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Subjectivity, phenomenology, and psychotherapy of schizophrenia

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www.cfs.ku.dk
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Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for the DSM-5 Future


“A gaping disconnect exists between the brilliant discoveries informing genetics and neuroscience and their almost complete failure to elucidate the causes (and guide the treatment) of mental illness”
Some concerns

Explosion of research publications, scales and interview schedules
Proliferation of diagnostic entities
Proliferation of’ co-morbidity’

No evidence of improved reliability and accuracy of clinical diagnoses
No etiological or therapeutic break-through
Mainly technology-driven development
Academic ’anti-psychiatry’
Questionable credibility of psychiatry as a profession
Additional response: revival of psychopathology

Phenomenological manifestations are constitutive of the definition of mental disorders. Therefore, the psychopathological distinctions have to be “faithful” to mental reality, in order to be used in research or therapy. Disorders of rationality, intersubjectivity, identity, etc., appear in a phenomenal space that does not completely coincide with the space of neuro-cognitive functions. A need of phenomenology: A) systematic investigation of subjectivity and its structures in mental disorders, B) adequate concepts and C) adequate epistemology, i.e., tailored to the nature of the study-object.
CLASSIC METAPHORS OF SCHIZOPHRENIA

"Le syndrome de discordance" (Chaslin)

Disunity of consciousness (Kraepelin)

Intrapsychic ataxia (Stransky)

Autism/Spaltung (Eugen and Manfred Bleuler)

Perte du contact vital (Minkowski)

Crisis of "common sense" (Blankenburg)

Schizophrenic Grundstimmung: Ich-Störung (Gruhle; Berze)
Features of schizophrenic autism:

Lack of attunement
Isolation ("growing from within")
Dislocation from social matrix

Perplexity, lack of meaning, loss of self-evidentness, loss of "natural self-evidence", lack of immersion, hyperreflexivity

In phenomenological terms: disorder of pre-reflective intentionality, lack of optimal grip

THE QUESTION OF THE SUBJECT and SUBJECTIVITY STRUCTURE?
Subjectivity structure in schizophrenia "Autism" as generative disorder

Disorder of the core self

Lack of immersion
Lack of self-evidence

Pre-reflective, pre-conceptual level of experience

Instability of 'intentional arc'
Kurt Schneider: diagnostic weight attached to self-disorders:

Among the basic characteristics of experience, certain disturbances of self-experience show the greatest degree of schizophrenic specificity; here we refer to those disturbances of first-personal givenness (*Ich-heit*) or quality of mineness (*Meinhaftigkeit*) which consist of one’s own acts and states not being experienced as one’s own (...)”
KINDS OF SELF

1. Transcendental prefix (Kant)

2. No self-doctrines

3. Experiential (phenomenological entity)

4. Narrative self
Self

Minimal (core) self-awareness: a first-person perspectival givenness of experience (mineness; me-ness; ipseity): a basic, elementary, structural configuration of experience.

Extended-narrative-personal self-awareness: self-awareness as a person— with individuated features and dispositions, mediated by language and narrative, representations and reflection (psychological terms: self-image, self-esteem)

Specificity for schizophrenia spectrum is linked to disorders of minimal self
SCHEMATIC ILLUSTRATION OF EXPERIENCE

"First person perspective" Perspectival "mineness" of experience, "me-ness"

Reflection and its own elusive subject

ELUSIVE subject

Sense of self; "self-presence"

PHENOMENAL CONTENT

PHENOMENALITY CONSCIOUSNESS-AS-MEDIUM
Anomalous self-experience

Unstable self-presence, distortions of first person perspective, feeling ephemeral, loss of privacy of one’s immanence

Varieties of disembodiment

Anonymity and spatialization of experience

Perplexity, lack of common sense, lack of immersion

Solipsism
Manual

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EASE: Examination of Anomalous Self-Experience

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Lennart Jansson\textsuperscript{a} Peter Handest\textsuperscript{a} Dan Zahavi\textsuperscript{d}

WWW.EASENET.DK
List of empirical and theoretical publications
Pathology of self in schizophrenia: phenomenality

Unstable, insufficient phenomenality of experience.

**Complaints**
- Insufficient distinction (awareness) of intentional modes
- Feelings of internal block, barrier, heaviness, opaqueness
  - "Everything feels hazy"
  - "I am not fully conscious"
  - "I am only 50% conscious"
- "Nothing is clear or vivid anymore" (perception unaffected)
  - "It feels as if I have a constant fog in my head"

**Hyperreflexive transformation of consciousness**
Disorder of perspective

Total obliteration of point of view

Instability of point of view (trembling, displacing)
Consciousness gradually loses its coherence. The center cannot hold. The “me” becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a vantage point from which to look out, take things in, assess. No core holds things together, providing the lens through which we see the world.
Disturbed “mineness” and écart between experience and self

- My feeling of experience as my experience only appears a split-second delayed
- I have “slightly strange experiences of a lacking relation between myself and what I am thinking”
- “Thoughts appear as strange and irrelevant, as if they were not mine”
- **Spatialization** of experience: e.g. sensed as inner thingly objects
Écart between experience and self: "simultaneous introspection"

“My first-person perspective is replaced by a third-person perspective” (explained by the patient that he constantly witnesses his own experiencing).

- I constantly inspect myself: e.g. during a conversation, I observe myself to the point of having difficulty in grasping what others are talking about.

”I live mainly in my head”
Disorder of self-presence

- It is as if I am not a part of this world; I have a strange ghostly feeling as if I was from another planet. I am almost non-existent.

I have a feeling ‘as if’ *it is not me* who is experiencing the world; it feels *as if* another person were here instead of me

- I feel that my “inner nucleus”, innermost identity, has disappeared.

- A feeling of total emptiness frequently overwhelms me, ‘as if I ceased to exist’.

- I do not really feel as a human subject, as a person with a soul; I feel like a dispensable thing, like e.g. a refrigerator.

I feel like a time-traveller.

- c.f. mirror-phenomena.
Pathology of self in schizophrenia

Disorders of minimal self

[ineffable] sense of self-transformation

Disorder of immediate self-coincidence (radical self-recognition)

Perspective
Self—content distance
Anonymity of experience
SPATIALIZATION
PERCEPTUALIZATION
Dis-embodiment
Motivational problems

Solipsism
Lack of ego-boundaries

Disorders of narrative self-awareness
Pathology of self in schizophrenia: LINKING CORE AND NARRATIVE

Disorders of pre-reflective self-awareness

Lack of sense of self. Failing self-coincidence (radical self-recognition)

Disorders of extended narrative self-awareness

PSYCHOSIS
Relative distribution of SDs (EASE and pre-EASE samples)

- Schizophrenia
- Schizotypal disorder
- Other mental illness
- No mental illness

EASE
Prodromal
Linkage

Dias 23
TOP study - Norway Diagnostic distribution

- Sch: 63%
- Bipolar: 23%
- Other Psy: 14%
## Bipolar versus Schizophrenia

<table>
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<tr>
<th>Model</th>
<th>B</th>
<th>S.E.</th>
<th>p</th>
<th>OR</th>
<th>95%CI</th>
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## Bipolar vs Schizophrenia

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<th></th>
<th>B</th>
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Some conclusions

Psychiatry needs a conceptual axis around which it can integrate its own manifold (rather than stay with additive listing)

It needs phenomenology and hermeneutics to address the "psychiatric object", i.e. assist description & understanding of the phenomenal realm

Philosophical thinking is indispensable for psychiatry and provides a link to its neighboring and overlapping disciplines

Phenomenological grasp needed for psychotherapy: a) understanding of the patient’s ontological position, b) therapeutic alliance, c) modification of experience, d) coping)
COGNITIVE-BEHAVIORAL THERAPY IN SCHIZOPHRENIA-some issues

Cognitive-behavioral therapy (CBT) has the most important role in psychotherapy for schizophrenia since the 1990s. Methodologically rigorous meta-analyses found modest effect-sizes of CBT treatment.

Questions emerge about for what and for whom CBT actually works.
The main assumption behind the CBT for schizophrenia is that neither the noxious events nor the experiences *per se* but rather the individual’s appraisals of these events and experiences, are pathogenic and influence the development of schizophrenia.

The information processing of stimuli is biased, causing distortions of the individual’s construction of experience. The distortions consist of cognitive errors (biases), dysfunctional beliefs, and maladaptive cognitive schemas.
Single symptom approach/”periodic table” of psychiatric symptoms

Atomization, reification

Two problematic assumptions of the single-symptom approach:

1) symptoms are readily definable isolated elements, similar to basic chemical elements
2) symptoms are traceable like elements in chemical composites
**Delusions**

conceptualized as *false* or *dysfunctional beliefs*, determined by distortions of information processing (of the so-called “theoretical rationality”).

Three (main) sources of such distortions:

1) “jumping-to-conclusions” data-gathering bias
2) externalizing attributional (explanatory) style
3) “theory of mind” (ToM) deficit