



## **Clinical manifestations of self-disorders and the Gestalt of schizophrenia**

Henriksen, Mads Gram; Parnas, Josef

*Published in:*  
Schizophrenia Bulletin

*DOI:*  
[10.1093/schbul/sbs033](https://doi.org/10.1093/schbul/sbs033)

*Publication date:*  
2012

*Document version*  
Publisher's PDF, also known as Version of record

*Citation for published version (APA):*  
Henriksen, M. G., & Parnas, J. (2012). Clinical manifestations of self-disorders and the Gestalt of schizophrenia. *Schizophrenia Bulletin*, Vol. 38(4), 657-660. <https://doi.org/10.1093/schbul/sbs033>

## Clinical Manifestations of Self-disorders and the Gestalt of Schizophrenia

Mads Gram Henriksen<sup>\*,1,2</sup> and Josef Parnas<sup>1,2</sup>

<sup>1</sup>Danish National Research Foundation: Center for Subjectivity Research, University of Copenhagen, Njalsgade 140-142, 25.5.23, DK-2300 Copenhagen S, Denmark; <sup>2</sup>Psychiatric Center Hvidovre, University of Copenhagen, Denmark

\*To whom correspondence should be addressed; tel: +45-3532-8694, fax: +45-3532-8681, e-mail: mgh@hum.ku.dk

**Anomalies of self-experience (self-disorders) constitute crucial phenotypes of the schizophrenia spectrum. The following qualitative study demonstrates a variety of these core experiential anomalies. From a sample of 36 first-admitted patients, all of whom underwent a comprehensive psychiatric evaluation, including the EASE scale (Examination of Anomalous Self-Experience), 2 schizophrenia patients were selected for detailed psychopathological presentation and discussion. The vignettes provide prototypical examples of what has been termed self-disorders in schizophrenia, ie, pervasive and enduring (mainly) trait phenomena which constitute essential aspects of the spectrum.**

*Key words:* schizophrenia/self/clinical core/experiential anomalies

### Introduction

Anomalies of self-experience (ie, self-disorders) have been studied as potential schizophrenia spectrum vulnerability phenotypes.<sup>1,2</sup> Although self-disorders were considered by many classical psychiatrists as intrinsic features of the clinical picture of schizophrenia (eg, Kraepelin, Bleuler, Berze, Jaspers, and Schneider), the prominence of self-disorders and their potential significance has disappeared from the current definitions of schizophrenia.<sup>3,4</sup> Certain nonpsychotic anomalies of self-experience have been described as the so-called “basic symptoms,”<sup>5–7</sup> but self-disorders were only recently rediscovered in a Danish study of first-admitted schizophrenia spectrum patients<sup>8</sup> and a similar study conducted in Norway.<sup>9</sup> A novel psychometric instrument (Examination of Anomalous Self-Experience [EASE]), descriptively articulating prototypical examples of single self-disorders<sup>10</sup> aids clinicians’ inquiries into these pervasive, enduring, and often alarming experiential disturbances.

Recent empirical studies demonstrate that self-disorders aggregate selectively in schizophrenia and schizotypy<sup>11,12</sup>

but not in bipolar disorder.<sup>13,14</sup> They occur in genetically high-risk individuals<sup>15</sup> and have been found to be predictive of incident cases of schizophrenia spectrum disorders in a 5 years follow-up of 155 first-admitted patients.<sup>16</sup>

The aim of this qualitative study is to illustrate manifestations of self-disorders and how they are similar to and different from other signs and symptoms of schizophrenia. We will present 2 illustrative patient vignettes and attempt to familiarize the readers with concrete examples of the experiential life of schizophrenia patients.

### Methods

The overall sample consisted of 36 first-admitted patients to Psychiatric Centre Hvidovre (a hospital serving the city of Copenhagen, with a catchment area of approximately 150 000 inhabitants) between May 2004 and September 2005. Patients with organic brain disorders or severe substance abuse as a primary or clinically dominating comorbidity were not included. Aggressive or involuntarily admitted patients were not included due to ethical concerns or because they were unable to undergo the full examination. The patients underwent a comprehensive semistructured psychiatric interview, eliciting social and psychopathological information, performed by a senior clinician (Dr Jørgen Thalbitzer, a coauthor of the EASE scale; for study details, see Raballo and Parnas<sup>17</sup>). The duration of the interview was between 1.5 and 3–4 h. The interview comprised a detailed psychosocial history, illness evolution, the OPCRIT,<sup>18</sup> the SCAN,<sup>19</sup> and elements of the PANSS.<sup>20</sup>

A cornerstone to the evaluation was the EASE scale.<sup>10</sup> It covers 5 domains of thematically grouped experiences: (1) cognition and stream of consciousness, (2) self-awareness and sense of presence, (3) bodily experiences, (4) demarcation, and (5) existential reorientation. Among experienced and trained psychiatrists, the reliability of EASE has been shown to be good–excellent.<sup>21,22</sup> The patients provided written informed consent and the relevant medical ethics committee approved the study.

The research diagnosis followed ICD-10 research criteria: 19 patients with schizophrenia (mean EASE score = 21.4), 8 patients with schizotypal disorder (mean EASE score = 17.0), and 9 patients outside the schizophrenia spectrum (mean EASE score = 5.7). The difference between the spectrum and nonspectrum group was significant (Welch's  $F = 16.899$ ,  $P < .001$ ).<sup>17</sup> Two patients with clearly manifest self-disorders and ability to provide detailed descriptions of their experiences were selected for presentation and discussion. Their EASE scores were significantly higher than that of the entire spectrum group. A description of their flamboyant psychotic symptoms is left out of this account. Here, we focus on nonpsychotic anomalies of self-experience. Biographical details have been modified to protect the patients' anonymity.

## Results

The following vignettes contain prototypical examples of self-disorders in schizophrenia. Not all reported self-disorders are included; rather, the focus is on those dominating the clinical picture and causing significant distress.

### Case 1

Jane, 22 (EASE score = 40), currently unemployed, is in a relationship and has a child. She is untrained and has had changing jobs, which she has been unable to keep. In particular, jobs that require working with many colleagues have proven difficult for her. She was admitted because of increasing isolation, suicidal ideation, and self-harm. During the previous 18 months, she felt an inexplicable sadness and did not want to live anymore. She felt empty, unable to feel anything, and everything seemed meaningless. Already from the age of 4 she felt profoundly different from others. She rarely played with other children, since they made her nervous and insecure, and she never invited them home because their presence was felt as deeply intrusive—"they would come too close to me." At puberty, her feelings of being different intensified and she felt as if she was an extraterrestrial. She often withdrew to her room, and the frustration and anger of not being able to be around others led to episodes of self-harm and suicide-attempts.

She stated that she had no idea who she was (I am like a puzzle with a piece missing). She described persistent experiences of not being fully present in the world and of a diminished transparency of consciousness: "It feels as if I am sleeping with my eyes open. It feels unreal as if everything happens in slow-motion." She feels that she does not truly perceive the world and that she is not really a part of it—as if there is a veil between her and the world outside. Frequently, she experiences the world as strange or meaningless. Objects may acquire an intrusive quality, in particular portrait photographs, which she always feels are watching her. She described alterations of

the first-person perspective, eg, she has the impression of perceiving everything "through" her head, "from a point located at the back of my head, as if my eyes were placed there."

The patient's most incessant complaint was that interpersonal contact is unbearable. This social anxiety seems associated with her ongoing experience of not knowing who she is and not feeling truly present (existing) in the shared world. Rather than being smoothly participating, she perceives worldly activities from afar (as a train rushing by). This felt distance includes a decreased ability to be affected and touched by others, as well as a diminished capacity to act. She feels that she is "not truly noticed or heard" by others, and this, she claims, is the true source of her loneliness. The distance she experiences toward the world may be accompanied by an altered visual perspective: "It's as if I shrink or the room I'm in enlarges and the distance to the walls increases." Moreover, she has the impression as if she is the only one who really exists and is "responsible for the world moving on." She manifests a sense of superiority over her fellow humans, eg, she perceives others as "robot-like," "empty shells," or "extras" in her life, and she finds it nearly impossible to image that they actually have a life of their own. She also has the impression as if her own experiential field is all that exists (If I perceive a door and then look away, then it's almost as if the door ceases to exist). These quasi-solipsistic experiences reflect her feeling of being a unique subject in the world, but as often seen in cases of schizophrenia, this feeling of solipsistic grandiosity is both fragile and paradoxical.<sup>23</sup> Although she regards herself as superior to others, she has simultaneously no idea who she herself is (I might as well have been a dog). She feels alienated from her body and finds it disconnected from her mind. Finally, she reports enduring problems in the sense of personal demarcation and privacy of thoughts, as if the others can see through her (they can see all my horrible thoughts and they know everything about me).

Moreover, Jane has perceptual disturbances, visual and auditory hallucinations, and persistent persecutory delusions. She is diagnosed with paranoid schizophrenia.

### Case 2

Peter, 18 (EASE score = 37), is a high school dropout, working part-time as a phone salesman and living with a roommate. Throughout his life he has had only one friend at a time. He was admitted because of suicidal ideation. He describes a sense of inner change occurring around puberty, accompanied by an awareness of being radically different: "I feel like I don't belong here, like there is no place for me among others." He has feelings of not being fully present: "It's as if I'm inside a glass dome"; "I don't truly feel the world, because I don't feel anything inside." Most of the time, he feels "as if sleepwalking": "everything seems so far away as if there

is an invisible wall I cannot penetrate.” He refers to his world as a “dream world” and himself as a “zombie,” “a shell devoid of emotions.” He describes an inner division (I-split), in which 2 parts are fighting for domination, pulling in opposite directions: a good, cheerful part, sensitive to beauty, and a bad part, filled with anger, resentment, and sadness. This sense of I-split undermines his fragile sense of identity (I feel like my body is housing an ongoing power-struggle. There is something alien about it. I don’t feel present at all). When dominated by thoughts of his bad part, everything becomes meaningless (it’s unimportant to take a shower because nothing matters anymore) and then he has to reflect intensely in order to arrive at some meaning (seeing something outside my window, I must say to myself ‘now that’s beautiful’, otherwise it’s meaningless).

The patient’s experiences are permeated by I-split and a diminished sense of existing as an embodied subject fully present to the world (I live in my own universe). This lack of immersion and a failing sense of self-presence are associated with multiple cognitive disturbances: uncontrollable, unconnected thoughts, usually with trivial or neutral content, interfere with his main line of thinking. He experiences how these thoughts almost physically enter one side of his head and exit the other. He hears his thoughts spoken aloud with his own voice inside his head. He avoids mirrors because his face appears somehow altered. He feels as if his body isn’t his own and his “brain is totally disconnected” from his body. This split is associated with experiences of motor disturbances: “My arms feel so heavy that I barely can lift them ... Also, my hands don’t really do what I want them to do. When I wash my hair, the washing is somehow blurred, as if I myself can’t keep up with my movements.” His sense of disembodiment and loss of control of bodily movements initially led to the formation of vague ideas about external influence (it sometimes feels as if someone else is performing my actions. It’s as if it’s not me. I feel like a puppet), which he eventually explained through clear delusions.

He was diagnosed with paranoid schizophrenia because of bizarre delusions, delusions of control, and commenting hallucinatory voices.

Note that both patients, through phrasings such as “it feels like ...” or the conditional “as if,” mainly indicate alterations in subjective experiences rather than well-articulated psychotic errors of judgement (delusions or hallucinations).

## Discussion

Self-disorders are not sharply delimited independent symptoms but are perhaps best conceived as mutually implicative, interdependent aspects of a more comprehensive Gestalt. The relation of the Gestalt to its manifestations is reciprocal: the Gestalt confers certain typicality on its constituents or parts while the latter infuse the Gestalt

with a concrete clinical rootedness. The individual features bear an imprint of a more global experiential alteration. This global alteration transpires through the patients’ often diverse anomalous experiences, shaping them, and keeping them to some extent interrelated. The Gestalt is not an imagined or inferred construct but is perceivable in the ways consciousness operates, ie, the Gestalt appears in “how” the patients experience themselves, others, and the world, and not merely in “what” they experience.

Many psychopathologists considered the diagnosis of schizophrenia irreducible to single symptoms or signs, but only graspable as a characteristic Gestalt,<sup>3</sup> a trait-condition, involving profound structural alterations of consciousness.<sup>24</sup> Empirical studies, referred to in the introduction, have documented that self-disorders are highly indicative of schizophrenia spectrum conditions.<sup>11–16</sup> We consider self-disorders to constitute crucial aspects of the psychopathological Gestalt of schizophrenia. Yet, the specificity of this Gestalt is irreducible to a quantitative sum of anomalous experiences. Rather, we believe that certain aspects are more essential than others. These reflect disturbances of self-awareness, in particular, waning first-person perspective, diminished self-presence and innermost identity, feelings of not belonging to the world, of profound difference from others, fuzzy self-demarcation, hyperreflexivity (ie, exaggerated and alienating forms of self-consciousness that involve distortions of the normal structures of awareness such as foreground–background, explicit–implicit, and focal–tacit, thereby enabling usually implicit aspects of, say, one’s body or inner life to be experienced in a strangely explicit and self-alienating way),<sup>1</sup> thought pressure or block, spatialization of mental states (ie, thoughts, feelings, or other mental processes acquire properties not completely unlike physical objects and thoughts, eg, may be experienced as located to a particular part of the brain or with acoustic or auditory qualities), perplexity, and quasi-solipsistic experiences. The patients’ psychosocial histories exemplify that self-disorders usually are pervasive, enduring trait-phenomena, typically dating back to childhood or early adolescence, and contributing to distress and dysfunction.

As the empirical studies also attest, patients from other diagnostic groups occasionally report self-disorders (eg, patients with depression, melancholia, or severe personality disorders). In these cases, however, the complaints do not, in our view, reflect the altered structure of subjectivity<sup>24</sup> but concern more complex, narrative aspects of selfhood. Yet, a further specification of the precise nature of the schizophrenia Gestalt will require relevant comparisons with other psychopathological Gestalts.

The concept of self-disorders may represent a step forward in grasping the essential aspects of the psychopathology of schizophrenia. First, it may have a transformative potential for the validity of the concept of the schizophrenia spectrum, eg, sharpening its distinction from affective illness. Second, a corollary of such diagnostic reemphasis

may enable more accurate and earlier identification of at-risk mental states tagged with a propensity to unfold into manifest schizophrenia or schizotypal disorder. Third, familiarity with self-disorders sensitizes clinicians to the disturbing, pervasive anomalies of experience of their patients, thus paving a path for better-informed therapeutic approaches. Finally, a focus on this particular phenotype may have a unique value in the search for neurobiological correlates of the illness. In this context, self-disorders are probably more proximate to the causally implicated mechanisms than the developmentally complex positive and negative symptoms.

### Funding

Faculty of Health Sciences, University of Copenhagen; Danish National Research Foundation: Centre for Subjectivity Research.

### Acknowledgment

The Authors have declared that there are no conflicts of interest in relation to the subject of this study.

### References

- Sass LA, Parnas J. Self, consciousness, and schizophrenia. *Schizophr Bull.* 2003;29:427–444.
- Parnas J, Handest P. Phenomenology of anomalous experiences in early schizophrenia. *Compr Psychiatry.* 2003;44:121–134.
- Parnas J. A disappearing heritage: the clinical core of schizophrenia. *Schizophr Bull.* July 19, 2011; doi:10.1093/schbul/sbr081.
- Parnas J. The DSM-IV and the founding prototype of schizophrenia: are we regression to a pre-Kraepelinian nosology? In: Kendler KS, Parnas J, eds. *Philosophical Issues in Psychiatry II: Nosology* New York: Oxford University Press; 2012:237–259.
- Gross G, Huber G, Klosterkötter J, Linz M. *Bonner Skala für die Beurteilung von Basissymptomen.* Heidelberg, Germany: Springer; 1987.
- Klosterkötter J. *Basissymptome und Endphänomen oder Schizophrenie. Eine empirische Untersuchung der psychopathologischen Übergangsreihen zwischen defizitären und produktiven Schizophreniesymptomen.* Berlin, Germany: Springer; 1988.
- Klosterkötter J, Hellmich M, Steinmeyer EM, Schultz-Lutter F. Diagnosing schizophrenia in the initial prodromal phase. *Arch Gen Psychiatr.* 2001;58:158–164.
- Parnas J, Jansson L, Sass LA, Handest P. Self-experience in the prodromal phases of schizophrenia. *Neurol Psychiatry Brain Res.* 1998;6:97–106.
- Møller P, Husby R. The initial prodrome in schizophrenia: searching for naturalistic core dimensions of experience and behavior. *Schizophr Bull.* 2000;26:217–232.
- Parnas J, Møller P, Kircher T, et al. EASE: examination of anomalous self-experiences. *Psychopathology.* 2005;38:236–258.
- Parnas J, Handest P, Jansson L, Saebye D. Anomalous subjective experience among first-admitted schizophrenia spectrum patients: empirical investigation. *Psychopathology.* 2005;38:259–267.
- Raballo A, Saebye D, Parnas J. Looking at the schizophrenia spectrum through the prism of self-disorders: an empirical study. *Schizophr Bull.* 2011;37:344–351.
- Parnas J, Handest P, Saebye D, Jansson L. Anomalies of subjective experience in schizophrenia and psychotic bipolar illness. *Acta Psychiatr Scand.* 2003;108:126–133.
- Haug E, Lien L, Raballo A, et al. Self-disorders and early differential diagnosis in first episode psychosis. *J Nerv Men Dis.* In press.
- Raballo A, Parnas J. The silent side of the spectrum: schizotypy and the schizotaxic self. *Schizophr Bull.* 2011;37:1017–1026.
- Parnas J, Raballo A, Handest P, et al. Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen Prodromal Study. *World Psychiatry.* 2011;10:200–204.
- Raballo A, Parnas J. Examination of Anomalous Self-Experience: initial study of the structure of Self-Disorders in Schizophrenia spectrum. *J Nerv Ment Dis.* In press.
- McGuffin P, Farmer A, Harvey I. A polydiagnostic application of operational criteria in studies of psychotic illness. Development and reliability of the OPCRIT system. *Arch Gen Psychiatr.* 1991;48:764–770.
- Wing JK, Babor T, Brugha T, et al. Scan. Schedules for clinical assessment in neuropsychiatry. *Arch Gen Psychiatr.* 1990;47:589–593.
- Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophr Bull.* 1987;13:261–276.
- Møller P, Haug E, Raballo A, Parnas J, Melle I. Examination of anomalous self-experience in first-episode psychosis: interrater reliability. *Psychopathology.* 2011;44:386–390.
- Vollmer-Larsen A, Handest P, Parnas J. Reliability of measuring anomalous experience: the Bonn scale for the assessment of basic symptoms. *Psychopathology.* 2007;40:345–348.
- Sass LA. *The paradoxes of delusion: Wittgenstein, Schreber, and the schizophrenic mind.* New York: Cornell; 1994.
- Parnas J, Sass LA. The structure of self-consciousness in schizophrenia. In: Gallagher S, ed. *The Oxford Handbook of the Self.* New York: Oxford University Press; 2011:521–546.