

# Schizophrenia as a disorder of the self

M.G. Henriksen<sup>1,2</sup>, J. Nordgaard<sup>1</sup>

<sup>1</sup> Psychiatric Center Hvidovre, University of Copenhagen, Denmark; <sup>2</sup> Center for Subjectivity Research, University of Copenhagen, Denmark

## Summary

*This paper offers an overview of a current direction of clinical and empirical research in schizophrenia, viz. the phenomenologically informed approach that regards the generative disturbance of schizophrenia as a specific disorder of the self. Empirical studies have recently documented that anomalous self-experiences (i.e. self-disorders) aggregate in schizophrenia spectrum disorders, but not in other mental disorders. What appears to underlie this aggregation of self-disorders is an instability of the first-person perspective, which threatens the most basic experience of being a subject of awareness and action. In*

*this paper, we elicit the meaning of the phenomenological notion of “disordered self” in schizophrenia spectrum disorders, we offer rich clinical descriptions of self-disorders, and we provide a concise overview of results from contemporary empirical studies. Finally, we provide some suggestions for future research on self-disorders, their nosological and diagnostic implications, and consider their potential value in psychotherapy for schizophrenia.*

## Key words

Self-disorders • Schizophrenia • Schizotypy • EASE • Phenomenology

## Introduction

The neglect of the phenomenology and epistemology of the psychiatric object, which occurred in the wake of the so-called “operational revolution” in psychiatry, has led to a vast oversimplification of psychopathological phenomena (e.g. delusions and hallucinations, but also syndromes), depriving them of their phenomenological validity and any overarching conceptual framework<sup>1</sup>. One possible remedy to this unfortunate development involves a return to the basic science of psychiatry, viz. psychopathology, and systematic explorations of the ways in which psychopathological phenomena manifest themselves in patients’ experiences and existence. Here, we must bear in mind that grasping mental phenomena is not similar to grasping physical objects. To place the “disordered self” in schizophrenia into proper perspective, some preliminary considerations on subjectivity and consciousness are required.

For a long time, the issue of subjectivity was nearly forgotten in psychiatry, but currently we are witnessing an almost global increase of interest in this particular topic. Psychiatry, existential psychiatry, phenomenological psychiatry, psychoanalysis, psychosocial rehabilitation and dialogical psychology all seem to agree that schizophrenia involves a “diminished sense of self” – a view also supported by many first-person accounts of schizo-

phrenia<sup>2</sup>. Yet, the meaning of the term “self” and the nature of its “diminishment” vary considerably among these approaches – some considerations on these approaches, similarities and dissimilarities can be found elsewhere<sup>2,3</sup>. Due to the ambiguities associated with the notion of “diminished sense of self”, we first illuminate the phenomenological notion of “disordered self” in the schizophrenia spectrum (i.e. schizophrenia and schizotypy). Secondly, we offer a series of typical and quite common clinical complaints of anomalous self-experiences (i.e. self-disorders) from patients diagnosed within the schizophrenia spectrum. Finally, we will summarise the results from contemporary empirical research and discuss their implications for future research and treatment in schizophrenia.

## The disordered self

For the purpose of providing the reader with a preliminary sketch of the conclusions we shall draw later, we anticipate here the central result from the empirical studies: collectively, these studies demonstrate that the self in schizophrenia is often fragile and unstable. Most importantly, the “self” that is found to be disordered in schizophrenia spectrum disorders in empirical studies does not refer to complex aspects of selfhood such as “social identity” or “personality” (although these as-

### Correspondence

M.G. Henriksen, Center for Subjectivity Research, University of Copenhagen, Njalsgade 140-142, 25.5.23, DK-2300 Copenhagen S, Denmark • Tel. +45 3533 5597 • E-mail: mgh@hum.ku.dk

pects certainly also may be affected), but to a very basic *experience* of being a self. This experience signifies that we live our (conscious) life in the first-person perspective, as a self-present, single, temporally persistent, bodily and bounded subject of experience and action <sup>4</sup>. In other words, it is the first-personal articulation of experience that implicitly facilitates a sense of “mine-ness” or “ipseity” <sup>5</sup>, transpiring through the flux of time and changing modalities of consciousness (e.g. perception, imagination, thinking), which appears to be unstable in schizophrenia. Consequently, the normally tacit, taken-for-granted, and pre-reflective experience of being a self no longer saturates one’s experiences in the usual and unproblematic manner. It is quintessential to realise that this experiential notion of “self” is not a hypothetical construct, but a real and phenomenologically accessible structure of consciousness. I am always pre-reflectively aware of being myself and I have no need for self-reflection or self-perception to assure myself of actually being myself. For example, I do not need to reflect upon *who* these trains of thoughts might belong to or *whose* image I perceive in the mirror in order to know that it is *me*. This intimate, foundational sense of self is not really a sort of knowledge, but rather prior to knowledge; it arises from a structure of consciousness that is operative in all experiential modalities; it is simply there, given and imbuing all my experiences with an elusive, yet absolutely vital feeling of “I-me-myself” (which we also may describe with the concept of self-presence). Following Henry, we can say that this basic sense of self arises from the “auto-affectivity” of subjectivity – a feature of the very givenness of consciousness <sup>6</sup>. Of course, I may still question *what* I think, *why* I have these thoughts or feelings and the possible allurements of my body or the nature of my being (e.g. my moral values, ability to exist in accordance to these values, and the purpose of my existence), but usually the question never arises if these thoughts, feelings or this body actually is *mine*.

In schizophrenia spectrum disorders, by contrast, this structure of consciousness is unstable and oscillating, resulting in certain characteristic anomalies of self-experience (e.g. a markedly diminished sense of mine-ness of one’s own thoughts, actions and body), which patients frequently report and which, in empirical studies, have consistently been found to aggregate in schizophrenia spectrum disorders but not in other mental disorders (see summary of results below).

From a phenomenological perspective, this basic experience of being a self is intrinsically bound together with an automatic, pre-reflective immersion in the world. Thus, it should come as no surprise that the disorders at the “self-pole” of experience in the schizophrenia spectrum disorders also frequently entail certain deformations at the “world-pole” of experience. For example, lack of spon-

taneous immersion in the shared world and diminished sense of being present in it, alienation from the social world (often leading to social isolation and withdrawal), perplexity (questioning what others consider quite obvious or just take for granted, e.g. why do people say “hello” to each other or why is the colour code in traffic signals “red-yellow-green?”) and various forms of de-realisation. Against this backdrop, it should be evident that the phenomenological notion of a “disordered self” in the schizophrenia spectrum disorders does not refer to a disturbance solely at the level of the subject, but rather to a disturbance of the tacit and foundational “self-world structure” <sup>7</sup> or, differently put, of “the intentional arc” <sup>8</sup>. This self-world structure appears to be fragile and unstable in disorders in the schizophrenia spectrum, constituting its core vulnerability, and resulting in a variety of specific self-disorders of which we provide clinical examples below.

It also merits attention that this “instability” does not equal something like a *disappearing* or *dissolution* of the self. Of course, patients with schizophrenia spectrum disorders continue to be subjects of awareness and action, and to affirm themselves with the first-personal pronoun (i.e. the “I”). Patients experience self-disorders within an overarching experiential-existential perspective, which constitutes their being-in-the-world, and no matter how many self-disorders they suffer from, their lives remain complete forms of human existence. The notions of “instability” and “dis-order” suggest, however, that the normally tacit and pre-reflective experience of being a subject of awareness and action no longer saturates one’s experiences in the usual, unproblematic way.

## Clinical descriptions

Many first-admitted patients with schizophrenia spectrum disorders complain of feeling as if they do not truly exist, of lacking an inner core and of being profoundly, though regularly ineffably, different from others (*Anderssein*). The distinctness of the quite frequent feeling of *Anderssein* seems to be a pervasive sense of being ontologically different; it is a feeling of being different in which one’s very humanity is at stake. As one of our patients put it, “I looked just like every other child, but inside I was different. It is as if I am another creature that somehow ended up inside a human body”. Another patient described this feeling in the following way: “I feel categorically different from others”. Occasionally, the feeling of *Anderssein* may evoke a sort of solipsistic grandiosity (e.g. “I often doubt if others have a soul or any feelings”), but no matter what form this underlying feeling may take, it is usually a constant source of solitude, isolation and suffering. Frequently, patients also describe a deficient sense of “mine-ness” of the field of awareness (e.g. “my thoughts

feel strange as if they aren't really coming from me"), which sometimes may be linked to various distortions of the first-person perspective (e.g. "I look out through my eyes from a retracted point, and I see my skull in my visual periphery"). In her autobiography, Prof. Elyn Saks shares a dramatic experience of what seems to be a rare, momentary dissolution of the very first-person perspective:

- And then something odd happens. My awareness (of myself, of him, of the room, of the physical reality around and beyond us) instantly grows fuzzy. Or wobbly. I think I am dissolving. I feel – my mind feels – like a sand castle with all the sand sliding away in the receding surf. (...) Consciousness gradually loses its coherence. One's center gives away. 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 sturdy vantage point from which to look out, take things in, assess what's happening. No core holds things together, providing the lens through which to see the world, to make judgments and comprehend risks <sup>9</sup>.

Often, patients complain of thematically unrelated thoughts breaking into and interfering with their main train of thoughts. Thought pressure is another frequent complaint, i.e. rapid, parallel trains of thoughts, occurring with a clear loss of meaning ("My thoughts are like rockets, shooting in all directions at once. It's one big chaos"). Some patients also describe thought block – one of our patients reported that his thoughts could suddenly "slow down, fade away, or just stop", and this emptiness of thoughts could last a few minutes. Many patients also describe a certain hyper-reflective stance toward their own experiencing, allowing them, so to say, to inspect their own thoughts or imaginations as "objects" of awareness. For example, some patients report that it is as if they can spatially locate certain thoughts to specific parts of the brain, feel certain thoughts move around or physically feel them press on the inside of the skull.

The process of spatialisation or objectification of thoughts is also implicated in incipient *Gedankenlautwerden*, i.e. hearing one's own thoughts spoken aloud internally. A normal sense of "mine-ness" implies a fusion or unity between the experiencing subject and its thinking. In schizophrenia, however, an experiential distance can creep in between the thinking subject and its thoughts, forcing patients to inspect, perceive or listen to their own thoughts in order to know what they are thinking. Similarly, in acts of imagination, the experiential distance can set in between the subject and the imaginary objects, thereby increasingly reifying and spatialising the imaginary objects. This transforms the apparent "obsession" into a pseudo-obsession (sometimes with quasi-hallucinatory qualities), which typically appears fairly ego-syntonic and occurs

with only minimal resistance (although its pictorial content may be anxiety-provoking) – e.g. a patient described that he often had pictures "in his head" where he perceived himself behead another and then kick the head around. During the experience, he took some pleasure in it and it never occurred to him to resist it. But when it was over, he felt disgusted by it (note that the subsequent feelings of discomfort and shame should not be mistaken for resistance, which possibly could translate the pseudo-obsession into a true obsession). Pseudo-obsessions have relevance in the context of diagnostically differentiating obsessive-compulsive disorders from the schizophrenia spectrum disorders – see also Rasmussen and Parnas <sup>10</sup>. Many patients complain of a diminished sense of being self-present and present in the world (e.g., "I live in a sort of bubble, where the world does not matter. I lack synchrony with the people around me"). The so-called mirror-phenomena and certain experiences of disembodiment are also frequently found in the schizophrenia spectrum – the following vignette illustrates some of these:

- The patient describes an "uncontrollable inner change" occurring at the age of 12. Ever since, she has not, as she puts it, "been able to find myself". She spends hours studying herself in the mirror and often she cannot recognise her specular image. She knows well that she perceives her own image, but "it is as if the reflected image is not supposed to be me (...) When I pass by a mirror, I must stop and make sure that there have not been too many changes". She reports various feelings of bodily self-alienation, e.g. "the body feels awkward as if it does not really fit. It feels like the body is not really me, as if it is rather a machine controlled by my brain, as if the body is a mere appendage". Regularly, she experiences motor inference (e.g. that her legs suddenly turn and walk in a different direction than she intends) and motor blockage (sometimes she cannot open her eyes or move her limbs). She also describes a myriad of unusual bodily sensations (typically that her body or parts of it feels unusually heavy or stiff), and she has spatialised experiences of her inner organs (e.g., she feels her brain wobbles).

Moreover, patients sometimes describe transitivistic experiences, e.g. persistent feelings of being radically exposed or "too open" (without any barriers) or confusion with others (as if being somehow "mixed up" with another in the sense of entirely losing one's sense of whose thoughts and feelings originate in whom). Finally, quasi-solipsistic experiences are also regularly reported by our patients – e.g. a fleeting sense of being at the centre of the world or as if feelings of having unique insight into more true dimensions of reality that usually remain hidden from others. The vignette below offers descriptions of

various quasi-solipsistic experiences and indicates how these experiences may be fused together with a feeling of *Anderssein*.

- The patient reports that during childhood she felt very different from others and often doubted if they had any feelings or a soul. All the time, she was preoccupied with philosophical questions about the meaning of life and she could not relate to her peers, whose life, values and topics of conversation she found utterly superficial. When walking in the street, she often feels as if people are looking at or talking about her, but she has never seen or heard anything to substantiate her feeling. When watching television, she sometimes has a fleeting feeling as if the commercials contain hidden messages intended for her alone. Frequently, she has the impression that the perceived world is not truly real (“it feels as if I’m in a play, like everything is staged for me”). During the time of hospitalisation, she had a transient feeling as if her visual field was all there existed – “the door at the end of the hall was the end of the world. Behind the door, there was nothing”. Occasionally, she feels as if that she has extraordinary insight into others’ psyche in the sense that she is, as she puts it, “almost able to permeate others and feel what they feel”.

### Assessment of self-disorders

Four clinical observations deserve mentioning here. First, the interviewer should not expect patients to simply offer verbal reports of self-disorders that just fit the relevant item definitions or effortlessly gravitate toward them, e.g. the items listed in the *EASE: Examination of Anomalous Self-Experience* scale<sup>11</sup>. On the contrary, patients’ initial complaints may frequently have a character of quite vague or trivial clichés, and often it is only when the patient is asked to give a concretely lived example of his vague (non-specific) complaint that a more characteristic (specific) configuration emerges. Blankenburg used the expression of “non-specific specificity” to describe this particular phenomenon in schizophrenia<sup>12</sup>. For example, a patient may mention, *en passant*, that he feels different from others. Seemingly, this is a trivial complaint; we all feel different and, in fact, are different from each other in numerous ways. Upon further questioning, it may, however, turn out that the patient’s feeling of being different is not at all specifiable in terms of concrete, *ontic* properties (e.g. feeling too clever or too fat, coming from a different socio-economic background or having other interests than one’s peers, etc.), but has to do with a feeling of being *ontologically* different, i.e. somehow not really human (e.g., robot-like, non-existent or alien). If this is this case, then the apparently trivial complaint of feeling different carries, in fact, great typicality for schizophrenia

spectrum disorders. In another case, a patient was asked if she sometimes experiences ambivalence with regard to simple, everyday decisions. The patient replied “no”. When approaching the issue from a different angle, the patient was asked if she sometimes experiences difficulties in deciding what to eat. Again, the patient replied “no”, but she also stated that she never eats breakfast. When asked to explain why she never eats breakfast, she replied that she is unable to decide she wants. When asked what then is different at lunchtime, she replied that she always takes a bit of everything, because she still cannot decide what she wants. In this case, the patient most likely experienced ambivalence, but the ambivalence was concealed behind her coping strategies. We raise here, in some detail, the issue of the “non-specific specificity” in schizophrenia, because important psychopathological phenomena, including self-disorders, may be easily overlooked if the interviewer is not attentive to the possibility that they also might be lurking beneath seemingly trivial complaints. Familiarity with the phenomenon of “non-specific specificity” in schizophrenia is, in our view, quintessential in the context of early diagnostic assessment, especially of patients who present with a quite vague, unelaborated picture of illness.

Second, when assessing self-disorders, it is not sufficient that the patient merely affirms the interviewer’s question; an affirmative answer must never simply be taken for granted. By contrast, the patient must always provide a concretely lived example of such an experience, and only upon further questioning, clarifying the nature of this experience, may the interviewer score the item as “present” if the experience fulfils the relevant item definition<sup>13</sup>. It also merits attention that assessment of self-disorders cannot be obtained by a series of structured questions on a checklist or, for that matter, by non-clinicians, selectively trained in the use of a specific structured interview. Instead, assessment of self-disorders requires considerable clinical experience, some level of psychopathological scholarship, reliability-training with experts in the *EASE* scale and, not least, a phenomenological interview approach that seeks to establish rapport and trust, and in which the psychopathological inquiry is adequately and smoothly integrated into the patient’s own narrative<sup>13</sup>.

Third, self-disorders appear to have a persisting, trait-like character, i.e. these phenomena tend to articulate themselves as a recurring or sometimes nearly constant infrastructure of the patient’s experiential life. Self-disorders are rarely fleeting mental contents similar to an isolated hallucinatory experience or a singular panic attack but reflect typically an enduring instability in the structure of consciousness. Although the temporal stability of self-disorders still needs systematic, longitudinal exploration (such studies are in preparation), our patients most frequently report that their self-disorders date back to child-

hood or early adolescence. At the time of first admission, many of their self-disorders have become almost indistinctly interwoven into their very mode of experiencing, and at least partly for this reason, our patients do often not seem to experience their initial self-disorders as “symptoms” of an illness (parallel to how jaundice is a symptom of liver failure), but rather as intrinsic aspects of their existence (“It is just who I am”). In our view, this particular aspect offers new resources for understanding the nature of poor insight into illness in schizophrenia<sup>4</sup>. Fourth, it is worth stressing that self-disorders are not psychotic phenomena. Self-disorders are typically reported with the “as if” or “it feels like” qualification (e.g. “*It feels like the body is not really me, as if it is rather a machine controlled by my brain*”). Thus, the patient’s reality judgment remains intact<sup>14</sup>.

### Summary of empirical results

In 2005, a semi-structured psychometric instrument for a qualitative and quantitative assessment of self-disorders was published, viz. the EASE scale<sup>11</sup>. The EASE scale offers phenomenological exploration of experiential anomalies that is believed to reflect a disorder of the basic experience of being a self. The scale comprises 57 main items, aggregated into five domains: 1) Cognition and stream of consciousness; 2) Self-awareness and presence; 3) Bodily experiences; 4) Demarcation/transitivity; 5) Existential reorientation/solipsism. Today, the scale has been translated into 10 languages (see [www.easenet.dk](http://www.easenet.dk) for details). The EASE scale exhibits a very high internal consistency (Cronbach’s alpha > 0.900<sup>15</sup>), a mono-factorial structure<sup>15 16</sup> and good to excellent inter-rater reliability among trained and experienced psychiatrists or clinical psychologists<sup>11 17-19</sup>. The empirical research employing the EASE scale or pre-

EASE analogue scales demonstrate the following results:

- self-disorders aggregate selectively in schizophrenia and schizotypy, but not in disorders outside the schizophrenia spectrum<sup>15 20 21</sup>;
- there is no significant difference in the level of self-disorders among patients with schizophrenia and patients with the schizotypy<sup>15 16</sup>;
- self-disorders differentiate between first-admitted patients with bipolar psychosis and schizophrenia<sup>22</sup>, and self-disorders occur more frequently in residual schizophrenia than in remitted bipolar psychosis<sup>23</sup>;
- self-disorders occur in individuals who are biologically related to probands with schizophrenia and who themselves suffer from a schizophrenia spectrum disorder<sup>24</sup>;
- prospective studies suggest that that self-disorders predict transition to psychosis in an ultra high-risk for psychosis sample<sup>18</sup>; that high baseline scores of self-disorders in first-admitted non-schizophrenia spectrum patients predict subsequent diagnostic transition to the schizophrenia spectrum at 5-year follow-up<sup>25</sup>; and that self-disorders are identifiable among non-psychotic help-seeking adolescents<sup>26</sup>;
- positive correlations have been found between self-disorders and positive and negative symptoms, formal thought disorders and perceptual disturbances<sup>15</sup>;
- correlations have been found between self-disorders and social dysfunction<sup>27</sup> and suicidality<sup>28 29</sup>, respectively;
- no correlations have been found between self-disorders and IQ<sup>15</sup> or neurocognitive measures, except for impaired verbal memory<sup>30</sup>.

For an overview of the aggregation of self-disorders, measured with the EASE scale, in schizophrenia, schizotypy, bipolar disorder, other mental disorders and in healthy controls, see Table I. For a comprehensive re-

**TABLE I.**  
Mean total EASE score, standard deviation, and sample size.

Study	Schizophrenia	Schizotypy	Bipolar disorder	Other mental disorders	Healthy controls	p value
Haug et al. (2012) <sup>22</sup>	25,3 (9,6) n = 57	n/a	6,3 (4,8) n = 21	11,5 (8,7) n = 3*	n/a	< 0,001 <sup>†</sup>
Raballo and Parnas (2012) <sup>16</sup>	21,4 (9,6) n = 19	17,0 (7,2) n = 8	n/a	5,7 (5,1) n = 9 <sup>‡</sup>	n/a	< 0,001 <sup>§</sup>
Nelson et al. (2012) <sup>18</sup>	n/a	n/a	n/a	n/a	2,37 (2,45) n = 52	n/a
Nordgaard and Parnas (2014) <sup>15</sup>	19,63 (8,39) n = 46	17,82 (6,82) n = 22	n/a	8,06 (5,89) n = 32**	n/a	0,00 <sup>††</sup>

n/a = not available; \* “Other mental disorders” comprises other *psychotic* disorders (i.e. delusional disorder and psychosis NOS); † Schizophrenia versus bipolar disorder and other mental disorders; ‡ “Other mental disorders” comprises major depressive disorders and one case of cyclothymic disorder; § Schizophrenia and schizotypy versus other mental disorders; \*\* “Other mental disorders” comprises anxiety disorders, OCD, and non-schizophrenia spectrum personality disorders; †† Schizophrenia and schizotypy versus other mental disorders.

view of all empirical pre-EASE and EASE based studies, see Parnas and Henriksen<sup>3</sup>.

## Implications for research and treatment

In our view, self-disorders constitute essential aspects of the psychopathology of schizophrenia. The results from empirical studies support the phenomenological notion of “disordered self” as an important phenotype of the schizophrenia spectrum. Although the idea that the generative disorder in schizophrenia is a specific disorder of the self was ventilated in most classic texts on schizophrenia<sup>31-33</sup>, empirical studies have only emerged in the last decade. More systematic research is needed to further elicit the specificity of self-disorders for the schizophrenia spectrum – e.g. by exploring potential self-disorders in certain non-schizophrenia spectrum disorders, which seem to involve some kind, though *presumably not the same kind*, of disturbance of subjectivity (e.g., anorexia nervosa or borderline personality disorder). Also, the time of onset and temporal stability of self-disorders need empirical corroboration. Self-disorders have potentially considerable implications for early detection and intervention, but today it remains unclear from what age it can make sense to screen help-seeking, young adolescents for self-disorders, since participation in an EASE interview require some linguistic maturity and ability to self-reflect. Clarifying this issue is also an important target of future research.

It is worth stressing that self-disorders are not sharply delimited, independent symptoms but rather interdependent aspects of a more comprehensive psychopathological Gestalt – reflected also in the mono-factorial structure of the EASE scale. This implies that it is not any singular self-disorders *per se* that are specific for schizophrenia but rather the psychopathological Gestalt, which is constituted in part by self-disorders. Moreover, we believe that the notion of self-disorders may help sharpen the diagnostic boundaries between schizophrenia spectrum disorders and affective illness, thus counteracting the recurring and, in our view, quite problematic unitary view of psychosis.

Finally, it is noteworthy that many of our patients, during an EASE interview, express feelings of relief when realising that the interviewer is familiar with the nature of their experiences or that others suffer from similar experiences; this may to some extent counterbalances, though perhaps only temporarily, the patients’ feelings of *Anderssein* and existential loneliness. Discussing self-disorders in group-sessions may thus have psychotherapeutic value. In our view, a psychotherapeutic approach that is better informed about the core of the patients’ suffering, vulnerability and experiential life is likely to be a more effective treatment<sup>34</sup>.

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None.

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