

## A Disappearing Heritage: The Clinical Core of Schizophrenia

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**This article traces the fundamental descriptive features of schizophrenia described in the European continental literature from Kraepelin and Bleuler, culminating with the creation of the International Classification of Diseases (ICD)-8 (1974). There was a consensus among the researchers that the specificity and typicality of schizophrenia was anchored to its “fundamental” clinical core (with trait status) and not to positive psychotic features, which were considered as “state”, “accessory” phenomena. The clinical core of schizophrenia was, in a diluted form, constitutive of the spectrum conditions (“schizoidia” and “latent schizophrenia”). The fundamental features are manifest across all domains of consciousness: subjective experience, expression, cognition, affectivity, behavior, and willing. Yet, the specificity of the core was only graspable at a more comprehensive Gestalt-level, variously designated (eg, discordance, autism, “Spaltung”), and not on the level of single features. In other words, the phenomenological specificity was seen as being expressive of a fundamental structural or formal change of the patient’s mentality (consciousness, subjectivity). This overall change transpires through the single symptoms and signs, lending them a characteristic phenomenological pattern. This concept of schizophrenia bears little resemblance to the current operational definitions. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, and ICD-10 seem to diagnose a subset of patients with chronic paranoid-hallucinatory variant of schizophrenia.**

*Key words:* schizophrenia/clinical core/Bleuler

### Introduction

The purpose of this contribution is to make a panoptic attempt to describe how schizophrenia was conceptualized in the continental European psychiatry and described since Bleuler and Kraepelin and as recently as in the 8th and 9th editions of the International Classification of Diseases (ICD) ie, in practical clinical use in Europe at least until the introduction of the ICD-10<sup>1</sup> in 1992.

The knowledge of the core features has gradually faded away in the operational permutations of the schizophrenia concept. This notion becomes increasingly alien to clinicians. This is partly due to a reification of diagnostic categories, associated with a general decline of psychopathological competence.<sup>2</sup>

A centenary of the publication of Bleuler’s “Dementia Praecox or the Group of Schizophrenias” is a pretext for this reflection. The reader should not expect a historical exegesis of Bleuler’s ideas. Rather, the goal will be to trace the evolution of the concept of the clinical core of schizophrenia into its common continental articulation in ICD-8,<sup>3</sup> before the creation of *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*, (DSM-III).<sup>4</sup>

The preoperational notion of schizophrenia may be considered as a zenith of psychopathologic research, creating conditions for the first major scientific accomplishments, eg, the foundational Scandinavian epidemiological studies,<sup>5</sup> the US-DK Adoption studies,<sup>6</sup> the US-DK high-risk studies,<sup>7</sup> longitudinal patient follow-up studies,<sup>8,9</sup> and the WHO’s International Pilot Studies of Schizophrenia.<sup>10</sup> The modifications of the concept of schizophrenia that happened in the DSM-III-DSM-IV-TR<sup>4,11</sup> and the ICD-10 entail obvious and important clinical and research consequences.

### What is Schizophrenia?

This trivial question hides certain important epistemological issues, intimately linked to the question of a “clinical core”. The DSM-IV-TR<sup>11</sup> defines schizophrenia in the following way:

The essential features of schizophrenia are a mixture of characteristic ( ... ) positive and negative [symptoms] that have been present for a significant portion of time ( ... ), associated with marked social and occupational dysfunction. The disturbance is not better accounted for by ...

Maj<sup>12</sup> criticized this definition for not offering any general account of what schizophrenia is but rather of what it

is not (nonorganic, nonaffective, etc.). The definition does not consider negative or positive symptoms (or their combinations) as specific to schizophrenia. Moreover, Maj claimed that operational criteria are only useful to a clinician who is already familiar with what schizophrenia is. The issue addressed by Maj is that of “whatness” (quiddity). It refers to the properties that a particular category (eg, a patient) shares with others of its kind. “What (quid) is it?” simply asks for a general description through some essential or prototypical commonality.

Asking such question does not presuppose a commitment to realism about natural kinds. It is a question prompted by clinical experience and based on the assumption that schizophrenia displays a characteristic core Gestalt, conferring a certain typicality or prototypicality on its concrete clinical manifestations. It is not the question of a pathognomonic symptom but rather of a characteristic Gestalt.

The question of the core dominated the psychiatric debate since the beginning of the 20th century.

### “Fundamental” Symptoms

European psychopathologists agreed that there was something phenomenologically distinctive and typical about schizophrenia, a “something”, a characteristic “whatness.” It resides in a prototypical core whose properties are not temporally fluctuating “surface” psychotic symptoms, but the features that reflect a phenomenological depth or a structure of the disorder. Here, it is important to emphasize that the core is not merely a construct but possesses phenomenological reality. It is perceivable and accessible to observation. Although it may be difficult to define verbally, it is open to ostensive definition and hence to teaching, intersubjective agreement, and analysis. The core was considered, by and large, as a trait condition. The diagnostic specificity was anchored in the prototypical Gestalt of the illness.

Bleuler (inspired by Hecker’s<sup>13</sup> description of hebephrenia) was among the first to distinguish between the fundamental symptoms, specific to schizophrenia and specifying its spectrum extension (schizoidia, latent schizophrenia) and accessory symptoms, nonspecific state phenomena, marking a psychotic episode (hallucinations, delusions, and flamboyant catatonic features). The fundamental features—also emphasized by Kraepelin and others—were many: autism, formal thought disorder, ambivalence, affective-emotional, and affect-expressive changes, changes in the structure of the person, disorders of volition, acting and behavior, and the so-called “schizophrenic dementia” (which Bleuler did not conceive on the analogy with organic dementia<sup>14,15</sup>).

The fundamental symptoms overlap each other, with descriptive redundancies. We will therefore concentrate on the prime fundamental symptom, the schizophrenic autism, which contains aspects of nearly all other funda-

mental symptoms as well. The autism concept became, in Europe, a shorthand term for the core Gestalt of schizophrenia, or for schizophrenia, tout court.

### *Autism: Withdrawal to Fantasy Life*

Bleuler<sup>16</sup> defined autism as a detachment from reality associated with rich fantasy life:

The [. . .] schizophrenics, who have no more contact with the outside world live in a world of their own. They have encased themselves with their desires and wishes [. . .]; they have cut themselves off as much as possible from any contact with the external world. This detachment from reality with the relative and absolute predominance of the inner life, we term autism.

He described a rich variety of clinical manifestations under the heading of autism: poor ability to enter into contact with others, withdrawal and/or inaccessibility, negativistic tendencies, indifference, rigid attitudes and behaviors, private hierarchy of values and goals, inappropriate expression and behavior, idiosyncratic logic and thinking, and a propensity to delusion formation. The description includes interrelated expressive, behavioral, subjective (cognitive, affective), and existential aspects.<sup>17</sup> This multitude, Bleuler and others explained, was caused by a disaggregation, dissociation (loosening of associations), “Spaltung,” or discordance between and within the modes and contents of consciousness.<sup>18</sup> Autism manifests a discordance in the operations of consciousness. Henri Ey<sup>19</sup> a renowned French psychiatrist, summarized the clinical expressions of the “discordance” in 5 general dimensions:

“(1) Ambivalence: a division of all states or operations of the mind into contradictory tendencies: desire/fear-repulsion; willing/not willing; affirmation/negation. (2) Bizarreness: impression of a strangeness that seems to reflect a disconcerting intention of the paradoxical or the illogical. (3) Impenetrability: all schizophrenic symptoms appear to be imbued by an enigmatic tonality; there is always some opacity of the understanding in the relations between the patient and the others. (4) Detachment: loss of vital contact with reality<sup>20</sup> [lack of attunement, loss of the world’s natural self-evidence, inability of immersion in the world, solipsism]. (5) “Destruction” of consciousness [ie, disorder of subjectivity structure; see below]”<sup>19(p53)</sup> (my translation and additions in square brackets).

Bleuler’s description of autism demonstrates its resilience to a medical definition. The definition of autism as a “withdrawal to fantasy life” became trivialized along the common-sense psychological and psychodynamic understanding: All can turn their back to an unpleasant or threatening reality and engage in a wishful thinking. What is overlooked in such a comparison is the fact that in schizophrenia, a confinement to interiority (inner life) is not primarily due to a voluntary choice to withdraw, but is more like an affliction or existential destiny.

Although Bleuler undoubtedly had a profound clinical intuition of the schizophrenic trait phenomena, the conceptual resources at his disposal did not permit a clear articulation of this intuition.

### *Autism As a Phenomenon with Subjective Dimension*

The panoply of clinical features making up the concept of autism is beyond what the notion of a symptom can contain. Aware of the problem, but not of the solution, Bleuler qualified autism as a “complex” symptom. Phenomenological notions of Gestalt and prototype offer more adequate conceptualizations here: autism is not an atomic single symptom but a phenomenon or a Gestalt, a certain whole reflecting a radically altered mental life. It is perceivable in the ways in which mentality (subjectivity, consciousness) operates and manifests itself. It is this alteration that transpires through the manifold of clinical manifestations of schizophrenia.

Eugène Minkowski<sup>20</sup> a French psychiatrist trained by Bleuler, was the first to grasp the notion of the core of schizophrenia on an adequate theoretical level. He did not think that the core of schizophrenia could be addressed by a list-wise description of single symptoms. What was needed was a background theory on the nature of mental life, a position that he shared with Jaspers<sup>21</sup> and for both authors, it was phenomenology that was relevant. Minkowski proposed that a mental state (eg, a hallucination) should not be treated in isolation and as a thing because it is an aspect, a trace of the whole from which it originates. This whole is the structure of subjectivity. Every anomalous mental state contains therefore an imprint of more basic experiential and existential alterations, comprising, for example, changes in time and space experience, self-experience or alterations in the elementary relatedness to the world. It is such structural alterations that transpire phenomenally in the single symptoms, shaping them, keeping them meaningfully interconnected, and founding the specificity of the overall diagnostic Gestalt.<sup>22</sup> Minkowski<sup>20</sup> considered autism as a disorder of self (*trouble de la structure intime du moi*), marked by an inadequate basic prereflective attunement between the person and his world, ie, a lack of immersion in the world, lack of “vital contact with reality”. Minkowski defined the “vital contact” as an ability to “resonate with the world”, to empathize with others, an ability to become affected, and to act suitably, as a prereflective immersion in the intersubjective world: “Without being ever able to formulate it, we know what we have to do; and it is that that makes our activity infinitely malleable and human.” Manifestations of autism involve a peculiar distortion of the relationship of the person to himself, to the world, and to his fellow men. There is a decline of the dynamic, flexible, and malleable aspects of these relations, and a corresponding predominance of the fixed, static, rational, and objectified

elements (one of our patients said: “I am unable to go directly to the world; for me, the world is always a matter of composition; there are no simple givens”). Autism may also transpire through the patient’s acting. Autistic activity shows itself not so much through its content or purpose, but more through an inappropriate manner by which it is enacted, its friction with the situational context (“crazy actions”<sup>23</sup>; see<sup>24</sup>, for several examples). A famous vignette of a “schizoid” father, who buys, as a Christmas present for his dying daughter, a coffin, illustrates this friction. The act is rational from a formal-logical point of view because, ultimately, the daughter is going to need a coffin, yet the act is nonetheless bizarre by any human standard of our culture.

### *Autism as “Crisis of Common Sense”: Exploring Subjective Dimension*

The subjective dimension of autism, addressed by Minkowski, became further articulated by a contemporary German psychiatrist, Wolfgang Blankenburg<sup>25</sup> who considered autism as “a crisis of common sense”.

What is at stake in common sense is not a possession of a sufficient stock of explicit or implicit knowledge of the world that can be expressed in sentence-like terms: eg, “I know that one says hello to greet the others”. Rather, it is the ability to see things in the appropriate perspective, an implicit nonconceptual grip of the “rules of the game,” a sense of proportion, a taste for what is adequate and appropriate, likely, and relevant. Briefly, it refers to a nonconceptual and nonreflective indwelling in the intersubjective world, a preunderstanding of the context and background, a necessary condition for the grasp of objects, other people, and situations. The patient finds himself in a pervasive state of ambivalence and perplexity (confusion about meaning). The loss of meaning is frequently associated with intense hyperreflectivity, ie, an excessive tendency to monitor, and thereby objectify, one’s own experiences and actions.<sup>26</sup> Everything may become a matter of deliberation (Why is the grass green; why has the nature chosen this particular color?), relating to others is felt disfigured, requiring preparatory efforts. There is no evident way to choose among options or to be sure of one’s own opinion. Blankenburg presents a case of a young female schizophrenic patient, whose monotonous complaint is the lack of naturalness, lack of ‘self-evidentness’ and ‘self-understandability’ (*Selbstverständlichkeit*):

What is it that I really lack? Something so small, so comic, but so unique and important that you cannot live without it [. . .]. What I lack really is the ‘natural evidence’ [. . .]. It has simply to do with living, how to behave yourself in order not to be pushed outside, outside society. But I cannot find the right word for that which is lacking in me [. . .]. It is not knowledge, it is prior to knowledge; it is something that every child is equipped with. It is these very simple things

a human being has the need for, to carry on life, how to act, to be with other people, to know the rules of the game.” [ . . . ] Another patient writes to his friend: “For your happiness, your lenience and your security, you can thank ‘a something’ of which you are not even conscious. This ‘something’ is first of all that which makes lenience possible. It provides the first ground.

Not surprisingly, lacking this “something so small, so comic” goes hand in hand with another lack, namely a diminished sense of self, lacking inner, persistent core of the person.<sup>27</sup>

### The Structure of Subjectivity: Self in Schizophrenia

A brief articulation of the structure of subjectivity or consciousness is now needed to grasp the notion of the disorders of the self in the core Gestalt of schizophrenia. The concept of self can be addressed at different levels of reality and abstraction. Here, we are concerned with its basic universal experiential aspects.<sup>28</sup> This ordinary phenomenological notion of the self means that we live our conscious life in the first person perspective, as a self-present, single, temporally persistent, embodied, and bounded (demarcated) entity, who is the subject of his experiences.<sup>29</sup> That these basic structural aspects of self-hood may become altered or even shattered in schizophrenia was noted already at the very conception of the notion the illness. Bleuler<sup>16</sup> considered self-disorders as belonging to the “complex fundamental symptoms” (affecting the person). He wrote that the patient’s ego tends to undergo “the most manifold alterations,” eg, splitting and loss of the directedness of thinking. “A very intelligent person needs hours of strenuous effort to find her own ego for a few brief moments”; “patients cannot catch up with themselves” or they “have lost their individual self”<sup>16</sup> (p143). Gruhle<sup>30</sup> talked about the disordered self-hood as reflecting a specific existential tonality of being in schizophrenia. Kraepelin<sup>31</sup> considered “loss of inner unity of consciousness” and “devastation of the will” (orchestra without a conductor) as the core features defining schizophrenia. Both notions imply a “devastation” of the self because it is the self that imposes a sense of unity on the multitude of mental contents. Right now, while I am typing this text into my notebook, the unity of my ongoing visual, tactile, auditory, etc. experiences is brought about through their shared feature or character of being my experiences. They are all given to me as their subject, making them inherent in one (my) field of awareness.<sup>28</sup> Kurt Schneider noted that:

(C)ertain disturbances of self-experience show the greatest degree of schizophrenic specificity. Here we refer to those disturbances of first-personal-givenness (Ich-heit) or mine-ness (Meinhaftigkeit) which consist of one’s own acts and states not being experienced as one’s own,<sup>32</sup>(p58).

The issue of disorders of self was widely addressed in psychopathological literature,<sup>19,27,30,33,34</sup> both at a clini-

cal and a theoretical level. The view of autism, as a manifestation of the fundamental changes of subjectivity came to mark the final articulation of European view on the “whatness” of schizophrenia. Thus, the ICD-8/9 Glossary<sup>35</sup> defines the clinical core of schizophrenia as a change in the patient’s structure of subjectivity: it is “the fundamental disturbance of personality (self), (which) involves its most basic functions, those that give the normal person his feeling of individuality, uniqueness, and self-direction” (p27; here, “personality in its most basic functions” refers to the structure of the person or the self).

More recently, 2 Scandinavian studies have independently rediscovered the disorders of self-experience in the schizophrenia spectrum conditions, a research inspired by extensive semistructured interviews with young first-admitted patients with beginning schizophrenia. The patients typically complained of feeling ephemeral, not really existing, lacking a basic identity core, feeling profoundly different from others, and not fully belonging to the shared world. This work was systematically replicated on 151 first admission cases followed up for 5 years<sup>36–38</sup> and on a large, diagnostically stratified sample at genetic risk for schizophrenia.<sup>39</sup>

It is important to emphasize that we are dealing here with the anomalies of experience and not with delusions or hallucinations. Self-disorders occur both in schizophrenia and schizotypal disorders. They comprise a pervasively diminished or insecure sense of existing as an embodied self-present subject, various distortions of first person perspective, eg, with anonymization of the field of awareness or deficient “mineness” (“my thoughts have no respect for me”), various alienations in the stream of cognition, spatialization of mental contents, eg, thoughts being experienced as located extended objects (“my thoughts always press from behind mainly here, on the left”), feelings of disembodiment, inadequate ego-demarcation, and, very importantly, lack of attunement to and inability of immersion in the world (“I only live in my head”). Isolation seems here to be more solipsistic, “growing from within,” ie, constitutive, rather than operating only as a defensive withdrawal. Bleulerian “retreat to the inner world” is more adequately seen as a constitution of a different, ie, “private world”.

The inability to project oneself forth in the world ( . . . ), the tendency to disperse oneself in the flux of subjectivity, the disproportion between the “inside” and the “outside” of existence, constitute a constant infrastructure of consciousness ( . . . ) in schizophrenia.<sup>40</sup>(p167)

Self-disorders are persisting and often pervasive (trait) phenomena, whose onset usually dates to early adolescence or even childhood. The schizophrenia spectrum patients may also experience a variety of anomalies in all perceptual modalities.<sup>41</sup>

### The Ill-Famed “Praecox-Feeling”

We will briefly address here the notion of “Praecox Gefühl”, now antiquated and out of use, but nonetheless important for an understanding of the attempts to capture the clinical core of schizophrenia. The expression “praecox feeling” was coined by a Dutch psychiatrist, Rümke<sup>42</sup> who claimed that the diagnosis of schizophrenia was sometimes bolstered by a (more or less) ineffable intuition, probably based on a fundamental inaccessibility of the patient. Rümke’s idea was almost as old as the concept of schizophrenia itself, and it was widely described in schizophrenia research. Similar terms included “diagnostic par pénétration,”<sup>20</sup> “diagnosis through intuition,”<sup>43</sup> or “atmospheric diagnosis”.<sup>44</sup> The term “intuition” refers in phenomenology to a direct apprehension of an object or state of affairs, an apprehension that is not mediated by reflection. Müller-Suur<sup>45</sup> emphasized that the original intuition of incomprehensibility could be strengthened by a more reflective diagnostic apprehension: the incomprehensibility in schizophrenia is not something vague but something “definitely incomprehensible”. No matter how well we come to know the patient’s psychopathology and personal history, we remain confronted with a residuum of definite incomprehensibility. Wyrsh<sup>43</sup> suggested that what was here at play was a perception of an existential change. We perceive a transformation of the modality of being into an order of its own (eine Daseinsweise). What is incomprehensible, but nonconceptually grasped by a clinician, are altered basic structures of the “being-in-the-world”, eg, the temporality and spatiality of being, the self, and basic self-world relatedness. These structures are not concrete, perceivable objects, like symptoms or signs; they are constitutive, ie, functioning as preconceptual conditions of our existence.<sup>46</sup>(p48) The clinicians may perceive such changes in a nonconceptual mode, a type of experience that is difficult to convey in a linguistic propositional (sentence-like) format.

The validity of the intuitive diagnosis by an experienced clinician was documented in a spectacular way by Gottesman and Shields<sup>47</sup> in their seminal Maudsley schizophrenia twin study. The study showed concordance rates among MZ- and DZ-co-twins of the schizophrenic probands to be around 50% and 10%, respectively. They invited an outsider, a renowned Swedish expert on the schizophrenia spectrum conditions (schizoidia), professor Essen-Möller, to blindly diagnose the vignettes of their sample, asking for a binary classification: within or outside the schizophrenia spectrum?. Essen-Möller’s schizophrenia spectrum cases demonstrated MZ a concordance rate of approximately 90%, without inflating the corresponding DZ concordance. Gottesman and Shields concluded that it was the most successful attempt of validation of the schizophrenia spectrum concept. However, Essen-Möller was not able to explicate his

diagnostic performance in a descriptive, symptom-list manner. His performance was, most likely, an instance of Gestalt–or pattern-recognition, executed by an extremely skilled and knowledgeable clinician.

The concept of praecox feeling gradually lost its theoretical and phenomenological baggage, and became trivialized into a notion of “instant” or “first 3 minutes” diagnosis. Eventually, it lost all clinical significance with the introduction of the operational criteria for diagnosis. In a theoretical debate preceding the formation of the DSM-III, the “praecox-feeling” was considered as emblem of psychiatry’s subjectivism, incompatible with its scientific aspirations. The term also served as ammunition for antipsychiatrists who pointed out the arbitrariness and the excessive power of psychiatric labeling.

There are certain misunderstandings, which, in my view, obscure a potential epistemological import of the notion of praecox feeling. The intuition arises mainly passively; it cannot be instigated at will. It needs not to be restricted to the first minutes of the encounter with the patient, but may arise at any moment throughout the interview. It may arise seemingly unprovoked or provoked by a single gesture, a facial expression, or something uttered by the patient, a something that changes the entire apprehension of the patient because it changes the significance of the perceived Gestalt. In such cases it resembles the experience of aspect dawning (like, when looking at an ambiguous figure, eg, a duck–rabbit, you start to see the rabbit and then, your way of viewing somehow changes, and now, suddenly, you see the duck.<sup>48</sup> (193c)) There is a change in the perception of the entire Gestalt despite no or minimal changes at the sensory level.

In an ordinary diagnostic situation, there is no extra intuition on the top of a Gestalt-recognition supported by the symptom/sign-based information. The passively experienced intuitive diagnostic hunch was never supposed to be applied as an autonomous classificatory arbiter in a random population of patients. Rather, it was believed to sometimes help the clinician in distinguishing between schizophrenia and other types of psychosis (schizophrenia vs “pseudoschizophrenia” [The Anglophone concept of a “schizophrenia like” psychosis [eg, in epilepsy], ie, a psychosis with hallucinations and delusions, was certainly not “schizophrenia-like” in the European perspective, where the specificity of schizophrenia was dependent on the clinical core features, rather than on the positive psychotic symptoms.]). It is obvious that praecox-feeling, for several reasons, cannot belong to the diagnostic tools in clinical psychiatry. That does not cancel its clinical reality or its conceptual/epistemological import for schizophrenia research.

### Gestalt, Prototype, and Symptom

Throughout the text, the notion of Gestalt has been reoccurring. This epistemological issue is in the need of

a further articulation because its understanding is essential in addressing the clinical core features of schizophrenia, ie, the defining features that constitute its “whatness”.<sup>49</sup> When the preDSM-III psychopathologists emphasized this or that feature as being very characteristic of schizophrenia, they did not use the concept of a symptom/sign as it is being used today in the operational approach. This latter approach envisages the symptoms and signs as being (ideally) third person data, namely as reified (thing-like), mutually independent (atomic) entities, devoid of meaning and therefore appropriate for context-independent definitions and unproblematic assessments. It is as if the symptom/sign and its causal substrate were assumed to exhibit the same descriptive nature: both are spatio-temporally delimited objects, ie, things. In this paradigm, the symptoms and signs have no intrinsic sense or meaning. They are almost entirely referring, ie, pointing to the underlying abnormalities of anatomic-physiological substrate. This scheme of “symptoms = causal—referents” is automatically activated in the mind of a physician confronting a medical-somatic illness. Yet the psychiatrist, who confronts his “psychiatric object”, finds himself in a situation without analog in the somatic medicine.<sup>21</sup> The psychiatrist does not confront a leg, an abdomen, not a thing, but a person, ie, broadly speaking, another embodied consciousness. What the patient manifests is not isolated symptoms/signs with referring functions but rather certain wholes of mutually implicative, interpenetrating experiences, feelings, beliefs, expressions, and actions, all permeated by biographical detail. The psychiatric typifications and reflections start from these meaning-wholes. The latter are not constituted by the referential symptom function but by their meaning. We do not (with few exceptions) know causal referents in any diagnostically relevant sense. From a phenomenological point of view, a diagnostic encounter is a second person situation, a process through which we evaluate expressions in conjunction with experiences. We extract, represent, and individuate from the flow of the patient’s subjective life certain repeatable (invariant) constellations of experience and expression, certain meaningful wholes. A psychiatric symptom or sign only emerges as an individuated entity (as this or that symptom) in the context of other, simultaneous, preceding, and succeeding experiences. A smile as such cannot be predefined as silly; the silliness of a smile can only emerge in the context of the flow of expressions relative to a particular discourse.

These are the epistemological constraints behind the fact that all descriptions of the phenomenological specificity of schizophrenia were invariably located at a more encompassing level than the notion of a single, context-independent symptom or sign (eg, the concepts of autism, lack of vital contact with reality, disunity of consciousness, etc.). Indeed, the very idea of a context-independent phenomenological feature would probably never cross

the mind of a preDSM-III psychopathologist. Imagine a case of “social phobia”, caused by fear of physical contact with other people, a proximity being experienced as engulfing and annihilating. We would probably not consider this “phobia” as an isolated behavioral dysfunction but rather as being indicative of a larger whole of insecure identity and self-demarcation, with avoidant coping behavior ensuing by implication. Consider, as another example, “mumbling speech”. In itself it is perhaps characteristic of 5% of population. Yet, in a specific diagnostic context, eg, if associated with mannerist allure, inappropriate affect, and vagueness of thought, it acquires a psychopathological significance.

The notion of Gestalt helps here to express the wholeness of the clinical picture that constrains the particularity of its component features and accounts for the epistemic nature of the diagnostic encounter. Gestalt elements are always present in the clinical diagnostic process, and so are the typification processes, ie, progressive differential diagnostic approximations that ultimately result in the allocation of the investigated entity into a particular class. A Gestalt is a salient unity or organization of phenomenal aspects. This unity emerges from the relations between component features (part-part-whole relations) but cannot be reduced to their simple aggregate (whole is more than the sum of its parts). The Gestalt’s aspects are interdependent in a mutually constitutive and implicative manner<sup>22</sup> and the whole of Gestalt codetermines the nature and specificity of its particular aspects, while, at the same time, the whole receives from the single aspects its concrete clinical rootedness. A Gestalt cuts across the dichotomies of “inner and outer,” “form and content,” “universal and particular.” The salience of eg, interpersonal encounter does not normally emerge in piecemeal-disconnected allusions to the patient’s inner life on the one hand, in addition to independently salient fragments of his visible expressions, on the other hand. Rather, the person articulates himself through certain wholes, jointly constituted by his experience, belief, and expression (inner and outer). “What” he says (content) is always molded by the “how” (form) of his way of thinking and experiencing. A Gestalt instantiates a certain generality of type (eg, this patient is typical of a category X), but this typicality is always modified, because it is necessarily embodied in a particular, concrete individual, thus deforming the ideal clarity of type (universal and particular). The Gestalt always expresses a certain likeness to its prototype. Typifications may be shared by other psychiatrists and assessed for the interrater reliability. The gestaltic nature of “mental object” does not preclude that the formal diagnosis may follow a list of prespecified criteria, because nothing a priori forbids constructing a list of criteria with reflect the diagnostic Gestalt (It takes 2 years of residency with a weekly 2–3 hours of psychopathology teaching [concepts, live interviews followed by

**Table 1.** Clinical Core Features of Schizophrenia: Descriptive Levels

Signs	Symptoms	Gestalt Designations	Structure of Subjectivity	Existential orientation
Various disorders of all modalities of expression/bizarreness	Perplexity	Discordance	Unstable first person perspective	Inaction
Inadequate (parathymia) or diminished affective modulation	Ambivalence/poly-valence	“Spaltung”	Diminished self-presence	“Crazy projects”
Paramimia (disorganized facial expression)	Sense of loss of meaning; emptiness, nonbeing (depression)	Disunity of consciousness	Hyper-reflexivity	Altered existential orientation: (new) interest in philosophy, mysticism, adherence to a religious or a political sect, or other “alternative community” etc.
Parakinetic and stereotypic facial (eg, paraocular) and other movements	Hyper-reflectivity	Intrapsychic ataxia	Diminished immersion in the world	
Peculiar stiff posture with lumbar hyperextension, forward cervical bent, and lack of arm swing (Gebundenheit)	Self-disorders: diminished self-presence, disturbed first person perspective, disembodiment, spatialization of mental life, disorders of the stream of thoughts (blocking, pressure, perceptualization), porous ego-boundaries, lack of basic sense of identity, sense of unclarity or opaqueness of consciousness, anhedonia, devitalization, solipsism/grandiosity, etc.	Autism	Changes in temporality	
Shifting, capricious, or shallow emotions/moods			Changes in embodiment	Clinician’s nonconceptual perception of an altered existential mode
Staring or elusive or vigilant gaze			Changes in intersubjectivity	
Excessive parallelism of ocular axes	Mirror-phenomenon-as subjective experience			
Radical impenetrability/no emotional reciprocity/rigidity	Ontological insecurity and anxiety, fear of existence, fear of dissolution			
Indifference	Disorders of attention and perception (esp. visual and auditory)			
Varieties of formal thought disorder, especially vagueness, derailment, metonymy	Anomalous bodily sensations			
Stilted, mannerist appearance/behavior/speech				
Eccentricity/Antagonomia/Negativism				
Mirror-phenomenon-observable				
Detachment, Withdrawal, Social isolation/social anxiety				
Inappropriate behavior (crazy actions)				

The table attempts to provide an extended but not exhaustive summary of descriptions of the clinical core of schizophrenia. The first 2 columns from the left list the single features, first as “signs” and then as “symptoms,” which are frequently described as trait-typical of schizophrenia and its spectrum conditions. The third column indicates the frequently utilized terms or labels for the perceived core Gestalt. The last 2 columns indicate the overarching Gestalt, first articulated as disorders of the structure of subjectivity (such as self-world relation or temporality), and the last column refers to certain global changes, perceivable at the level of the patient’s existence. The question of specificity or “whatness” of schizophrenia was answerable with a reference to these larger Gestalts.

diagnostic and interview-technical discussion] to produce a reliable and competent “prototypical” clinician). Recently, a more gestaltic approach has been proposed for the DSM-V.<sup>50</sup>

### Conclusions and Implications

There was a consensus among schizophrenia researchers in the European tradition that the specificity of schizophrenia was not to be found in the positive psychotic symptoms. Even Kurt Schneider, while cherishing his diagnostic notion of first rank symptoms, referred to a larger Gestalt and to the disorders of subjectivity structure (self-disorders) as a condition for the emergence of certain psychotic phenomena. When confronting schizophrenia, we say, paraphrasing Jaspers and others, “ununderstandable,” “impenetrable,” or “bizarre,” we express a sense of confronting a condition not only marked by circumscribed abnormal mental contents but also, rather, a structural change of subjectivity (mentality, consciousness). The clinical core manifests itself, and is graspable, as a larger whole, a Gestalt emerging across a manifold of symptoms and signs. These single features may occur in all domains of mental life: affect-expression, motivation, mood, cognition, willing, and action table 1.

This core disorder was believed to possess a generative status, making the clinical picture less enigmatic and endowed with certain coherence between its elements (vide supra, the “social phobia”).<sup>22,36</sup> A subtler articulation of such core marked the extension of the schizophrenia spectrum disorders. Needless to say, it was the core that was considered as etiologically significant. Minkowski<sup>20</sup> was among the first to propose a diathesis-stress model of the etiology of schizophrenia:

The notion of schizophrenia as a mental illness can be decomposed into two factors, of different order. First, the schizoidia [the clinical core], which is a constitutional, highly specific and temporally enduring factor, and, second, a noxious nonspecific factor of [environmental] evolutive nature. This noxious factor, acting upon the [vulnerability of] schizoidia, transforms the latter into schizophrenia,<sup>20 (p50-51)</sup> my translation and insertion in square brackets).

This presentation of schizophrenia paints a picture that is rather different from the corresponding concepts of the DSM-IV and ICD-10. The operational definitions only capture a fragment of the clinical core. Both the negative and disorganized symptoms are, because of reliability concerns, stipulated on a very high severity level, effectively precluding a diagnosis of many nonparanoid cases. More importantly, the negative symptoms are conceived of as quantitative deficits, fall-outs of normal functions (too little), which are signaled by the deprivative alpha: a-logia, a-volition, an-ergia, etc. This deficit view, however, has a limited resemblance to the clinical core of schizophrenia.<sup>15</sup> Blankenburg<sup>25</sup> evoked here an insightful

and useful dictum: “the Minus (the deficit) in schizophrenia is caused by the Aliter (the different [strange]), whereas the reverse is true for the organic dementia.” Psychiatrists, trained today, have difficulty in indentifying and describing clinically significant formal thought disorder, disordered discourse, and varieties of disintegrated expressivity. Most importantly, however, the sense of the fundamental Gestalt or prototype has vanished. Clinicians are not taught and therefore not aware of the characteristic Gestalt of schizophrenia, of its “whatness”. This prototype, especially salient in hebephrenia, eludes the diagnostic radar. These patients become frequently diagnosed as borderline personality disorder, social phobia, anxiety disorders, obsessive-compulsive disorder (OCD), and affective disorder. We know from the statistics of the Danish National Psychiatric Register that since the introduction of the ICD-10, the “borderline” diagnosis has exploded while hebephrenia diagnosis now only accounts for 1% of all first diagnosed cases of schizophrenia (there is no reason to believe that the situation is dramatically different with DSM-IV). The polydiagnostic studies indicate that DSM-IV/ICD-10 schizophrenia definition reliably captures a chronic paranoid-hallucinatory subset of schizophrenia patients. Chronicity is here inbuilt, partly by the duration criteria, but mainly because the disorganized and negative symptoms are defined on a very high severity level, the number of original Schneiderian criteria is reduced, and many of those retained have been transformed from anomalous experiences to delusions (taking time to become articulated).

Viewed through the lens of the continental concept, many of the currently “easy” psychopathological issues (considered as merely technical psychometric problems) would reacquire important conceptual dimensions (eg, chronicity, onset, datability of onset, the concept of psychosis, and the issue of early detection).

It is beyond our scope to assess the consequences of the phenomenological and epistemological discontinuity between the classic European and the current operational versions of the schizophrenia concept. The change in the concept of schizophrenia is, at least in part, a reflection of a more overarching epistemological change, concerning the status of “psychiatric object” (the reasons why a patient sees a psychiatrist). This change may be viewed, depending on perspective, positively, as a sign of progress, or negatively, as a sign of regression (or as a mixture of both). It would require another study to articulate the contents and processes of that change.

### Funding

This work has been financially supported by the Faculty of Health Sciences, University of Copenhagen.



## Acknowledgments

The authors have declared that there are no conflicts of interest in relation to the subject of this study.

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