

## Disturbance of Minimal Self (Ipseity) in Schizophrenia: Clarification and Current Status

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The assessment of psychopathology in most contemporary research is based squarely on signs and symptoms of disorder, often measured in fairly crude checklist-type fashion. This approach has tended to indicate significant overlap in psychotic and other symptoms across disorders, eg, between schizophrenia and bipolar disorder<sup>1</sup> and between psychotic disorders and borderline personality disorder.<sup>2</sup> This may partly be the result of the assessment tools and conceptual frameworks being used. By contrast, insights from phenomenological psychiatry and philosophy, focused on disturbed subjectivity,<sup>3</sup> indicate that disturbed *self-experience or selfhood* may underlie and generate many “surface-level” psychotic symptoms, particularly in schizophrenia spectrum disorders.

There are many different meanings and controversies surrounding the notion of the “self.”<sup>4</sup> These controversies mainly concern its ontology or ultimate reality status, eg, as a kind of “substance,” object, or process. The experiential, subjective notion of the self (the *sense* of self) is, however, widely acknowledged, both in the analytic philosophy of mind<sup>5</sup> and in phenomenology.<sup>6</sup> Two levels of the experiential self are typically proposed:

1. “Minimal” self, also referred to as “basic” or “core” self or as “ipseity.” This is a *prereflective, tacit* level of selfhood. It refers to the implicit first-person quality of consciousness, ie, the implicit awareness that all experience articulates itself in first person perspective as “*my*” experience. In other words, all conscious acts are intrinsically self-conscious,<sup>7</sup> a feature sometimes designated as “self-affection.” “Minimal” or “core” self constitutes the foundational level of selfhood on which other levels of selfhood are built.<sup>6-8</sup>
2. “Narrative” or social self. This refers to characteristics such as social identity, personality, habits, style, personal history, etc. Psychological concepts such as “self-esteem”

or “self-image” refer to this level of selfhood. This level is widely understood to *presuppose* the sense of existing as a subject of experience (“minimal self”) and often involves reflective, metacognitive processes, in which one’s self is largely an *object* of awareness.<sup>6,9,10</sup>

Many classic and early texts about schizophrenia proposed that disturbance of minimal self is at the core of the disorder,<sup>11,12</sup> a view reinforced and extended by recent empirical studies (see below). The ipseity-disturbance model (IDM), developed by Sass and Parnas, presents distortion/instability of the minimal self as consisting of 2 complementary aspects: hyperreflexivity and diminished self-affection. While hyperreflexivity refers to heightened awareness of aspects of experience that are normally tacit or implicit, diminished self-affection refers to a weakened sense of existing as a *subject* of awareness (see Henriksen and Parnas<sup>13</sup> and Parnas and Handest<sup>14</sup> for clinical and Sass and Parnas<sup>15</sup> and Sass *et al*<sup>16</sup> for theoretical description). These processes necessarily disrupt a person’s “grip” or “hold” on the conceptual or perceptual field of awareness. The IDM posits that disturbance in the *structure* of experience, normally permeated by stable first person perspective, characterizes schizophrenia spectrum disorders. This instability manifests itself in a range of anomalous subjective experiences, typically already present in childhood or early adolescence, including forms of depersonalization, diminished sense of existing as a bodily subject, distortions of first-person perspective with weakened sense of “mineness” of the field of awareness (thoughts, sensations, etc.), diminished sense of coherence and consistency in fundamental features of self (eg, sense of anonymity, identity confusion, etc.), and disturbed self-other/self-world boundaries.<sup>17</sup> Being self-present and present in the world of others and objects (the self-world *structure*) exist as 2 sides of the same coin.<sup>18</sup> Accordingly, minimal self-disturbance involves

diminished attunement and immersion in the world, inadequate spontaneous grasp of self-evident meanings (perplexity, diminished “common sense”), and hyperreflectivity.

The IDM provides a parsimonious way of understanding not only the *evolution* of psychotic symptoms and the often *shifting* expression of its single features (ie, why one symptom might recede and another become more prominent),<sup>11,19</sup> but also the profound transformations of subjectivity often reported in schizophrenia spectrum conditions. First-person accounts of schizophrenia are replete with descriptions of this form of self-disturbance. It is quite distinct from the disturbing *impact* psychotic illness can have on an individual’s sense of self (thus, more a trait-vulnerability factor than a *reaction* to psychosis).<sup>20</sup>

A recent account of self-disturbance in schizophrenia<sup>21</sup> differs from the IDM in that it seems to characterize the disturbance as existing primarily on the level of the narrative self (level 2 above). That model posits that self-disturbances in schizophrenia are fundamentally grounded in disruption of the processes with which complex ideas of self and others (“narratives”) are formed, “resulting in a collapse of self-experience and goal-directed behavior” (p. 5). These narrative-generating processes are thought to rely on metacognition, ie, “thinking about thinking.” A similar model by Lysaker and colleagues<sup>22</sup> stresses disturbance of dialogical aspects of selfhood, ie, difficulty in sustaining interaction (or “dialogue”) between different facets of context-dependent narrative selfhood. There is no doubt that disturbances of narrative self and metacognition are also important in schizophrenia spectrum conditions. It is unclear, however, how *specific* such disturbances are to schizophrenia spectrum conditions, or indeed to psychosis more broadly. No studies of this dimension have compared schizophrenia with other forms of psychosis. Also, there is extensive work showing such deficits (of “metacognition” and “mentalizing”) in borderline personality disorder<sup>23,24</sup> and some other conditions including autism. In contrast, empirical data on the IDM indicate that disturbances of minimal self are not a prominent feature of borderline or other personality disorders, nor of bipolar disorder.<sup>25–27</sup> Both research and theory in cognitive neuroscience, phenomenology, and the philosophy of mind suggest, as well, that disruptions of ipseity will affect narrative self and metacognition far more than the reverse.<sup>6,9,10,16</sup>

It is incorrect to characterize the IDM as postulating an “essence” somehow devoid of relationship with others/world, and as something purely passive.<sup>21</sup> As noted, the IDM (following virtually all phenomenological models of subjectivity/selfhood) is based on the notion of instability in the *self-world structure*, not a *self that is a private internal “object” or “thing.”* Also, Sass and Parnas<sup>15,19</sup> have stressed not only automatic or basic alterations, but also consequential and compensatory processes; these can have an active, albeit often counterproductively pathogenic import and help explain temporal variability of symptomatic expression.

There has been much empirical investigation of the IDM in recent years, largely involving the Examination of Anomalous Self-Experience (EASE),<sup>17,28</sup> a semistructured interview format now translated into 9 languages. These findings indicate that minimal self-disturbance characterizes schizophrenia spectrum disorders independent of intensity or presence of frank psychotic symptoms (ie, is present both in psychotic schizophrenia spectrum disorders and schizotypal disorder)<sup>17,27,29</sup>; is dramatically more prominent in schizophrenia than in psychotic disorders outside the schizophrenia spectrum, such as bipolar disorder with psychosis<sup>29–31</sup>; strongly predicts future onset of schizophrenia spectrum disorders in nonpsychotic clinical populations<sup>32</sup> and in those at high risk for psychosis<sup>33</sup>; increases in relation to symptomatic expression along the schizophrenia spectrum in a large genetic linkage sample<sup>34,35</sup>; and correlates with suicidality (more strongly than do positive symptoms),<sup>36–38</sup> lack of insight,<sup>18,39</sup> and social dysfunction.<sup>40</sup> Other exploratory studies, comparing schizophrenic self-alterations with subjective changes in psychotic depression, mania, depersonalization disorder, and heightened forms of introspection, attempt to clarify the specificity, internal structure, and pathogenesis of ipseity disturbance in the schizophrenia spectrum.<sup>41,42</sup>

There is revitalized interest in disturbed selfhood in schizophrenia (eg, see recent Special Issue of *Schizophrenia Research* devoted to this topic). Further empirical and conceptual work may help:

1. Provide a richer understanding of psychopathology in research and clinical training, thereby mitigating overreliance on “symptom checklists.”
2. Identify core features and boundaries between psychiatric disorders, notably schizophrenia spectrum and other disorders with psychotic features such as bipolar disorder, severe depressive disorders, and borderline personality disorder. In this sense, it may provide a bedrock that orients understanding of the schizophrenia spectrum and reduces the sometimes obfuscating influence of surface-level symptomatic expression that overlaps between psychiatric conditions.
3. Enrich early identification and intervention efforts.<sup>43</sup> The IDM has important implications for treatment<sup>18,44,45</sup>. It can help one understand subjective disturbances experienced by patients, thus fostering therapeutic alliance and treatment compliance, and guiding clinical formulations and “psychoeducation” work.
4. Function as a unifying or integrative concept across “levels” of inquiry including psychopathological/clinical, neurocognitive (particularly with regard to concepts of aberrant salience and source monitoring), and neurobiological domains.<sup>46,47</sup>

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