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SELF-DISORDERS AND THE EXPERIENTIAL CORE OF SCHIZOPHRENIA SPECTRUM VULNERABILITY

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SUMMARY

An increasing amount of empirical studies demonstrates that anomalies of self-experience (self-disorders) are characteristic of schizophrenia and related spectrum conditions, indicating that self-disorders (SDs) are likely to constitute important vulnerability phenotypes. On a clinical level, SDs are non-psychotic alterations of subjective experience that include disturbances of self-awareness (e.g., fading first-person perspective, waning sense of basic identity, depersonalization and hyperreflectivity), autopsychic disorders (e.g., thought pressure or block, perceptualization of mental stream and spatialization of thoughts), loss of common sense (e.g., perplexity), and existential alterations (e.g., solipsistic grandiosity). Such experiences, define essential aspects of the clinical expressions of schizophrenia lending psychopathological coherence to its spectrum manifestations. Furthermore the experiential nature of SDs makes them amenable to the patient´s introspection which can be elicited in the dialogical context of the psychiatric interview with important implication for the therapeutic relation. The aim of this presentation is to illustrate the phenomenological core of these experiential anomalies, emphasizing their topicality for the exploration of vulnerability to schizophrenia spectrum conditions and their coherence with the overall clinical picture.

Key words: *schizophrenia spectrum – vulnerability – self - subjective experience – diagnosis - phenomenology*

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INTRODUCTION

Schizophrenia spectrum disorders (SzSpD) are characterised by profound experiential distortions, which can be articulated both in flamboyant, characteristic symptoms (such as positive, negative and disorganised ones) or more pervasive, personologic-existential patterns (e.g. schizotypal social aversiveness or eccentricity), accompanied by subtle, quasi-ineffable changes in the structure of subjectivity (Parnas 2011, Sass & Parnas 2003).

Those include subtle feelings of estrangement and perplexity, distortions of the stream of consciousness and fluidity of the basic sense of identity as well as transformations in bodily experience.(Parnas & Handest 2003) Although such anomalous experiences are not incorporated in current diagnostic criteria, they nonetheless recur in the narratives of subjects vulnerable to schizophrenia, and have been captured by phenolmenological psychopathology with expressions such as “loss of the natural evidence” (Blankenburg), “loss of the vital contact with reality” (Minkowski) or “inconsistency of natural experience” (Binswanger) (Parnas & Handest 2003).

All these expressions allude to a basic change in the field of awareness which impregnates the very first-personal givenness of experience, so that the patients might complain of feeling detached, ephemeral, ineffably different from others, somehow lacking a core sense of identity and of existing as an almost disincarnated mind opposed to an hyper-concrete, almost robotic body. Similarly, they might complain of feeling alienated from the social world and radically unable to immediately attune to its conventions or of having a fading sense of “mineness” of their own psychic life, as if the stream of thoughts was more impersonal and uncontrollable or even perceptualized.

CLINICAL MANIFESTATIONS OF SELF-DISORDERS (SDS)

The following vignettes, might offer a direct impression of how SDs inform prototypical SzSpD existential and psychopathologic trajectories:

Vignette 1 (SzSpD – prodromal phase)

E.I., 23 years, attempts to elaborate on the unbearable anguish that she experienced before the admission (few days before she cut her hairs abruptly, “in order to send a message to other people” and attempted suicide). She refers a deep sense of existential change since the year before ("I was lively, sociable, traveling independently ... now I can no longer stand in the midst of others...") and a progressive withdrawal from social interaction (“I deliberately waste time... arriving late to appointments or running out quickly from the classroom to avoid having to talk or interact ... I cannot organize myself anymore ... before I arrived early to talk to others ... there is a rule in anything ...it is as if I *lost my rhythmic sequence*, I cannot take it any more…”) with an increasing feeling of interpersonal uneasiness and conversational incompetence (“I do not seem to understand even the jokes ... when my friends talk I do not know if they are joking or not ... I am at the mercy of others ... only when friends bring their speeches to the extreme, only then, I realize if they are joking...”). Similarly, she complains of cognitive-attentional

difficulties which emerged some years before, progressively eroding her academic performance ("... I cannot concentrate, I cannot even make notes on the books I read, or I do extract a synthetic pattern that is schematic but incomprehensible… If I look back at those schemes to study I do not find the meaning of my schematization, I do not understand it and I just stare at the words and go further and further: I read but I do not reach the meaning, I cannot grasp it..."). She also describes a persistent feeling of being on a drift, "rambling ...when I'm at home, it is hard for me to get something done, it is as if I could not speak, I use language as a child, my actions are always trivial and I self-censor myself ... it's like I cannot go deep into the things, I do not sense the depth of things anymore... when I go to sleep, the sleep is restless, I am constantly brooding, it is as if my mind does not give me brake ... I think to the things that have happened to me during the day and that even today I could not relate in the normal way with the others…"). Then she describes a painful change in her own psychic activity which became disturbingly transformed ("... It is as if my thoughts melted in my head ... I can no longer use even my intelligence to put them in order...") and an overall sense of becoming "disharmonic, clumsy ... as if I were a robot, a kind of rigid a scheme that every day clashes against something that is not hard, but malleable...".
(Excerpted from the clinical file, Psychiatric Intensive Care Unit, Reggio Emilia, 2006)

Vignette 2 (Schizotypal personality disorder)

C.S., 45, reports pervasive problems in the social sphere (which he terms "social phobia") that have been heavily conditioning him in the last year and a half inducing progressive avoidance of interpersonal contact, fear of disproportionate reactions, primary self-reference (although not elaborated in psychotic sense), impressionability and interpersonal irritability. He specifies that he goes out of his house "only during the night, with my dog, particularly when it is foggy, so that I don´t *feel the gaze of the others on my skin*…". However, he admits, already "at the age of 7-8 I was seen as a strange little thing by my mates as I used to alternate moments of weakness and absurd arrogance: I considered all the others stupid and inferior". Later, at 14 years "I realized I was strange ... *I had a different psychology from my peers*: I had no friends and my only contact was with my parents, I really liked math and numbers and I did not like socializing …when I started high school I felt that I had been *catapulted* into civil society". At 16-17 years he "felt extremely effeminate, and I was so terrified of having some feminine features, to physically look like a woman that *I constantly checked myself in the mirror*…however I realized only much later that this was because I have a certain repulsion for female bodies…". Then, during the military service, he started more pro-actively to "tend to isolation and engage in "mental wars" with others", and he further explains: "my *psychological warfare* always went well: the others could not follow me, they didn´t understand the game I was playing...". Along with this way of relating to others, he developed what he termed "my *voyeur syndrome*… I like to observe others without them being aware of that …so that *I often have the impression of being suspended, as if on the bank of a river, looking at things sliding around me*".
(Excerpted from the clinical file, Primary Care outpatient consultation, Reggio Emilia, 2012)

Vignette 3 (disorganized schizophrenia)

F.B. is a 24-year-old man whose main psychopathological feature is disorganization. Especially at the sunset hour, he complains of panic-like attacks of psychotic severity. During these attacks, which he calls *"feelings of vagueness," he sees colors more brightly and hears sounds more acutely than usual, and he undergoes experiences of self and body transformation*. He is aware that these are pathological experiences and cannot find any suitable explanation for them. He also sees other people as strange and unfamiliar. These experiences of *derealization and depersonalization* are somewhat "naked" and *not otherwise conceptualized.* Although these phenomena of world and self transformation are often accompanied by experiences of reference, only sometimes do they become truly delusional, that is, changes in the outside world or in the facial expressions of people are usually not interpreted according to a paranoid attributional style (Stanghellini 2000).

Vignette 4 (paranoid schizophrenia)

K.C., 29, reports that he already from childhood felt different from others and he *often doubted "if others have a soul or any feelings"*. He doesn't really know who he is, and he can *feel that his identity is dissolving*. He describes a worsening at the time of puberty. It started, he explains, when he *began to analyse all words, which made not only the meaning of the words, but "every meaning float until nothing made sense"*. He felt apathetic and distanced from the world and others—"*as if* I was *living enclosed in glass case or bubble*". For years, he has been living inside this bubble and regularly it gets, as he puts it, "so *foggy* that I lose contact with the outside world". In these situations, he is unable to communicate with others, but more generally he also finds that *his native language isn't sufficiently precise to express his experiences*, and he therefore considers learning Latin, because he was told that it is the most precise language in the world. Moreover, he is able to *spatially locate his thoughts inside the bubble* and he is *"almost able to see" his thoughts, which he reports appear like on a filmstrip*. He describes a *distance to his own thoughts*—"they are my thoughts but not me", which he tries to explain with an analogy: "it's like when I put on my jacket. It's my jacket, but it's not me". He experiences *thought blockage*, which he describes as a kind of paralysation or feeling of emptiness - "a shrieking emptiness or silence", and intrusive forms of derealisation (Henriksen et al. 2012).

Vignette 5 (paranoid schizophrenia)

E.B. is a 30-year-old man who says of himself "I am a paranoid schizophrenic. That's science's verdict. So let it be." He is very religious and shows *esoteric and metaphysical interests*. During one hospitalization, he was often *perplexed* and found it very *difficult to relate to other people* and in general to the *external world.* Almost every time he *perceived an object*, the perception evoked in him one *concept or word*, and *that word was kindling an overwhelming trend of word associations*. It was like a "*Hood of words"* that *made him lose his grasp on the actual situation.* Therefore he could not engage in the most simple activities and participate in conversations. He explains that in the beginning it was a way "to exercise memory through perception. A way to enhance my mind. I was looking at one thing and I *had to* put my strength in order to evoke another thing, and so on. *I was fixed on potentiating my brain*. It all started as a *voluntary action* that later turned into a *passive experience."* (Stanghellini 2000).

Overall, the vignettes exemplify the subjective experience of vulnerability in SzSpD, and, specifically, they illustrate how normally tacit structural aspects of mental life (e.g. stream of consciousness, sense of intersubjective presence and spontaneous attunement with others, transparency of cognitive activity, immediate accessibility of daily social and linguistic significations) often are altered in schizophrenia

Independently of their position along the spectrum, all the patients undergo a profound change in how they experience themselves, others, and the surrounding world. What is at stake here is a fundamental transformation of the structure of experiencing that undermines their feeling of being embodied, active subjects naturally immersed in a social space in which they can navigate unproblematically.

Crucially, such change affects the biographic trajectories as well as the self-understanding of the person, before and aside the emersion of overt diagnostic symptoms and often impregnating both premorbid functioning and the socio-relational sphere, frequently interfering with the sense of primary inter-peer reciprocity. Moreover, the vignettes show that SDs tend to be pervasive and enduring trait-phenomena, whose onset typically dates back to childhood or early adolescence.

THE SELF AND SCHIZOPHRENIA: AN ARCHEOLOGY OF SDS

The notion of a disorder of the self as being a core feature of schizophrenia is not new. *Bleuler* mentioned a "basic disorder" of personality as a fundamental feature of schizophrenia, highlighting that in such condition the self may undergo the most manifold alterations, which might culminate in splitting or disintegration. Similarly, *Kraepelin* claimed that a disunity of consciousness (which he assimilated to an "orchestra without a conductor") manifested in the loss of inner unity of understanding, mood, and will, is the core feature of schizophrenia. Along a convergent line *Berze* identified in a "primary insufficiency" of self-consciousness the fundamental disorder of schizophrenia. Later, *Schneider* emphasized a cluster of experiences (so called First Rank Symptoms) characterized by a reduced experiential mineness (i.e. the primitive, implicit feature of perceiving one´s own mental states and acts as one's own) has the highest degree of diagnostic specificity. (Parnas et al. 2002, Parnas & Handest 2003)

Following this tradition, Gerd Huber and coworkers, elaborated the concept of "basic symptoms" (i.e. subtle, subclinical self-experienced disturbances in drive, stress tolerance, affect, thinking, speech, perception and motor action, which are phenomenologically clearly distinct from psychotic symptoms) and documented their diagnostic specificity. Furthermore they detailed phenomenologically coherent transitional sequences leading from non-psychotic basic symtoms to first-rank symptoms, following three phases of increasing psychopathological salience: basal irritation, psychotic externalization and content concretization. (Huber 1983, Huber & Gross 1989, Schultze-Lutter 2009)

However it is only in the last 15 years that SDs have become the focus of a specific research program, explicitly addressing them as experiential, non-psychotic phenotypes reflecting core SzSpD vulnerability traits (Parnas et al. 1998, Parnas 2000). In this perspective, major diagnostic symptoms, such as auditory verbal hallucinations, bizarre delusions or negative and disorganized symptoms are conceived as end-phenotypes (or symptomatic super-structures) that emerge in a developmental continuity from early, non-psychotic disturbances of self-experience (e.g., self-awareness, cognition, and perception) to full-blown schizophrenia.

This research program, inaugurated by Josef Parnas and his group in Copenhagen, is based on a combination of empirical research and clinical experience, and is inspired by a phenomenological approach as a guide to explore anomalous self-experience (Parnas 2012, Parnas & Bovet 1995).

LEVELS OF SELFHOOD: A PHENOMENOLOGICAL STRATIGRAPHY OF SELF-EXPERIENCE

Although the term Self and its wide semantic halo are endowed with an intrinsic polysemy, from a phenomenological viewpoint it is essential to discern three fundamental levels of selfhood (Parnas & Handest 2003, Zahavi 2005) (see Figure 1).

First, the prereflective level of selfhood (also termed "ipseity" or "core"/"minimal" self"), which refers to the first-personal givenness of experience (i.e. the implicit awareness that the stream of experiences I undergo is "my" experience). Concretely, this level entails a protopathic sense of subjective presence as a pole of experience which accompanies the stream of consciousness.

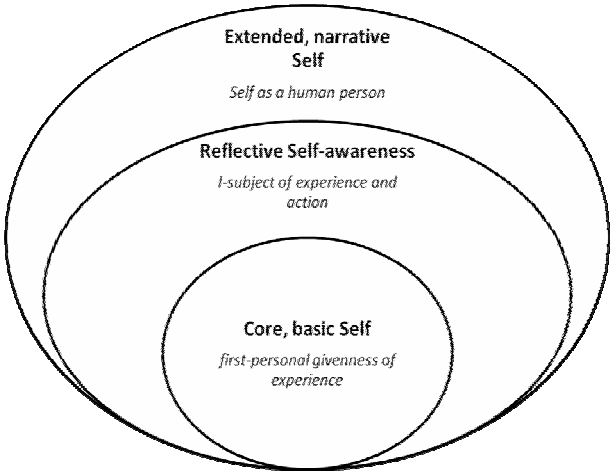

Figure 1. Levels of Selfhood

In this sense, the core self is an inchoate sense of embodied subjectivity, a tacit or pre-reflective self-presence, which is distinguished from the reflective consciousness of an objectified "I".

The latter, attest a second, more explicit or complex level, i.e. reflective self-awareness. This is an awareness of self as an invariant and persisting bounded entity, an I-subject of experience and action with sense of existing as an Ego.

Finally, the third level of selfhood is the narrative, extended Self, which corresponds roughly to the concept of person: a human being in his totality, i.e. including egoic experiential features, cultural and linguistic elements, cognitive and emotional dispositions (e.g. temperament, character, personality) as well as interpersonal styles and autobiographical orientation. Common psychological concepts such as self-image, self-representation, and self-esteem, apply to this level of selfhood.

Although psychiatric disorders frequently contain symptomatic elements that are related to the issues of self and personal identity, the main assumption of the phenomenological model of SDs is that in schizophrenia spectrum the alteration of subjectivity occurs primarily at the most basic level of self-awareness, in contrast to other mental disorders (in which the self is disturbed on a more extended, narrative level with the basic sense of self remaining somehow preserved).

EMPIRICAL RESEARCH ON SDS

Considerable empirical evidence has accumulated for the concept of self-disturbance as a phenotypic marker of SzSpD. First, two qualitative studies(Moller & Husby 2000, Parnas et al. 1998) on subjects admitted for suspected prodromes of schizophrenia, showed that all patients had profound and alarming changes of self-experience (including the sense of embodies self-presence, psychophysical unity, naturalness of world immersion and interhuman relations, hyperreflexivity and spazialization of experience); nearly all complained of the ineffability of such self-alteration; and most of them reported overwhelming preoccupations with metaphysical, supernatural, or philosophical issues. (see Table 1)

Following qualitative explorations, a study (Parnas et al. 2003) comparing the lifetime frequencies of experiential anomalies among patients with residual schizophrenia (n=21) and remitted psychotic bipolar disorder (n=23) found that the schizophrenia group scored significantly higher in the domains of self-awareness, perplexity, and perception. Then, these findings were corroborated on a larger clinical sample of 151 first admitted patients (Handest & Parnas 2005, Parnas et al. 2005a) grouped according to their ICD-10 diagnosis in non-affective psychosis, schizotypal disorder and other, non-SzSpD mental disorders. Patients inside the SzSpD had significantly higher SDs scores than patients with other mental disorders. Such findings were replicated on a genetically high-risk sample, addressing the levels of self-disorders in 305 subjects belonging to multiplex extended pedigrees (Raballo et al. 2009, Raballo & Parnas 2010). Even in this population, which was not confounded by help-seeking and psychopharmacologic treatment, SDs were comparably high in both schizophrenia and schizotypal personality disorder, and significantly more elevated in SzSpD than in the non-spectrum groups (i.e. other mental disorders and no mental disorders). The diagnosis of SzSpD was associated to a 11 (schizotypal disorder) to 21 (schizophrenia) times higher risk of experiencing at least one SD as compared to the pedigree members with no mental disorders.

Table 1. Qualitative changes in self-experience in the prodrome of schizophrenia

Disturbance of perception of self	Extreme preoccupation with and withdrawal to overvalued ideas
▪ Painful emotional indifference and distance to myself. ▪ Something inside me had turned inhumane. ▪ Scaring feeling of being unreal, changed, and hazy. ▪ Enduring and pervasive feeling of unreality. ▪ Felt like a spectator to my own life. ▪ Tried to find out who I was by scrutinizing my photos, notes and diaries.	▪ Occupied by, and scrutinizing, my own inner world. ▪ Needed new concepts for the world and humane existence. ▪ I had to define and analyze everything I was think about. ▪ The new ideas about supernatural mental phenomena gradually took over my way of life and thinking, left marks on my whole life, just everything.

Adapted from (Moller & Husby 2000)

Overall, these studies show that SD aggregate specifically in the schizophrenia spectrum disorders (schizophrenia and schizotypal personality disorder) compared to other psychiatric conditions in both clinical and genetically high-risk samples (Raballo et al. 2009, Raballo & Parnas 2010). Moreover, a recent 5-years follow up on the sample of 151 first admitted patients, showed that SDs prospectively predict incident of new cases of SzSpD in the subgroup with a non-psychotic illness at baseline (Parnas et al. 2011).

Finally, the availability of a newly developed instrument (Examination of Anomalous Self-experience (EASE), (Parnas et al. 2005b) specifically designed to support the psychopathological exploration of SDs in both research and "real world" clinical settings, has boosted the research in the field (Haug et al. 2012a, Haug et al. 2012b, Haug et al. 2012c, Moller et al. 2011, Nelson et al. 2012, Raballo & Parnas 2012, Skodlar & Parnas 2010) and provided a platform for the systematic assessment of SDs.

A TAXONOMY OF SDS: THE FIVE DOMAINS OF THE EXAMINATION OF ANOMALOUS SELF-EXPERIENCE

Following qualitative explorations, SDs have been catalogued in five major clusters that recur in SzSpD. These clusters are deeply intertwined and constitute the backbone structure of the domains of the Examination of Anomalous Self-Experience (EASE) (Parnas et al. 2005b, Raballo & Parnas 2012). The EASE is a clinically-derived, qualitative catalogue of possible manifestations of SDs, designed to facilitate their clinical mapping. The clusters, which are intimately interrelated,(Henriksen & Parnas 2012, Parnas 2012, Raballo & Parnas 2012) include: disturbed stream of consciousness, self-awareness and sense of presence, bodily experience, self-demarcation, and existential reorientation. (see Figure 2 and Table 2).

Cognition and Stream of Consciousness

The tacit sense of "mineness" of mental content is jeopardized so that the stream of conscious experiences is rather witnessed from the outside, as if thoughts were taking on an almost autonomous and anonymous character. For example, patients may complain of though block, interference (e.g. anodyne, unrelated thoughts popping up in the ongoing stream of thoughts and the interfering with it), sliding away or conglutination of mental contents or unrestrained proliferation of chains of impersonal thoughts. Patients may describe thoughts in physical (e.g. spatial or perceptual) terms or as if they were located in a particular part of their head, and the ‘inner speech’’ might be reified.

Such emerging experiential gap between the self and mental content, may evolve into frank psychotic symptoms, such as schneiderian thought insertion and thought broadcasting.

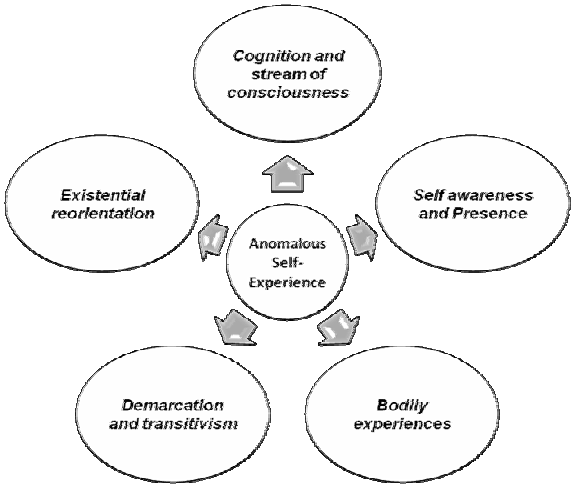

Figure 2. Self-disorders

Self-awareness and Presence

Normal human experience consists of being smoothly absorbed in activity among a world of (animate and inanimate) objects, providing us with a tacit, always pregiven, sense of inhabiting the self. According to phenomenology, indeed, our basic sense of self and sense of immersion in the world are co-constituting and, therefore, inseparable. Hence, our experiences appear to us in a first-person mode of presentation (i.e. we automatically or prereflectively experience them as "ours") and our ongoing stream of experiences is always permeated by an intrinsic sense of self-presence.

Such sense of presence or basic self-awareness is the background upon which explicit, thematic, or objectifying conscious activity takes place. In SzSpD, such basic sense of presence can be attenuated and no longer "saturate experience". Patients might report a sense of inner void or lack of a sustained identity, of being radically different from others, or complain of a pervasive sense of distance between the self and experience. Similarly, they might report a reduced ability to be affected by others or events as if the person is no longer fully participating or entirely present in the world. Varieties of depersonalization and derealization experiencees, as well as a feeling of perplexity (i.e. difficulty in automatically grasping the meaning of everyday events or spontaneously attuning to implicit interpersonal codes) can emerge.

Bodily experiences

A disturbing experiential distance emerges between the self and bodily experience, so that the body is no more a tacitly "inhabited" aspect of selfhood but a sort of object-like, mechanic entity. This may manifest in various forms, including: discenesthesias and impaired bodily sensations, feeling of morphological change (e.g. sensation of constriction or enlargement of the body as a whole or of some parts), or deautomatization of motor action (conscious effort and attention become necessary to perform even habitual, automatic acts).

Table 2. Examination of Anomalous Self-Experience: domains and item list

Cognition and stream of consciousness	Domain 1
Thought interference	1.1
Loss of thought ipseity	1.2
Thought pressure	1.3
Thought block	1.4
Silent thought echo	1.5
Ruminations-obsessions	1.6
Perceptualization of inner speech or thought	1.7
Spatialization of experience	1.8
Ambivalence	1.9
Inability to discriminate modalities of intentionality	1.10
Disturbance of thought initiative/intentionality	1.11
Attentional disturbances	1.12
Disorder of short-term memory	1.13
Disturbance of time experience	1.14
Discontinuous awareness of own action	1.15
Discordance between expression and expressed	1.16
Disturbance of expressive language function	1.17
Self-awareness and presence	Domain 2
Diminished sense of basic self	2.1
Distorted first-person perspective	2.2
Psychic depersonalization (self-alienation)	2.3
Diminished presence	2.4
Derealization	2.5
Hyperreflectivity (increased reflectivity)	2.6
I-split (‘Ich-Spaltung’)	2.7
Dissociative depersonalization	2.8
Identity confusion	2.9
Sense of change in relation to chronological age	2.10
Sense of change in relation to gender	2.11
Loss of common sense, perplexity, lack of natural evidence	2.12
Anxiety	2.13
Ontological anxiety	2.14
Diminished transparency of consciousness	2.15
Diminished initiative	2.16
Hypohedonia	2.17
Diminished vitality	2.18
Bodily experiences	Domain 3
Morphological change	3.1
Mirror-related phenomena	3.2
Somatic depersonalization (bodily estrangement)	3.3
Psychophysical misfit and psychophysical split	3.4
Bodily disintegration	3.5
Spatialization (objectification) of bodily experiences	3.6
Cenesthetic experiences	3.7
Motor disturbances	3.8
Mimetic experience (resonance between own movement and others’ movements)	3.9
Demarcation/transitivism	Domain 4
Confusion with the other	4.1
Confusion with one’s own specular image	4.2
Threatening bodily contact and feelings of fusion with another	4.3
Passivity mood	4.4
Other transitivistic phenomena	4.5
Existential reorientation	Domain 5
Primary self-reference phenomena	5.1
Feeling of centrality	5.2
Feeling as if the subject’s experiential field is the only extant reality	5.3
‘As if’ feelings of extraordinary creative power or extraordinary insight into hidden dimensions of reality	5.4
‘As if’ feeling that the experienced world is not truly real, as if it was only somehow apparent, illusory or deceptive	5.5
Magical ideas linked to the subject’s way of experiencing	5.6
Existential or intellectual change	5.7
Solipsistic grandiosity	5.8

Adapted from (Parnas et al. 2005b)

Transitivism and Self-Demarcation

These anomalous self-experiences consist of subtle phenomena indicating a loss or a permeability of self-world boundaries, such as feelings of confusion of boundaries between self and others (e.g. a sense of passivity in relation to the world and others, losing sense of whether thoughts or feelings originated in oneself or another person, or even experiencing the physical presence and contact of others as threatening).

Solipsism and Existential Reorientation

Preoccupation with overvalued ideas, especially on philosophical, supernatural, and metaphysical themes somehow implicating a quasi-solipsistic or cosmic perspective (e.g. language and signification, the meaning of the world, a system to decode interhuman interactions) are often reported already in the prodromal phases of SzSpD or constitute the hinge of psychotic externalizations. Most of these preoccupations emerge when the patients are trying to accommodate their anomalous experience to existing interpretative schemas that can allow some form of self-understanding. The rupture of the natural frame of self-experience and the intense feeling of subjectivization (so that SDs are felt as difficult to share with other people) might elicit such a preoccupation. Feelings of centrality, uniqueness or solipsism may become prominent.

EDGES OF UNDERSTANDING: FROM SDS TO DIAGNOSTIC SYMPTOMS

These anomalous self experiences (SDs) are pervasive and enduring trait-phenomena which typically emerge in childhood or adolescence and accompany the developmental trajectory of the person.(Parnas 1999, Parnas 2000) They are not yet of psychotic intensity, but rather remain in the domain of "as If", metaphorical descriptions.(Parnas & Handest 2003) Nonetheless they shape the very way the person feels immersed and vitally engaged in the world and reverberate in his mode of experiencing the intersubjective reality.(Raballo & Krueger 2011, Sass & Parnas 2003) In this sense, clinical awareness of self-disorders may improve early identification of at-risk mental states that unfold into schizotypal personality disorder or schizophrenia.(Haug et al. 2012a, Parnas 2005, Raballo & Laroi 2009, Raballo & Parnas 2012)

For example, in the transition to a frank psychosis, these anomalies might be strengthened and thematized in the form of delusions, hallucinations, and passivity phenomena (e.g. the loss of presence or ‘‘mineness’’ of experience, can progress into a sensation of external influence and or a persecutory delusion) or enacted in terms of bizarre behavior (e.g. solipsism and existential reorientation or the loss of interpersonal common-sense, might induce a proactive non-mundane retreat or facilitate eccentric conducts with disregard of implicit behavioral codes).

Similarly, with respect to the emergence of schizotypal features, SDs might act as developmental catalysts or amplifiers of - for example - introvertive self-absorption, magical idiosyncratic concerns, or schizotypal social aversiveness.

Hence, as partly seen in the clinical vignettes, a certain cross-sectional and developmental coherence transpires between basic disorders of self-experience (SDs) and the major clinical expressions of SzSpD vulnerability ranging from at risk mental states (vignette 1) to schizotypal personality (vignette 2) and full-blown schizophrenia (vignettes 3-5).

CONCLUSIONS

In SzSpD, subjective experiences are pathologically transformed at a deeper level than the psycho-behavioural one captured by positive, negative and disorganized symptoms. This is the case of SDs such as a diminished sense of basic self (e.g. sense of inner void, lack of identity, being different from others); distorted first-person perspective (e.g. decreased sense of mineness of experience, spatialization of experience and reification of the self); a decreased ability to be affected by objects, people, or events; a constant feeling of exposure and abnormal permeability to others; and pervasive difficulty in automatically grasping the meaning of everyday events, leading to exaggerated reflectivity, perplexity and felt loss of “common sense”. These subtle alterations of the structure of subjective experience interfere with the basic, implicit sense of existing as a vital, embodied agent in the world, bounded and temporally continuous, endowed with a transparent access to the world as given to him in the ongoing stream of consciousness. Hence, they cause profound psychological and existential distress, with important impact on psychosocial functioning (Henriksen & Parnas 2012, Raballo & Parnas 2012) and eventually leading to psychopathological manifestations such as psychosis.(Parnas et al. 2002, Raballo & Laroi 2011, Sass & Parnas 2003)

In this sense, phenomenological psychopathology, views SDs as core trait-features of schizophrenia spectrum vulnerability, reflecting a partial dissolution of some of the constitutive structures of consciousness that remain endangered independently of the waxing and waning of clinical symptoms.(Parnas et al. 2002)

Therefore, besides being potentially important for (early) differential diagnosis and the identification of subjects at risk for psychosis, an appropriate exploration of SDs allows a more comprehensive, experience-close understanding of the overall clinical expressions of the disorder, and thereby is crucial for a person-centred clinical care and therapeutic support.

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