersubjective concordance, but follows, at the same time, the scale of an optimal perception of the world. Thus, while one can imagine an entirely colour-blind population (cf. Husserl, Ms. D 13 XIV, 31), Husserl assumes, upon meeting a population of people who can see colour, the colour-blind population would acknowledge that perception with color is better suited for a differentiated and true perception of the world.⁸ Husserl strongly believes that every perception is teleologically oriented not only towards a relative but also towards an absolute optimum, i.e., an adequate perception.⁹ However, most concrete, intersubjective optima, as well as individual optima, are relative with regard to environmental, and thus also social and cultural, circumstances. While individual optima are relative with respect to the subject’s current actions, interests, or habitual style of experiences, relative optima on an intersubjective level are based on common interests, needs, and goals of action on the one side and on a culturally formed style of experiencing on the other.

Normality, one can conclude, is the result of an ordering or synthesizing process within experience that has a normal structure of consciousness as well as a normal constitution of the body as its conditions. A totally non-normal or

⁸ For a critical discussion of the ethical dubiousness of Husserl’s ideal of an absolute optimum – as an adequate perception or a rational striving towards an ever more clear and distinct perception (stemming from the rational influence of Descartes) - cf. Heinämaa, 2013; Wehrle, 2010.

⁹ Leaving the problem aside of whether such an objective measure of optimality is even possible and if so, how we could be able to decide what is objectively optimal, one can opt for a less rationalistic interpretation and try to understand objective optimality anthropologically, i.e., with regard to the best possible existence of an organism within a respective environment (cf. Canguilhem, 1991). In this sense there is no optimality as such, as there is no health or sickness as such (see also Jaspers, 1973), but only better or worse conditions of life for respective living creatures that are not indifferent to these conditions.

unordered experience is, at least for Husserl, not imaginable since, as the name suggests, everything that is abnormal can only be grasped and defined as a deviation from or modification of the normal condition. The normal must therefore always already be presupposed. Nonetheless, and here the paradox of every investigation of the normal comes to the fore, this very deviation must come first if the experiencing subject wants to become aware of or investigate normality as such. Normality, even though a presupposition for every coherent or meaningful experience, can only be experienced in retrospect and implicitly through a deviation, interruption, break, or the disappointment of an anticipation. Every time Husserl concretely describes normality, he must therefore turn to its deviations and modifications. This is where psychopathology comes into play, since only through an observation of the abnormal can we explain the normal (Jaspers, 1973: 49). Normality and its underlying implicit norms are only recognized as such “when they are broken”, for “functions are revealed only when they fail”, as Canguilhem emphasized. Although such deviations or failures already imply a certain normality that was already at play, this normality together with its “immanent norms”, as Elisabetta Basso defines them (Basso, 2012: 168, 169)¹⁰, “rises to the consciousness and science of itself only through maladaptation, failure and pain” (Canguilhem 1991, 209). Indeed, the phenomena of disease or psychological illness is a constant provocation for a phenomenology which is oriented around the paradigm of normality (cf. Luft, 2008: 49). However, this paradox can only come into view through a phenomenological description (cf. Jaspers, 1973).

¹⁰ Immanent norms are thereby inscribed in experiences and function as internal rules that guide experience, and are also constituted and retained within experience, i.e., through repeated interactions with the environment that results in skills or habits, such as in the acquirement of new motoric and perceptual sense/meaning. Basso explains this with a citation by Merleau-Ponty, who states that there is no external unfolding or pre-existing reason or norm to begin with, and there is no external condition of a norm, but only “the birth of a norm” within the interaction of the bodily subject and the world. Cf. Basso, 2012: 168f; cf. Merleau-Ponty, 2012: 62.

3. Psychopathological disturbances of normality

I will now show how a revisited Husserlian account of normality can be fruitfully applied to the diagnosis or explanation of psychopathological experiences. Based on the genetic schema of normality developed above, one can differentiate between disturbances of normality on the most fundamental passive-receptive stages (temporal concordance), object perception, and practical and habitual behavior, as well as interests and beliefs (although the latter is not the topic of this paper). These genetic levels are thereby not to be considered as completely separate or distinct, but are “normally” intertwined and influence each other respectively. Nonetheless, the more genetically fundamental the disturbances are, the more they will influence the other levels of normal experience. While disturbances at the level of dis-concordant or deviating beliefs can leave the underlying workings of temporal experience intact, the converse would probably not be the case. Furthermore, such disturbances have consequences for both individual and intersubjective normality. While an individual concordance can still be established within some pathologies (although with much explicit and reflective effort), they radically deviate from intersubjective normality, i.e., what most people perceive, do, and believe, and thus result in social isolation. In this sense, one could also ask where the disturbances originate: does a social disturbance lead to more fundamental fragmentations of experience? Or is a dis-concordance of temporal experience at the heart of most “higher-order” disturbances of normality?

In what follows, I will not be able to settle or even adequately address these questions, but rather try to review and classify pathological findings in the light of such an account of normality. Concretely, I will discuss research in psychopathology which traces major symptoms of schizophrenia and depression back to fundamental disturbances of temporal organization and experience. I will argue, in this regard, that one can use Husserl’s criteria of concordance and optimality to descriptively differentiate between the respective disturbances: While schizophrenia is primarily characterized by a disruption of the fundamental temporal concordance (which has consequences

for the other levels of normality, including the deviation from intersubjective normality), the symptoms of depression can best be explained by a lack of the inherent aim of behavior and perception, that is, its tendency towards optimality.

However, in order to explain the respective phenomena properly, I will have to once again revisit or broaden Husserl's account of normality. In doing so, I will connect his notion of optimality to his genetic account of an operative-bodily or drive intentionality that expresses itself as a striving or tendency (cf. Husserl 1973, Husserl 1966; Wehrle 2015a), and illustrate this with Merleau-Ponty's description of a bodily intentionality, i.e., his notion of the intentional arc.

a) Schizophrenia as disturbance of “concordance”

Along with current research in phenomenological psychopathology (cf. Fuchs, 2013; Maiese 2018; cf. Gallagher, 2015; Bovet & Parnas, 1993: 584), one can argue that symptoms of schizophrenia are best described as disturbances of the concordant temporal organization of experiences. Several well-documented symptoms of this pathological condition, like movement disorders involving a lack of self-monitoring, forward-monitoring, or preparatory movements, or cognitive disorders such as unwanted, disconnected, or inserted thoughts or hallucinations, are characterized by a lack of agency (Gallagher, 2005: 174f.). The respective patients, for example, report that their movements are caused or even made by someone or something else (cf. Frith, 1992: 66), or that their thoughts are not intended but externally inserted. Such a lack of agency in bodily as well as cognitive domains can be explained by an underlying interruption of the “constitutive synthesis of time consciousness” (cf. Fuchs, 2013: 75) or, more specifically, the breakdown of the protentional or anticipatory function.

To guarantee a sense that movements as well as thoughts are generated or intended by oneself, they have not only to be connected retrospectively with previous movements or thoughts but within the experience of a melody or a movement in which the next tone or movement must proactively be anticipated or aimed at. The incoming impressions, according to Husserl, are thus embedded in a temporal field of retention-impression and protention.

Impressions are thus not only continuously modified into a retention and integrated into the continuum of retentions. In addition, on this basis of retentions or former experience, we already await the upcoming impression and thus anticipate it. This could be just a formal and vague awaiting or protentional tendency in the sense that something is about to come, or a rather a specific anticipation more determinate in content. When we, for example, actually perceive the front side of a house, we anticipate to see a back side that is, in its shape, color, and design, similar to the front side. When we then instead see no real back side because the supposed house was just a part of film scenery, the anticipation or intention is disappointed. Nonetheless, the underlying protentional structure is intact (i.e., that there is something about to see), while it is just the content of the respective anticipation which does not match with previous perceptions. When, however, the formal protentional structure as such has broken down, and thus the overarching *continuity and concordance*, every new input is experienced as sudden, surprising, overwhelming, and even penetrating, in that it bears no connection to our former experience.

Thoughts, for example, would appear to come from nowhere, although they appear in my stream of experience. One would be able to make sense of them only in retrospect, but not as something self-generated. As Gallagher explains, “Protention normally puts me in the forefront of my thoughts and allows me to take them up as my own product, as they develop. Lacking protention, thoughts would seem to impose themselves on me” (Gallagher, 2005: 194). The same holds true for actions and movements. In an experiment where the EEG signals with regard to self-generated vs. externally generated tones were measured (Frith & Done, 1988; Shafer & Marcus, 1973; Posada et al., 2001), in contrast to normal participants, schizophrenic patients showed no significant difference in response. The schizophrenic patients did not expect the tone, even when they generated it themselves.¹¹ This is in line with observations from earlier phenomenological psychopathologists like Minkowski, who described behavior of schizophrenic patients as characterized by “fixed acts”,

¹¹ In the same sense, it is reported that respective patients show difficulties in planning and initiating action (Levin, 1984), voluntary movement (Singh et al, 1992), temporal organization (DePue, Dubicki & McCarthy, 1975), and self-temporalization (Bovet & Parnas, 1993).

“purposeless acts”, and “acts that have no concern for tomorrow” (Minkowski, 1933; cf. Gallagher, 2005: 196).

To explain the disruption of the protentional function in its concrete form, one can turn to Merleau-Ponty and his descriptions of the *intentional arc*, which constitutes the continuity of lived time (cf. Merleau-Ponty, 2012: 137f.). Merleau-Ponty thereby takes Husserl’s theory of inner time consciousness as a starting point, but ties it not to consciousness but to concrete bodily movements and interactions with the world. Thus, according to Merleau-Ponty, temporal constitution concretely takes place in the lived body’s actual performance of movements, which integrate, in turn, the dimensions of past, present, and future by means of an intentional arc. In this regard, bodily movement always points beyond itself, spatially and temporally. While engaged in a bodily movement, we are “here”, but also already “there”; that is to say, we are already anticipating the thing or action that drives our intentional project of activity. This inherent temporality of bodily intentionality is illustrated by the gesture of pointing: “The gesture of reaching one’s hand out toward an object contains a reference to this object, not as a representation, but as this highly determinate thing toward which we are thrown, next to which we are through anticipation, and which we haunt” (Merleau-Ponty, 2012: 140).

In schizophrenic patients, the passive temporal synthesis is disturbed, which results in a fragmentation of experience¹². This would, for example, explain why patients struggle to follow a conversation or focus on a train of thought as they no longer experience them as coherent and meaningful wholes: temporal

¹² This implies not only a disturbance in external perception, movement, and thinking, but also with regard to the normal or concordant relation to one’s self. Temporal experience and organization is, in this sense, tied to the lived body and implies a pre-reflective self-awareness, as Zahavi argues (cf. Zahavi, 2003: 2018). Disturbances within these passive stages of normality thus lead not only to a fragmentation of hetero experience but also of (bodily) self-experience (Zahavi & Parnas, 1998; Legrand, 2006). In hearing a melody, I do not only hear concordant tones, but I am immediately affected (cf. Depraz, 1994: 75) and thus experience them as heard by me: “The tone is not only given as having-just-been, but as having-just-been experienced [by someone, auth. amendment]” (Zahavi, 2003: 172). In this regard, schizophrenic patients do not only feel alienated by their actions and thoughts, but also from their affects, body, and skin (cf. Gallagher, 2005: 204).

gaps occur and there is an inability to anticipate what comes next (as in a melody or conversation), and this renders the occurrence of events too rapid, causing the patients to feel overwhelmed and even intruded upon by external events or their own thoughts. With a disturbance of the intentional arc, which is the overarching temporal synthesis that allows for concordance, one loses the ability to actively direct one’s actions towards the future: one is stuck in that-which-has-just-passed. Most patients thus have to focus on what *just* occurred, i.e., the sensory feedback of one’s just-passed movement (cf. Fuchs, 2013: 86). That is the reason why experiences no longer feel as if they were one’s own. One could say that consciousness, or one’s bodily self, is continually surprised by itself, and that is why schizophrenics often experience their own movements as controlled by others or their own thoughts as if inserted or manipulated from without (Wehrle, 2018).

Protentional disturbances thus lead to a “disintegration and alienation of routine units of activity”, and this forces patients, in turn, to produce “every single movement intentionally: the body’s implicit knowledge has been lost, and its place taken by ‘hyper-reflexive’ self-observation and self-control” (Fuchs, 2013: 90). The lacking concordance in the passive organization of reception thus also results in a lack of general optimality. Upcoming impressions are not only dis-concordant with previous experience, but the whole structure of experience and action lacks the connection to an inherent optimum. As a result, one is no longer able to aim or strive at something, perception is no longer self-induced but is surprised and thus always comes too late, and one can no longer act but is doomed to react. This results in a radical break in one’s affective attunement to the world which must be overcompensated with explicit, that is, intellectual, aspects.

The immanent fragility of normality here turns radical and becomes threatening: as it cannot be passively constituted, retained, or adapted, patients have to try to explicitly establish a second-order normality in order to regain an overall concordance and keep control over their experience. In schizophrenic patients, this mode of explicit temporal experience, self-relation, and behavior tries to compensate for the lost temporal, perceptual, and bodily concordance. But this attempt is doomed to fail because this “new normality” cannot be termed as such, since it lacks the sense of usualness, effortlessness, and self-evidence which is characteristic of every normality. Furthermore, this intensive

engagement in creating a concordance and a narrative for one's life hinders one from spontaneously acting and being open to future possibilities. Thus, the prize of gaining a concordant narrative is the loss of a self-set aim or optimum in experience. Moreover, such a constructed, hyperreflective, and narrative normality deviates on several levels with intersubjective normality and thus leads to social disturbances or the social isolation of the respective patients.

b) Depression as a disturbance of “optimality”

While schizophrenia could be phenomenologically described as a major disturbance of the criteria of concordance at the lowest genetic level (the passive-receptive stage of normality), in depression, this formal concordance in temporal experience seems to remain intact. Depressive patients have, in this regard, no fundamental disturbances in movement: they have no problems with initiating, observing, or planning movements. Nor do depressive patients have disturbances in temporal experience as such, i.e., in following their own stream of thoughts or an external conversation. The observed symptoms in depressive disorders are rather characterized as “lack of motivation”, including the loss of libido, appetite, or drive, or a sense of hopelessness or pointlessness (cf. Smith, 2013: 615). In contrast to schizophrenic patients, it is not the unexpected intrusion of the future into their present which leaves depressive patients paralyzed, but rather the lack of forward-looking or protentional striving. In this sense, one could argue that both are trapped in the present or cut off from the future, but in very different ways.¹³

Fuchs and Maiese argue in this regard that depression can also be understood by a disturbance of the protentional factor of temporal organization or implicit time, as Fuchs defines it (cf. Fuchs, 2013; Maiese, 2018).¹⁴ Fuchs

¹³ Cf. Maiese argues that depressive patients are stuck or trapped in the present. I would argue in this regard that while schizophrenic patients are violently trapped, depressive patients suffer from a stagnation and thus get stuck. Cf. Maiese, 2018.

¹⁴ Depression can thus not be primarily characterized by a feeling or an affective relation of guilt (cf. Ratcliffe, 2010), or a lack of (social) care, as Maiese points out, because the first explanation differs within cultures, while the later has to be regarded

thereby differentiates between two components of the pre-reflective experience of lived time, namely synthesis and conation. The latter is described by Fuchs as a vital or affective force. While synthesis is affected for patients of schizophrenia, depressive patients suffer from a weakened conation. Fuchs uses Merleau-Ponty’s notion of the intentional arc to illustrate this difference: while the arc is disrupted or breaks down entirely in the case of schizophrenia, the arc becomes lame or loses its tension in the case of depression. Applying our scheme of normality, one could argue that the first case can primarily be characterized by a lack of concordance, while the latter can be characterized by the lack of an inherent reference to an optimum.

In this sense, we have to revisit and broaden Husserl’s account of normality with regard to his criteria of an optimum. Connecting this notion with Husserl’s genetic phenomenology, we can understand optimality primarily as a forward looking, bodily, and practical striving towards the world and things that is informed and motivated by our needs, interests, and desires. In this regard, we do not merely perceive things, but are involved with them and concerned by them, i.e., they are significant and practically important to us. Only secondarily, on the level of object perception, can an optimum be understood as representing determinate or objective features of an object. Moreover, if normality relies on an inherent striving for optimality, this means that the experiencing subject or organism is not indifferent to their conditions and thus is inherently normative, as Canguilhem emphasized, while the respective normal experience is necessarily not only concordant but also selective in character¹⁵.

merely as a consequence of the disturbance of protentional function, and is thus a secondary phenomenon (cf. Maiese, 2018: 707f.).

¹⁵ Even on the lowest levels of perceptual organization, there has to be a selective structuring of the field of experience: a differentiation between the horizon and a focus or theme of perceptions, as well as between foreground and background consciousness. Perception, in this sense, is never neutral but selective from the start. One can find empirical support for this selectivity in research on inattentional and change blindness. In experimental conditions where we should see something prominent like a woman dressed up as a gorilla in the middle of our visual field, subjects just do not see it, because they are involved in counting the passes of the basketball players. So, from a third-person perspective, this perception is highly selective and even exclusionary, but from the first-person-perspective of the perceiver it is concordant with their current

To guarantee a normal, that is, a coherent and meaningful, experience, concordance is thus not enough, but needs an inherent motivation and openness towards future possibilities, i.e., a striving for an optimum. The criteria of optimality can thus be concretely understood as a bodily and affective intentionality (cf. Slaby, 2008) or striving with a forward looking motivational structure (cf. Thompson, 2007: 362) or “teleological direction” (Ratcliffe, 2012: 122), i.e., an inherent openness to the future.

Such an affectively framed “forward looking trajectory” (cf. Maiese, 2018), striving, tendency, or openness to future possibilities is precisely what is lacking in patients with depression, according to Fuchs and Maiese. Depression as a long-term affective condition or “deep emotion” (cf. Ratcliffe, 2010) thereby shapes the overall way we are related to the world, what kind of significances we are receptive to, and what matters to us. Without a striving towards an intended or imagined future, a concrete aiming towards things that we regard as significant (over others), everything seems equally relevant or irrelevant. As the early phenomenological psychiatrist Minkowski would describe it, “It is the orientation of our life toward the future which gives it a meaning, a direction; when this orientation is missing, everything seems to amount to the same thing, seems stupid, without rhyme or reason” (Minkowski, 1970: 303). When one’s future is in this sense blocked, one finds oneself stuck in the past, i.e., in stagnation. This is often accompanied with boredom (Ratcliffe, 2010: 611), or a sense of hopelessness or pointlessness (Jacobs et al., 2014). In this regard, as Maiese points out, it is not that patients merely cease to hope, but rather that they lose the ability to imagine a concrete future (content-wise) and, as a result, fail to imagine what they would do or how they would feel at a specific point or situation in their future (Maiese, 2018: 710; McKenzie, 2000: 126). One could say that, in depression, one is nostalgically related to a meaningful past instead of a meaningful future, but this does not seem to be correct. When we lack concrete interests, desires, or needs with respect to the future, there are, in turn, no salient future possibilities or

actions and interest. They focus on what is relevant for their task and a gorilla falls outside of this as long as she is not able to play basketball (cf. Simons and Resink, 2005).

significant events. Speaking with Merleau-Ponty, one could say that if the intentional arc loses its tension, this affects the whole temporal experience and not only one’s relation to the future. Concretely, which past seems relevant to us or how events matter to us always “depends heavily on the ways we are heading” (Ratcliffe, 2012: 129).

Such a lack of concrete future directedness, which necessarily implies an inherent relation to practical aims or optima, in turn, leads to a dominance of habitual patterns of behavior. In normal experience, habit enables normality in the sense of concordance, such that it generates familiarity and orientation. However, in depressive states, the constraining aspects of habit become predominant. While “normal” habit or the habitual body, as Merleau-Ponty has shown, can be regarded as creative in that it establishes a new motoric meaning or skill (cf. Merleau-Ponty, 2012: 143f.) that can be applied in various contexts and remains flexible and open to new circumstances, habitual behavior in depressive patients is limited to routine responses and severely limits any flexible and spontaneous responses to the environment. Under normal conditions, we develop a habitual style of experience according to past experiences, which provides the basis for our selective and affective relation to the world and thus motivates future experiences and helps make them significant. In depression, however, habit loses this function.

In the same sense that the past loses its meaning when it is no longer affectively connected to the future, habit loses its motivating function when disconnected from current desires, actions, or future plans. Motor behavior is thus merely drawn to certain patterns within the environment (cf. Juarrero, 1999: 153f.), mental dispositions fixate on the negative, and the behavior of devaluing oneself, as well as habitual affective responses like alienation, grief, or anxiety, (Jacobs et al., 2014: 100ff.) seem fixed. These states do not flexibly adapt and can no longer be willingly changed.

This conative disturbance of the protentional structure, or the lack of an inherent optimum or normativity, not only has consequences for individual normality but also manifests as a deviation from intersubjective normality. With respect to temporal experience, Fuchs argues that, under normal conditions, the temporalities of individual living and operating bodies are synchronized into an “intersubjective now” (Fuchs, 2013: 82), and thus into intercorporeal resonance. Because of the lack of the inherent protentional

striving, however, depressive subjects get desynchronized from the external world and from others. A commonly observed form of comportment in patients with depressive disorder is that they move slowly (Jacobs et al., 2014: 99) and experience their bodies as heavy, static, and even as a burden (cf. Fuchs, 2013: 96). From this follows a “temporal mismatch” between their individual course of time and those of the outer world. Time is thus explicitly experienced as a “loss of simultaneity” (Fuchs, 2013: 83). The patients feel as if they are “falling or lagging behind” (Fuchs, 2013: 94) as they are literally out of tune and thus no longer able to participate in social life and intersubjective interactions.

4. Conclusion

As I have tried to show, fragility, or inherent instability, is an essential aspect of every normality. Deviations, interruptions, or irritations of the current status of normality are thus necessary for constituting or establishing a future normality, i.e., to make normality sustainable and open for change and adaptation. While abnormalities or anomalies can only be defined as a modification of (current) normality, research on normality is likewise heavily dependent on this inherent fragility, since we can only grasp or become aware of normality through an experience of this very deviation. This is why we need psychopathology in order to be able to define or classify what is normal, as Merleau-Ponty famously emphasized, among many others.

But this observation seems rather cynical when we turn to the subjects or patients who actually suffer from pathological experiences. In the concrete context of psychopathology, the fragility of normality is an existential risk or problem. Normality, from the first-person perspective of experiencing patients or subjects, is something that is desired and needed, and the loss of which causes suffering. Normalization, i.e., the implicit or explicit process of constituting normality within individual and intersubjective experience, is in this regard necessary and needed, i.e. having “too little” normality thus seems to be an existential problem and risk.

But if we now change perspectives and take a critical stance from without, as for example in a critical discursive or social genealogy like that of Michel Foucault, the situation radically changes. When normality is investigated as a discursive historical term that expresses the dominant forms of power, it is not

something established within experience, but rather the result of a process of an external normalization according to dominant social or discursive norms. Along these norms—or even normality in the form of a measured average that functions as a norm—individual behavior is evaluated, classified, disciplined, conformed, or optimized, i.e., made normal. For example, in current neoliberal societies where subjects have internalized the norms and ideals of progress and success, we are happy to normalize and optimize ourselves to not fall or lag behind in the competitive race of private, economic success and recognition (cf. Oksala, 2016). In this sense, everything that is different or deviates from the dominant norm is either sanctioned or—when it cannot be normalized—excluded, and thus considered pathological.

In his early work, Michel Foucault described how the concept of modern rationality (as normality) necessarily depends, in its definition as well as its stability, on its excluded counterpart: madness (cf. Foucault, 2006). In this sense, he unmasked the fragility of normality in showing the immense effort and creativity humans invested at different times to hide and overcompensate by means of defining, classifying, fixating, producing, and separating the normal from the pathological. In his later works, Foucault analyzed different practices of normalization as respective strategies of modern power, namely discipline, biopolitics, and governmentality (cf. Foucault, 1991a; 2006; 1980; 1991b). From such a historical and power-sensitive perspective, the risk or problem would not be too little but rather “too much (or a too stable) normality”.

In this regard, the fragility of normality could be understood as the “crack that is in everything”, a little space where “the light gets in”¹⁶, i.e., a chance for freedom. While the fragility of normality always bears the risk of fragmentation, alienation, and pathology, this might also be the reason why experience can never be completely normalized or made to conform, thereby leaving space for new, different, and deviant experiences. In this regard, we must be affectively open for the pathological experiences of others, which are not so different from our normal ones, but perhaps just a radicalization of our

¹⁶ See Leonard Cohen’s song “Anthem”: “There is a crack in everything, that how the light gets in.”

already-inherent tendencies. Indeed, this offers the possibility to accept our inherent fragility and vulnerability, to admit that this could happen to us as well, and that normality is always just a breath away from disruption. We must therefore listen to the voices and experiences of those who deviate from what we are used to, not only because we need them to define what normality amounts to, but also to adjust and broaden our scope of normality, and to create a livable and shared normality for the future.

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