Self-Disturbance in Schizophrenia: A Phenomenological Approach to Better Understand Our Patients

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ABSTRACT

A phenomenological approach explains the apparently unintelligible experiences of patients with schizophrenia as a disruption of the normal self-perception. Patients with schizophrenia suffer from a decline of "me," the background core of their experiences. Normally tacit experiences intrude into the forefront of their attention, and the sense that inner-world experiences are private diminishes. These patients lose the sense that they are the origin of their thoughts and actions; their self-evident network of meanings and a solid foundation of life disintegrate. Subsequently, their experiential world is transformed, alienated, intruded, and fragmented. In this article, a phenomenological investigation of the self-experiences and actions of 4 patients with schizophrenia is presented.

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Imagine that both you and your world have changed in a mysterious way. Thoughts keep popping up; your head fills with unrelated thoughts; it seems as if they are humming like bees. There is no room for these thoughts. They do not seem to be yours. Where do they come from? You do not exactly sense the presence of your body, where it is, where it ends. The proximity of others feels like an intrusion. You experience strange alarming sensations that you never had before. Your body has changed; it seems to disintegrate as if you have an alarming disease. All of these experiences feel like violations of your inner and private world. Eventually, you hear strange voices while no one else is around. Or, you sense an intrusion of strange thoughts in your head. Or, you experience your actions as being induced by strange forces. You are losing control!

Patients with schizophrenia who have these experiences repeatedly will behave strangely. They may stare, make idiosyncratic comments, and avoid personal contact. They are petrified or gesture oddly. Their erratic stories bewilder friends and family. Or, they become unintelligible while expressing fragments of sentences or words. Eventually, family members will grow more and more convinced that the patient is no longer the same familiar person. These patients seem essentially changed; they feel misunderstood and end up isolated and stigmatized ("mad").

This description is the classic story of schizophrenia: puzzling experiences that lead to serious isolation. The usual diagnostic formulation includes hallucinations, thought insertions, delusions of control, and incoherent behavior within the framework of schizophrenia.

However, closer inspection might challenge the incoherence of the schizophrenia patient's behavior. Might this behavior be a normal consequence when we look at the patient's abnormal self: their self-experience and personal story, which has been upset in a very specific way? There seems to be a gap of understanding between the symptoms, as formulated by professionals (a third-person explanation), and the experiences of patients (a first-person story). Clara Kean,[1] a woman diagnosed with schizophrenia, illustrated this gap lucidly in her first-person story. In addition to hearing voices and suffering from alien thoughts, what scared Kean was the constant feeling that her self no longer belonged to her. She suggests that psychiatrists should help patients reconstruct their "selves" within the world that surrounds them. Our article advocates a phenomenological investigation to bridge the gap between the patient and the physician by giving some insight into the experiential world of patients with schizophrenia and by connecting these experiences to the observed symptoms. First, we explain what phenomenology of self-experience is and make some clarifying conceptual distinctions. Second, we report self-experiences of 4 patients with schizophrenia. Third, we perform a phenomenological investigation of these self-experiences. Finally, we conclude that a phenomenological investigation enables us to understand the experiences of patients with schizophrenia more thoroughly.

PHENOMENOLOGY OF SELF-EXPERIENCE

Phenomenology is a philosophical approach that seeks to describe and understand how people experience themselves and their surroundings.[2] Phenomenological philosophers bracket all scientific operations concerning experiential phenomena (formulating hypotheses, explanations, causality

Clinical Points

- Patients with schizophrenia may suffer from a disturbance of the normal self-perception.
- Due to puzzling experiences of self-disturbance, patients report incomprehensible experiences, leaving them misunderstood by others.
- A phenomenological investigation may help to bridge the gap between the patient and clinician by giving insight into the experiential world of the patient and by connecting these experiences to the observed symptoms.

claims, etc). These philosophers are first concerned with the essentials of experiences.[3] Edmund Husserl (1859–1938) designed the approach and Karl Jaspers (1883–1969) introduced it into psychiatry as a tool for psychopathological research.[4] Phenomenology influenced psychiatry strongly in the first half of the 20th century. Since the beginning of the 21st century, we discern a resurgence in contributions of modern phenomenologically oriented philosophers and psychiatrists.[2,3,5,6]

To begin, we should clarify some concepts that are frequently used in modern phenomenological investigation. A phenomenological investigation in psychiatry is a first-person approach that pursues an understanding of experiences in their meaning for the subject.[2] For example, a chair on which one's late mother used to sit is different than a chair one has never seen before, as it is attached to memories that elicit emotions. Thus, one can feel intimately related to a chair; the experiences of the subject have an intentional structure (experiences are essentially directed at their surroundings, they are about or of something).[2] In addition, experiences have a Gestalt structure, which means that they have something in focus while the rest is in the background.[2]

The phenomenological tradition distinguishes 2 dimensions with regard to the concept of self or personal identity ("my person"). On the one hand, there is the dimension of an experiential self ("me"), a basic awareness of self-sameness, with an embodied structure, that remains stable during life and of which we are prereflectively aware.[2] For example, our nose is continuously present in our visual field, but we are seldom aware of it unless we focus on it. If our nose disappeared, we would miss it, but would we know what is missing? That is how we experience our "presence," in every concrete experience and action of our body and mind, as an implicit background of our day-to-day experiences. Our feeling of presence is an important part of our inner world. Our inner world is private in contrast to the outer world, which is perceptible to us all. In this sense, we are the owner of our experiences (sense of ownership) in contrast to public outer experiences. On top of this sense of ownership, we have the sense of being the source or author of our thoughts (inner movements) and will, intentions, and actions (sense of agency).[2] As a central gathering point, we receive and create our private experiences, intentions, and actions ("my ownership" and "my authorship").

On the other hand, the dimension of a narrative self ("my story") is a personal story that evolves over time by our personal moral and intellectual convictions, decisions, and actions, arising from our presence and daily involvement in the world.[2] How can an experiential self construct a narrative self? Gallagher and Zahavi[2] reviewed the conceptual and empirical literature about this issue. They indicate 4 cognitive capacities of the subject that are necessary for the construction of a narrative self as follows: (1) a capacity for temporal integration of information (locating information within a past, present, and future perspective), (2) a capacity for minimal self-presence (locating the "I" who experiences and receives sensory information and who also is the origin of thought, intention, and action), (3) a capacity needed for encoding and retrieving episodic autobiographical memories (recollecting the specific time in the past when an event took place and attributing the past event to the "I" who is remembering it), and (4) a capacity for engaging in reflective metacognition (delivering a helicopter view, allowing translation of an event in "my story"). Patients with schizophrenia can have problems with one or more of these capacities, which can result in self-disturbance.

CASE REPORTS

In the following 4 case reports, we describe the self-disturbance of people with schizophrenia.

Case 1

Ms A, a 47-year-old artist with schizophrenia, began experiencing prodromal complaints during adolescence. At the age of 24 years, these complaints merged into positive symptoms (hallucinations and delusions of control). Several psychotic episodes followed until she learned to accept her disease and to manage it. She recovered substantially in spite of on-going strange experiences and hallucinations. Looking back on her disease, Ms A said that changes started with a kind of background feeling when she was 16 years old. She thought, "I can't be myself," and did not know how to change that feeling.

> It began with the feeling when pressure is exerted on you to adapt, and you are not allowed to be yourself. At a certain moment, this grows into a psychosis in which I do not notice that I am not myself anymore; a wizard has taken control over me. It goes constantly a step further. An example in between those extremes: a man on the railway station asked for 2 euros. I gave him the money, but moreover, I gave him a kiss. At that moment I'm confronted with something, which is beyond my control. I did not want to kiss him; I did not have that intention; it came out of the blue.

She explains how paranoid thoughts could flourish upon a basic tone of ominous tension. She had catatonic moments.

> I suddenly was quiet—the feeling of all cells losing tension. I cannot talk, I cannot think, it is quiet. I still can receive; I can see the environment and move my eyes a little bit. And then,

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> all of a sudden, it flows back in, or something like that. In fact, everybody always feels that tension, but nobody is aware of it. But when this tension breaks off, you suddenly realize how weird it is that we always have tension.

The extreme involvement in her inner world of thoughts made the outer world become distant and led to neglect of her body.

> If you are psychotic, the only thing you can do is produce: meanings, words, thoughts. The outer world is threatening because you cannot correct the outer world, it comes directly inside. If you are psychotic, your body is living another life; it is superfluous. The focus for the body is gone; the body is negligible; hence, you neglect it. Your body goes its own way. . . .

Case 2

Mr B, a 39-year-old unmarried man, was diagnosed with schizophrenia at the age of 25 years. After the sudden death of his grandmother and concomitant changes of medication, he relapsed with experiences that he recognized from psychotic periods in the past. Mr B felt as if his skull was shrinking. He did not feel his body and felt as if he was someone else. Movements felt strange, as if controlled by others. Sometimes, it was as if he heard in his head that he was not capable of doing things. Eating was laborious, because Mr B feared that he might damage something with his fork. Mr B compares present experiences with psychotic relapses in the past, "Earlier, when I used to have these kinds of sensations, I always attributed them to others. Now I know that a disturbance in my head causes these strange experiences."

Case 3

Mr C, a 24-year-old student of molecular biology, could not finish his undergraduate studies and sought help at a very early stage of psychosis. He had noticed in past years that his emotions were absent at moments that he expected them to be present (eg, natural disasters and the assault on the Twin Towers did not affect him).This lack of emotion made him wonder whether he might be antisocial. He stated, "It seemed as if the world lost its 3-dimensionality; sometimes, I had to touch things to perceive if they were real. It seemed as if the environment moved twice as quick through time as I did." A constant mixture of different thoughts on completely different subjects gave Mr C the feeling of pressure inside his head. "Thoughts came uninvited; it is as if they were drained into my thoughts, without asking. And then, at a sudden moment, my mind was empty, and I forgot what I was doing." He isolated himself. "I could sit for days, doing nothing, having no will to think at all."

Antipsychotic medication helped Mr C regain his ability to study and pick up his social life. But after 1 year he said, "I still miss my former self; I am indifferent to my current self compared to the one I used to be."

Case 4

Ms D, 30 years old, was admitted to an inpatient psychiatric unit. She had treatment-resistant psychotic symptoms such as hearing voices and delusional thoughts, and she was suffering from depression. The voice commanded her to kill herself and threatened to hurt her family if she would not obey. Ms D developed worrying thoughts that she was about to disappear. She needed to hold on to firm objects to stop herself from vanishing. A constant process of hyperconscious thinking, even of the simplest task, bothered her. After some time, Ms D became convinced that her own soul was removed and replaced by the soul of another patient. She realized that she had become the other patient, "I have her soul and lost my own…." Later on, Ms D became convinced that her soul was replaced by the devil. This delusion was stirred up by a foul commentary voice. The voice gave sexual and discriminating commentary about people near to her. The world became ugly, disgraced, and soiled by the voice. She felt severely deprived of her soul and of her familiar emotions and was unable to reach into the outer world, as if living in a bubble. She could no longer experience love for children or affection for elderly people.

Looking at herself in the mirror, Ms D found no reassurance of herself being there, seeing a pair of strange eyes that did not belong to her instead. She struggled to regain her familiar rhythm of conversation and connection with her self and to be able to make contact with others again. But, she felt frozen and inhuman. These experiences were inexplicable for Ms D; she could not recognize herself anymore and compared her symptoms with a neurologic disturbance that she had read about:

> I sympathize with the patients of Oliver Sacks.[7] We can read about prosopagnosia, but we can't begin to imagine what it must be like to be unable to see or recognize faces. I feel the same in explaining my complaints. Losing sense of being me, not being able to make sense of what happens to me, and being unable to connect with others, makes me feel inhuman. . . .

DISCUSSION

How can a phenomenological investigation help clinicians to understand the disruption of experiential self and distortion of personal narrative in patients with schizophrenia? According to modern phenomenological theories, schizophrenia can be specified as a self-disturbance with 2 features: diminished self-affection and hyperreflexivity.[3]

Diminished self-affection brings forward an abnormal intentional structure and Gestalt structure of experience by which patients suffer from an exaggerated decline of the experiential self ("me"), which normally functions as a stable, tacit, unnoticed background core of their experiential field. In other words, the patient's "me" is fading away. However, patients cannot grasp this perceived loss of self as this vacuum intrudes into their field of attention.

Hyperreflexivity is an abnormal intentional structure and Gestalt structure of experience by which patients suffer from an exaggerated attention for phenomena that are usually not central to one's awareness because they form a tacit part of the background. Concomitantly, attention to other phenomena is

reduced. Thus, the preoccupied part of the attentional field is disconnected from the relational context. This disruption occurs automatically, a kind of popping up of normally unnoticed phenomena (perceptions, thoughts, feelings). These disruptions become the center of focus, separated and objectified as alienating, intruding, and fragmented things. In other words, the patients' experience of their "world" is strange, intrusive, and fragmented.

The disruption of the patients' experiential self expresses itself in a diminishing sense of ownership of experiences ("my private experiences") and a loss of agency of actions ("my authorship") concerning their experiences and actions.[2] In other words, their private inner world feels invaded and their basic sense of being the origin of their actions is vanishing.

Finally, this overwhelming sense of vanishing "me" (diminished self-affection) and this perplexing preoccupation with inner experience (hyperreflexivity) are accompanied by a "disturbed grip or hold"[3]: the alienated, intruding, and fragmented phenomena are bereft of their familiar meaning. Patients lose their self-evident network of meanings and with that a solid foundation in daily life. In other words, they lose control.

Accordingly, the case reports presented here may be understood as expressions of a self-disturbance. Ms A tells about the disappearing presence of her embodied self and the loss of meaningful control over her actions; Mr B tells about his shrinking body parts, alienating body movements, and intrusion of others; Mr C discusses his vanishing emotions, intruding thoughts, change of ownership, and loss of agency over thinking; and Ms D provides insight into her disappearing soul, the intrusion of verbal sounds and others, and the accompanying loss of grip on familiar meaning networks.

How can a disturbed experiential self evolve in a disturbed narrative self? According to Gallagher and Zahavi,[2] the disturbed narrative self of patients with schizophrenia is the effect of abnormalities in the temporal structure, minimal self-reference, autobiographical memory, and metacognition. The self-disturbance seems to be a basic trait that may manifest itself in the prodromal period of schizophrenia.[8] For instance, impairment of self-temporalization can lead to a confused or fragmented self-narrative. Lack of self-presence reduces the awareness of being the author of one's own thoughts and actions. The lack of being present as an "I" in the center of one's own experience reduces the ability to feel a part of the events that one is involved in and hinders storage of being a subject in one's own memories. The lack of a feeling of authorship of thoughts and actions can lead to misattribution of agency, with symptoms of thought insertion, delusions of control, and/or hallucinations. Difficulties remembering personal events can lead to impoverished content of the narrative. Exaggerated attention on normally tacit dimensions of background experiences can lead to confabulated or delusional narratives, which symbolize the patients' experiences of alienation, intrusion, and fragmentation.

Therefore, the patients presented in our case reports tell distorted narratives that are impregnated with the evaporation of their embedded selves and with feelings of intrusion and fragmentation, which they express in words of their cultural heritage (*voices*, *powers*, *ghosts*, *God*, *aliens*, etc). Their profound and puzzling sensations are fertile ground for existential explanations, which distort reality and alienate them even more from the people around them. Ms A and Mr B had growing awareness of their disease and capabilities of reflecting on previous episodes. In their cases, these abilities helped to stabilize the fragile self by recognizing present self-disturbances as strange experiences belonging to their disease instead of falling back to previous strategies such as delusional explanations. For them, it was possible to restore their distorted narrative as a consequence of proceeding insight.

CONCLUSION

Are the experiences of patients with schizophrenia understandable? We hope to have illustrated that phenomenological investigation can offer some insight into the inner world of patients with schizophrenia by unprejudiced and open-minded listening to the language in which they express themselves. As Stanghellini has said, we must take care not to "amputate the madness from the man who embodies it,"[5(p46)] but rather to take notice of the first-person perspective and the story that it provides to the clinician. This investigation may help to enhance our comprehension of patients with schizophrenia. By understanding their narratives, we can improve treatment alliance and help patients to regain parts of their selves.

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