Disorder of Selfhood in Schizophrenia: A Symptom or a Gestalt?

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Abstract
Introduction: The concept of schizophrenia (SCZ) was originally associated with a disorder of formal strata of the self. During the last two decades, empirical studies have demonstrated a selective hyper-aggregation of self-disorders in the SCZ spectrum. As with other scientific research areas, the role of self-disturbances in SCZ has been up for debate in various disciplines including cognitive sciences, philosophy of mind, and psychopathology. Several philosophical papers have used the psychopathological phenomena of “thought insertion” as an alleged example of a complete loss of minimal selfhood. In the field of psychopathology, it has been claimed that self-disorders may comprise a transdiagnostic phenotype. Common to these approaches is the underlying assumption that self-disorders reflect well-delineated and isolated symptoms akin to the notion of symptom in the medical model. The aim of this paper was to argue that the clinical manifestation of self-disturbances is to be seen as aspects of a Gestalt of disturbed experiential selfhood. Methods: Seven videotaped interviews of patients with SCZ who were emblematic of very diverse symptomatological constellations were selected and jointly watched and discussed by the authors, who reached a consensus assessment. The interviews were semi-structured and narrative in nature in order to obtain faithful self-descriptions according to the standards of phenomenologically oriented interviews. For the purpose of this article, we chose 4 videos from which excerpts were verbatim transcribed and translated from Danish into English. Results: The patients describe unique combinations of various psychopathological phenomena such as diminished sense of embodied self-presence, loss of ego boundaries, diminished sense of self, alienation and objectification of the experiential processes, mirror-phenomena, and Schneiderian passivity phenomena. Discussion: Through an interweaving of the four vignettes and their subsequent psychopathological discussions, we argue that the invariant commonality across the different symptomatic expressions in these patients resides in a Gestalt of pervasive disturbance of self-experience. From a phenomenological perspective, these self-disturbances target a basic structure of phenomenal consciousness, namely, the first-person givenness of experience. We conclude that self-disorders reflect a trait-instability in the most basic structures of consciousness in SCZ and that its clinical manifestations are to be seen as aspects of a particular Gestalt rather than appearing as separate and well-delineated symptoms.

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Introduction

The focus on disordered selfhood in schizophrenia (SCZ) appeared in the mainstream contemporary psychiatry around the turn of the millennium [1–4]. The reorientation was motivated by psychopathological insights gained through long-term prospective studies of children of mothers with SCZ [5], genetic linkage studies in SCZ [6], and clinical work with young first-onset SCZ patients. In 2005, the Examination of Anomalous Self Experience (EASE), a psychometric instrument for the detection and registration of self-disorders, was published [7]. The instrument included a manual that explained the nature of particular self-disorders as aspects of an underlying core disturbance of subjectivity, namely, an instability of the first-person perspective, also known as the minimal self [8, 9]. This approach was framed by clinical data and a phenomenological approach to psychopathology. Empirical studies have consistently shown increased levels of self-disorders among SCZ patients and schizotypal patients as opposed to patients with bipolar psychosis or other non-SCZ spectrum disorders (for review and meta-analysis, see [10–12]). Importantly, an empirical study saw that self-disorders as measured by the EASE manifest a mono-factorial structure [13, 14].

Since the introduction of EASE, the number of publications focusing on self-disorders has exploded. A search for "self and schizophrenia" on the PubMed results in approximately 6,500 hits. Most of these publications are either theoretical pieces or case reports. As with other research areas, the role of self-disturbances in SCZ has been up for debate in various disciplines including cognitive science, philosophy of mind, and psychiatry. Several philosophical papers have made use of the psychopathological phenomena of “thought insertion” to criticize the notion of minimal selfhood as the fundamental structure of phenomenal consciousness [15–18]. In psychopathology, it has been suggested that self-disorders are transdiagnostic features [19]. In general, the transdiagnostic approach in psychopathology regards psychopathological phenomena as symptoms comparable to symptoms of the medical model [20]. A crucial and recurrent problem with these papers concerns their treatment of the psychopathological phenomena of self-disorders. Rather than seeing the manifested self-disorders as aspects of a more basic and encompassing Gestalt, each symptom is considered an isolated and distinct feature of consciousness.

The aim of this paper was to problematize this approach by illustrating in what way the disorder of selfhood constitutes a psychopathological core feature of SCZ spectrum disorders and how self-disorders manifest as a clinical Gestalt. Through an interweaving of clinical vignettes and conceptual discussions, we will address how self-disorders manifest as a core structural instability, a kind of essential Gestalt across the manifold of clinical expressions of SCZ.

Materials and Methods

The Sample

The subjects of this study are selected from a larger group of patients participating in a project targeting neurophysiological correlates of self-disorder SCZ [21, 22]. Thirty-five patients diagnosed with SCZ (mean age 22.11 years, SE 0.665, 14 males) were included in the study. The patients were recruited between May 2017 and February 2019 from three psychiatric outpatient clinics in Region Zealand in Denmark.

The inclusion criteria were: (1) being between 18 and 40 years of age, (2) having been diagnosed with SCZ within the last year according to Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) [23], (3) being in a stable phase of the illness. Exclusion criteria were: (1) active drug abuse, (2) any organic pathological conditions likely to affect cognition or the somatosensory system.

Clinical Evaluation

All participants went through a comprehensive psychopathological evaluation including Examination of Anomalous Self Experience (EASE) [7]. The psychiatric evaluation was performed by K.E.S., a senior resident in psychiatry, who was specifically trained and reliability tested by the lead author of the EASE scale (J.P.) and another senior EASE expert (Dr. Julie Nordgaard).

The Assessment of Self-Disorder

The interviews were semi-structured and narrative in nature in order to obtain faithful self-descriptions according to the standards of phenomenologically oriented interviews [24]. The EASE consists of 57 items, sometimes divided into subtypes. The instrument targets five domains of experience: (1) alienations of the stream of cognition, (2) disorders of basic self and presence, (3) disorders of embodiment, (4) problems with self-demarcation and solipsistic experiences, and (5) existential reorientation. None of the patients had been subjected to an EASE interview prior to the study. The mean EASE-score of the total sample was 25, comparable to reports from other studies [25–27].

The Subsample Selection

For the purpose of this qualitative study, we selected 7 videotaped interviews of patients who were emblematic of very diverse symptomatological constellations. The 7 videos were jointly watched by the authors: K.E.S., an MD PhD with 7 years of clinical experience in psychiatry, J.P., a professor of psychiatry with extensive clinical and research experience in SCZ spectrum disorder and first author of the EASE, and D.Z., a professor of philosophy with expertise in phenomenology and philosophy of mind. Each video viewing session was followed by a discussion between the authors, who reached a consensus assessment. For the purpose of this article, we choose four videos from which excerpts were verbatim...
transcribed and translated from Danish into English. We limited the number to four because of space considerations. The mean EASE-score for this selected sample was 27.5.

Results (Clinical Vignettes)

Henry (H) 24 Years Old, Unemployed, and a Former Student of Anthropology (EASE-Score: 22)

(A) H: Before it all started, I had a clear sense of myself. In that I felt encapsulated in my body, first and foremost. I guess that’s how most people feel, as if they are a small pilot inside their head and then they are the owner or the agent of their body, which is a machine they control. And then there are sense organs, which are like barriers to the objective world. So, there is a world inside which is me or my own private sphere and then there is a world outside which I experience with my body, so there is a me and a not-me. Or a subject-object barrier. That barrier has melted down for me. So… for instance, my eyes no longer feel as windows that I look out through, but more like holes, and then everything just flows… in and out (gesticulates back and forward with his hands in front of his eyes). There is no clear line between what is subject and object. Sometimes it feels as if I don’t even have a head. So, instead of my consciousness being something inside me, encapsulated, it more feels like a room or space where things just move in and out. I sometimes feel that I am the space outside myself. That I identify myself with everything.

(…) H: There is at least no inner space or inner object, which make out my self or ego. I have no sense of being an agent, being someone who does things. It is not because there is another thing or agent who controls me instead; I don’t feel taken over by something, but things just happen spontaneously or automatically. So, this sense of being an immaterial pilot or a small man inside the body and the body then being a machine or vehicle that I control, that sense is gone.

(…) H: So, the way I would describe things is different. I feel that if I, for instance, did this (he lifts up his cup of coffee from the table) it would be wrong to describe it as “I am lifting up the cup,” there being a subject performing an action on an object. For me it is more like “There is an arm which lifts a cup.”

(Hi: So, there is a body and there is a mind. You know I still have thoughts and I can pull out memories, but they are just something I don’t really own. They have become non-personal.

(…)

(B) H: The past and the future is something I have a very loose relationship to. It is more practical, a concept. So, I am somewhat forced into this Zen Buddhist way of thinking, just live in the present moment and don’t concern yourself with anything that you don’t experience directly.

(…)

H: Everything that I do not experience directly, empirically, feels more or less unreal. I can use it as concepts for practical purposes, like “tomorrow I shall brush my teeth,” but the idea that time reaches out into the future, in a linear fashion, and that the time actually exists like dots on a line, that does not feel real. It feels like an idea.

(…)

(C) H: Sometimes I do feel that my mental sphere has become somewhat public. Because this I has become a carpet that flows out on everything. Moreover, I would say, it is not so much the I that is gone, but more the me, if you understand? There is an I which is subject of experience, but there is not so much a me, being a person with an autobiography and an agent for actions and owner of that consciousness. So, I feel as if I have been reduced to something very simple, a pure subject without the personal element.

(…)

I mean a first-person perspective would include that I was separate from my surroundings, then there had to be a subject-object barrier and that’s not the case. When I say that my I is still there… My consciousness is still there. So, I feel as if the I who has the experience of the phenomenal world is there, but it has become this carpet which covers everything. And then because there isn’t this strong connection between the I or my consciousness and the body, then this me disappears a bit. Because this me, or the personal, is a more complex matter. It consists of both the I-consciousness, and the mind which contains personality, memory, autobiography and of course the body which makes one a person.

Comments

The patient is obviously familiar with basic concepts of philosophy. He describes normal selfhood as that of a pilot encapsulated in a body-machine and linked to the world by his sense organs (A). This self-description re-
Conversely, if I get compliments, which is one of the reasons I don’t have as much self-confidence as I thought, then it is due to him. “What would you have done if I hadn’t been there for you?” And “You wouldn’t have managed that conversation if I weren’t there to help you with what to say.”

(M) He can also access my thoughts and manipulate them such that I think in a certain direction. But I have never viewed him as a negative character. He is there for my sake, but he is just not a friendly-minded person. His intentions still feel to some extent good because the influence they have had is mainly positive.

I have been able to pretend that I had self-confidence and have had conversations with very adult and intelligent people since I was young. This is because, I received interjected words which I did not understand but which my sub consciousness had caught in a movie or read somewhere and thought “Well this context is similar.” So now, you shall use this word, which you do not really understand… You know, when you have a conversation then you write a sentence inside your head, you do not say the word simultaneously in the conversation. So, you have some construction, where you say, the sentence which I am about to say will have a certain outcome. And then this person comes in and erases a word and replaces it with another, in time to make me surprised. Why? What does this word mean? What is the purpose? But I quickly learned to go with the flow. If I am told to use the word “ambivalent,” I now happen to know this word, but it could be one of these words that I did not understand and then I just used this word and ninety nine percent of the time it was correct. I think I see him as a character who has a better overview than me, because I have no overview. So, I use him as a character to manage a situation, this is the best possible outcome for us in this situation, and in order for us to get us there, the sentence has to be like that. And so, he has manipulated me in the direction that is best for us, as a person. So, I see him as a part of me, because his actions are about us, benefits us, for me or… And then there is the third level which is rare. Level two works in the shadows. I barely have contact with him. I cannot ask a question and get an answer. I cannot force him to come. He is there when he is there. But on the third level there is a voice and a character and a personality, but it is not the same. And it can be heard, not inside the head but outside. As when I am lying in my bed and trying to get some sleep, I relax and I am calm, and suddenly there is a person who is shouting at me. I cannot make out what is being said, there is just shouting.
Comments

The patient reports a discomforting experience of viewing himself in the mirror (A). This phenomenon is described with a vivid sense of alienation towards his objectified subjectivity in the mirror. This amounts to a certain self-division where he feels that the self-image remains in the mirror after he has gone away. In the subsequent section (B), M describes his thoughts as articulated in different “levels.” The “first level” is his habitual way of thinking. Here, his relationship to the thinking process already reveals an experiential distance between the thoughts and the sense of self with beginning objectification of his thoughts. On the “second level,” he has lost his sense of agency and the sense of ownership remains ambiguous or uncertain to the patient. Because of the unclear identity of the voices, he has chosen the masculine gender “him,” in order to establish a personal relationship to the voice. This section points to a split or alteration of his consciousness, where the voice can be regarded both as a hallucination and as a passivity phenomenon. The incipient stage of these phenomena is called “involuntary self-witnessing” [28]. Despite this apparent division of consciousness, the subjecthood of the patient is not divided and there is only one point of view, that of the patient. The section (C) also reveals a perceptualization of thinking in the form of quasi-visual written words. The third level described by M, seems more vivid, and unlike level two, has a distinct sensory-like quality (voice) and a personality being located outside his head. It seems to us that the description as a whole reveals a progressive self-alteration, beginning with experiential distance between the sense of self and thinking and culminating with externalization and perceptualization [29].

Kasper (K) 18 Years Old, High School Student (EASE-Score: 24)

(The patient says that he sometimes feels that he is “not himself” and explains how he can recognize it.)

K: In the way, my head works. I can feel that things change. I guess all people have a certain way that they think. I think in a certain way and when this change I think in a different way. The way I look at things are different. It is not because things visually change shapes or something like that, but the way of looking at the world is different.

(…)

I feel a bit like another person, but only from the way I observe things. I refer to them as other personalities. I call them “him” instead of “me.” I often end up having discussions with them in my head, because they want me to behave in a certain way while I decide to behave differently. I discuss with them in my head, but sometimes if I don’t pay attention I can be made to say harsh things to people without intending to.

(…)

K: I hear them as “thought-voices.” I don’t hear them from the outside, but in here (puts his hands to his head). But they are still disturbing. The way I believe everyone else experiences thoughts, is that when they think, it is like having your own voice in your head, but without the sound. It is just like that, but it is not me who is doing the thinking. So, it is a foreign body, which is not coming from the outside, but is within as a slightly different voice. And the voices are foreign, so I am not in control of them whatsoever.

(…)

K: I don’t feel that the voices have a lot of contact with each other. But it is because I feel that I am a sort of a body in between. I am a medium for them and their contact.

(…)

K: Sometimes it feels as if I am being pulled out backwards (gesticulates with his hand behind his head) while my body continues to do whatever it is doing. It doesn’t happen so often, but it depends on how stressed I am. That has a huge influence on what it is like. When I am outside my head, I sometimes see the back of my head.

(…)

Then I feel that my presence in my head, in who I am, observes my body walk, doing something, making myself a sandwich. At the same time the Kasper I am is in the back outside and he can move his arms in all kinds of different ways. I am not in the body anymore. It is not me, who is controlling the body.

(…)

K: There are moments when I just sit and sometimes start hitting myself on my thigh. Completely out of control. I am not the one who is doing it. I just do it. I can stop it, if I become aware of it, but often I don’t. I sometimes experience it while it happens, but only if I am personally there. That is, however, not always the case. Sometimes I just disappear completely. And they are the ones having the control and then I wake up at some point and regain control.

Comments

The patients’ expression of being another person does not refer to a dissociative split of subjecthood into two or more subjectivities unaware of each other, but simply to another presence, an Alter, within his stream of consciousness. As with Michael, we see a complete self-alter-
ination leading to voices and influence phenomena without a specific external agency. Moreover, the patient describes a spatial dislocation of his perspectival point of view (seeing himself from behind), varieties of spatialization of experience, and at times a fleeting disappearance of his sense of being a subject.

Stefan (S) 21 Years Old, Just Enrolled at the University to Study Mathematics (EASE-Score: 30)

(A)

S: I have felt different since childhood. I have doubted whether I was a human being. I felt so different that I thought I must be coming from outer space or something. Another creature than a human. That made more sense to me in my head. I have on several occasions believed that I was turning into a dragon. Actually, I had a creeping sensation under my skin, which I made myself believe was the growing of a hide. I just felt that life was so hard in a way. I didn’t understand how others could stand life when it was this hard so I thought there was something wrong with me if it was so difficult to just be alive.

(...)

S: I just can’t figure out who I am. Who is Stefan? It is a floating strange substance without meaning. Sometimes when I use an expression, which one of my friends uses, I feel that I have become that guy. I say it with his voice and similar gestures. For that time being, I am another person.

(...)

(B)

S: I have two type of attacks. The first type is occasionally there every day and many times a day and often an hour each time... Then I can’t move. I can’t move my body, I cannot speak, I can do nothing but move my eyes and breathe. I have learned to nod “yes or no” with my eyes when I have these attacks. I feel that my body disappears. The only thing I have is a sense of what goes on in my head... I feel like I am floating around. I can think clearly and hear what people around me say. And react to what people say or signal “yes” or “no” with my eyes.

(...)

(C)

S: The other type of attacks are those I cannot control and they are the ones I am most afraid of, since I risk doing harm to others. I scratched my mother and tried to hit my dad. It happens when something takes over, often an animal, a cat, a dog, a tiger. Once it was a little girl. It doesn’t happen that often, fortunately, and it is rather new. But it is like there is another creature inside me that suddenly breaks out and says “now I am in control of this body.” It is almost as if I have two brains and now the other brain takes over. It is a bit weird with these streams of thoughts I have, because I have my own thoughts and the thoughts of the one who has taken me over. And I can follow its thoughts but it cannot follow my thoughts. So, I can follow along its thoughts and see the pictures that are put forward there… It is often one emotion that really kicks through when I get these attacks. Weariness, anger or the need for isolation. So, the time when I was a little girl I was extremely happy and I was not happy before. And if it is an animal, a tiger, or a mythical creature that is taking over, then it is often anger that breaks through. If it’s a cat I become very defensive. If I am a dog, I become amorous…

(...)

S: Well, actually I am not completely aware of which type of animal I am, it’s a bit of a guess. But it’s because I can follow its thoughts and then it’s what I imagine a cat would think, kind of. Or a dog or aggressive animal... I am not completely sure if it’s a tiger or if it’s an animal that even exists. Or a beast... Because then the beast gets pictures of eating other people. If I feel that it is on its way, I try to eat a lot of meat to reduce the craving for meat... I actually feel that I still have some control somehow. I can resist it a bit. It is very difficult to persuade whatever has taken over to stop. I start walking on four legs and say strange sounds, hiss or bark and such.

(...)

S: Most of the time I am somewhat conscious of what is happening... It is a bit difficult. It is half blurry. But I do remember what has happened. Or what I observe from the eyes of the thing that has taken over... The episodes normally last somewhere between half an hour and an hour and I can’t stop them.

(...)

I can listen to the other’s thoughts. But I also have my own thoughts at the same time and those are often panic thoughts. What is this and what to do about it? But I cannot do anything.

(...)

S: There was a time when I walked behind a boy, whom I knew from high school and the beast then took over. And I felt that I was this close (gesticulating with his fingers) from putting my teeth in his flesh… It is sometimes difficult to differentiate between my own thoughts and the beast’s thoughts. They can mix up. But I really felt that I was not far from taking a chunk of his shoulder.
S: I have thoughts in the foreground, middle ground, and background. Those in the foreground are very clear, in the middle ground less so and in the background even less. The direction of these thoughts are very different. It can be about things that have nothing to do with each other. In the foreground, it could be: “What did she say yesterday?” while in the middle ground it could be “What’s for dinner tonight?” Often when I play computer games, a thought can appear out of nowhere like “I wonder what my mom is doing?” It is often there when I focus, and I can’t understand why it comes. I am surprised every time.

(...) I often picture my thoughts like a stream, where the fish are my thoughts and I can catch one fish while observing the others there in the stream. Sometimes the stream is full of fish, jumping around and I can’t keep track of them. In the end, it goes “caput” and it feels as if I had no thoughts. There is nothing, my head is completely empty.

Comments

It is clear that this patient has suffered from severe problems of identity since childhood (A). The problems pertain to his most basic self-identity. As a child, he felt as if he was not human and thematized this feeling of difference by fantasies of being extraterrestrial etc. This fundamental feeling of being different from others is a feeling of difference that precedes finding out what precisely it is that is different and which in psychiatry has been called a feeling of “Anderssein” [30]. In other words, the patient experiences an ineffable difference that is located at the pre-predicative level. This sense of alienation is later converted into the experience of being possessed and controlled by some other creature (C). Although he does not ascribe this control to external forces, these states of possession are akin to the Schneiderian influence phenomena. In the beginning of the vignette, the basic identity disorder is associated with the loss of ego boundaries and a fusion with interlocutors (A). When having the experience of being possessed, the patient is often able to distinguish his own thoughts from those of the possessor; however, the thoughts may also mix up. In his self-description, we notice spatialization of experience, perceptualization of thinking either in the quasi-acoustic form or visual form (C), thought interference (D), thought block (D), and motor-blocking with somatic depersonalization (B). The experience of being possessed and acting out the “creatures” intentions must be classified as clearly psychotic. His sense of self-presence varies in intensity and is sometimes close to obliteration.

Discussion

Limitations

The presented samples and vignettes were chosen for illustrating some core psychopathological and phenomenological points. The selected patients were above average when it came to being able to articulate the nature of their abnormal experiences. They all had EASE-scores numerically similar to the mean of the entire sample (27.5 and 25, respectively).

Psychopathological Analysis

At first glance, the 4 patients seem to display different symptoms and each patient presents a unique combination of clinical features. However, we do not think that these patients suffer from an arbitrary collection of mutually independent symptoms. Moreover, the symptoms in the different patients display a certain phenomenological affinity. Let us briefly summarize the phenomenological core of each vignette: in the first patient, Henry, we encounter a basic diminished sense of embodied self-presence, with a dwindling sense of agency and a loss of ego boundaries. In the case of Michael, we are faced with a peculiar layer-like experiential structure that progressively involves an increasingly diminished sense of self and an increasing alienation and objectification of the experiential processes. In Kasper, we see a deep-seated self-transformation where parts of the self-turn into invading personalities. Finally, Stefan has since childhood had a feeling of a profound (ontological) self-transformation that becomes psychotically elaborated in adulthood with the emergence of “quasi-subjects” (invading animals/creatures). Thus, from a phenomenological perspective, we think all 4 cases exhibit common features. They all involve a pervasive disturbance of self-experience. We would characterize this profound disturbance as amounting to a shattering of the normal structures of subjectivity, an impaired sense of being an embodied self-present and stable subject of experience. In phenomenological terms, this unstable sense of self comprises phenomena such as a diminished sense of presence, agency, a loss of ego boundaries, a disorder of temporality, and a felt distance between the self qua subject of experience and the concrete experiences, which consequently become objectified and converted into increasingly alien entities. These entities eventually convert into hallucinations or influence phenomena. This process has been called “alterization” by Ey [31] or externalization and thematization by Klosterkötter [29]. It is this basic self-disorder that not only comes to expression in a variety of reported symp-
toms but which also links and organizes the symptomatic facets. It is here helpful to introduce the notion of a psychopathological Gestalt [32, 33]. A Gestalt is a clinically meaningful whole that connects and permeates different symptomatic aspects, imbuing them with their clinical significance and diagnostic specificity. The single aspects instantiate the Gestalt’s manifestation [34]. Rather than being seen as mutually independent clinical features, the different symptoms reported by each individual patient should be seen as aspects of a whole. In somatic illness, the notion of a symptom signifies a well-delimited, objectively existing entity with a referential function, e.g., jaundice as indicative of a liver disease. In the psychopathological vignettes presented above, the symptoms by contrast overlap each other with gradual transitions and are mutually linked by meaningful relations of implication, entailment, and interdependence. That this holds true in the case of psychopathology was already recognized by Jaspers:

All research differentiates, separates and studies individual particulars in which it tries to discover certain general laws. Yet all these individual particulars are taken out from what is in reality a complex unity. In grasping particulars, we make a mistake if we forget the comprehensive whole in which and through which they exist. This never becomes the direct object of our study, but only does so via the particulars. It is never examined in itself but only in the form of some schema of its essence. […] We can state the following in relation to it: the whole comes before its parts; the whole is not the sum of its parts, it is more than them; it is an independent and original source; it is form [Gestalt]; the whole cannot therefore be grasped from its elements alone. [35]

Such a view has a profound epistemological significance. In the current permutations of operational systems, we see a proliferation of entities defined by a restricted number of symptoms that on the basis of a superficial description look alike. The result is a lack of diagnostic clarity, significant overlaps between categories, and very high levels of comorbidity. In the domain of psychosis and their spectrum disorders, there is an urgent need to complement the criteria-based approach with the notion of a Gestalt (whole) that assures the diagnostic specificity of the symptoms. The psychopathological grasp of such Gestalts can only be performed by an experienced and knowledgeable psychiatrist, who is in possession of a theoretical understanding of how the different aspects of consciousness – bodily, temporal, social – are interconnected and interdependent. It should thus be clear that merely quantifying these phenomena as isolated symptom-like features without a proper grasp of their Gestalt is insufficient. Put differently, a psychopathological investigation of self-disorders requires the clinical skills to enable the articulation and detection of the Gestalt during the interview. Furthermore, such skills enable the clinician to notice seemingly banal and vague complaints as being potentially reflective of a profoundly disordered self (in Blankenburg’s terms “specific non-specificity”) [36].

However, not all SCZ patients reveal such a Gestalt. Some patients may exhibit hostility/suspiciousness, dissimulation, negativism, severe poverty of speech or incoherence. In melancholia, we can observe another and qualitatively different Gestalt involving self-disorder, but in this case, we are dealing with a state phenomenon [37]. Fleeting self-disorders such as feelings of depersonalization may transiently occur in people outside the SCZ spectrum under severe stress or trauma.

Conclusion

Arguing that an instability of the basic structures of consciousness plays a generative role in SCZ spectrum disorder is an important step forward in elucidating the psychological mechanisms involved in SCZ. But it must be recognized that self-disorders are aspects of a Gestalt rather than separate and well-delineated symptoms that appear in isolation from each other. The four presented vignettes and our discussion should illustrate how a phenomenological approach can help grasp these tacit structures of experience. Such an approach should prove helpful to psychotherapy and empirical research [11]. As trait-phenomena self-disorders are currently the closest, we can get to a psychological understanding of SCZ.

Statement of Ethics

The project from where these patients were recruited was approved by the Ethics Committee of Region Zealand Denmark (approval February 20, 2017, ref. No. SJ-599) and in accordance with the Declaration of Helsinki 2013. Each of the participants in this paper provided written informed consent to participating in the videotaped interview and that the material could be used for research publications. The subjects in this paper have been anonymized with pseudonyms.

Conflict of Interest Statement

The authors have no conflict of interest to declare.

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Author Contributions

All the authors have viewed the original interview videos and jointly selected the four vignettes in the manuscript. K.E.S. and J.P. have written the first drafts of the manuscript. D.Z. have critically revised the manuscript. All authors have jointly contributed to the final version of the manuscript.

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