The core Gestalt of schizophrenia

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The recent debate in *World Psychiatry* on prototypes versus operational criteria (1) invites a prototypical reassessment of the clinical-phenomenological presentation of schizophrenia, especially in the light of recent developments in phenomenological psychopathology (2).

Although schizophrenia has been intensively studied for more than a century, with a bewildering accumulation of empirical data, we have still only a very partial understanding of its diagnostic boundaries (3) and pathogenetic mechanisms (4,5). This epistemic resistance motivates a variety of responses: e.g., shortcutting the phenotype-related problems by studying more easily graspable proxy variables; attempts to convert schizophrenia into a dementia-like neurocognitive disease; proposals of further simplification of psychopathological diversity (e.g., the notion of a “unitary psychosis”); or elimination of the notion of schizophrenia altogether.

It seems unlikely, however, that a strategic evasion of a defiant phenotype and silencing the epistemological problems associated with this defiance will somehow lead to an ultimate scientific enlightenment. One additional and timely response is to reexamine the clinical nature of schizophrenia, highlighting its distinctiveness and the theoretical difficulties of its current nosological representations. Perhaps, the epistemic difficulties are related to a disappearance of the phenomenological distinctiveness of schizophrenia in its reifying operational permutations.

EPISTEMIC CONSTRAINS

The epistemological issues at stake are related to the so-called “problem of description” in psychiatry, which is a particular version of the mind-body issue. It is a question of how to address the phenomena of consciousness: e.g., which distinctions are relevant and adequate here, what is the nature of “mental object” (symptom and sign), what is particular to the first-, second-, and third-person perspectives, and what kind of methodology is needed in addressing these phenomenal realms (6).

Since the advent of behaviorism and operationalism, the topic of consciousness vanished from the academic discourse, only to become rediscovered in the last 20 years in the philosophy of mind, cognitive sciences and the neurosciences. Consciousness (subjectivity) is at the forefront of today’s scientific debate, constituting perhaps its most important challenge (7). Unfortunately, these developments have largely eluded mainstream psychiatry. Yet, the concepts of mental illness in general, and of schizophrenia in particular,

are founded on the abnormalities of experience, belief and expression, i.e. abnormalities of consciousness.

Historically viewed, the notion of schizophrenia crystallized itself as an end-achievement of successive phenomenological descriptions (2). These descriptions may be seen – in retrospect – as a reiterative quest for a characteristic phenotypic pattern, prototype or Gestalt. This search clearly transpires in a famous passage from a Dutch psychiatrist, Rümke, claiming that certain hallucinations and delusions are diagnostic of schizophrenia, but only if they exhibit a certain characteristic schizophrenic taint; a tautological claim, which Rümke himself qualified as “a scientific absurdity”, yet absurdity “familiar to every experienced clinician” (8).

The notion of Gestalt refers to a *salient unity* or *intrinsic organization* of diverse phenomenal features, based on reciprocal part-whole interactions. In this framework, psychiatric symptoms and signs cannot be considered as mutually independent, atomic features that become individuated (i.e., identified as *this* or *that* particular symptom) “in themselves”, independently of their experiential context. A smile as such cannot be *predefined* as inappropriate or silly. The silliness of a smile only emerges in the *flow* of expressivity and communication. In contrast to somatic medicine, where symptoms and signs possess a clear *referring* function or “extensionality” (e.g., chronic coughing → suspicion of a lung disease), psychiatric phenomena are individuated through their meaning or “intensionality” (e.g., “avoiding others” changes its significance when arising, respectively, due to a paranoid attitude, a melancholic sense of self-reference, or a fear of external access to one’s own thinking).

The diagnostic identification of schizophrenia in the pre-operational psychiatry was not based on a cross-sectional, momentary, or, metaphorically speaking, “two-dimensional” summation of mutually independent symptoms and signs (“symptom counting”), but linked to a Gestalt recognition, necessarily imbuing the diagnosis with a dimension of “depth”, i.e. contextual interrelations between single features, their *qualities*, *developmental* and *temporal* aspects.

Two, interdependent, clinical features belong to the notion of schizophrenia: a) a *developmental* aspect, i.e., that schizophrenia typically does not arise abruptly, *ex nihilo*, but is nearly always preceded by a premorbid trajectory, b) schizophrenia belongs to a *spectrum* of conditions, with varying intensity and qualitative profiles, which nonetheless share important trait-phenotypic commonalities. Both aspects are not contingent, *additional* clinical facts but are constitutive of the notion of schizophrenia as involving an essential trait dimension.

"FUNDAMENTAL" SYMPTOMS

The articulation and development of the concept of schizophrenia was founded on the recognition of its phenomenological distinctiveness and typicality, a prototypical "whatness" or phenomenological *core Gestalt*. The core properties are not temporally fluctuating state phenomena (psychotic symptoms), but trait features, reflecting its *phenomenological structure*. To phrase it differently: the validity of the schizophrenia spectrum concept was linked to the clinical manifestations of this core.

There were many attempts to grasp and describe this core Gestalt through a list-wise enumeration of symptoms and signs. Bleuler and others distinguished between *fundamental symptoms*, characteristic of the core and *specifying the spectrum of schizophrenia* (schizoidia, latent schizophrenia, schizotypal disorders) and *accessory* state phenomena, indexing a psychotic episode (hallucinations, delusions, flamboyant catatonic features). The former were typically described on the level of expression and behavior, i.e. mainly as "signs": withdrawal, inaccessibility, inadequate or strange affectivity, emotional- and affect-expressive changes, formal thought disorder, ambivalence, changes in the structure of the person, disorders of volition, acting and behavior (2).

Many of these features overlap on a closer inspection. More importantly, their predominantly expressive ("objective") sign character is usually associated with anomalies of experience (symptoms). Thus, rather than functioning as self-subsistent, mutually independent signs, the single "fundamental features" are *aspects* of larger wholes, jointly constituted by anomalies of experience *and* expression, and with a diagnostic significance that manifests itself contextually and most pregnantly in the interpersonal and communicative-symbolic space. We witness here a part-whole reciprocity of a Gestalt: the single features infuse the Gestalt with its concrete clinical rootedness, whereas the wholeness of the Gestalt confers on its single features their diagnostic significance.

GENERATIVE DISORDER: ALTERED STRUCTURE OF SUBJECTIVITY

There were many, often metaphoric, designations for the underlying structure or Gestalt, e.g., "disunity of consciousness", "discordance", "intra-psychic ataxia", "autism", "loss of vital contact with reality", "global crisis of common sense", "cognitive dysmetria", etc. A common referent of these designations is not a modular psychological dysfunction or a delimited, fleeting, pathological mental content, but rather *a trait alteration of the very structure of consciousness* (subjectivity, mentality). It was phrased in the ICD-8 as "the fundamental disturbance of personality [i.e., self], [which] involves its most basic functions, those that give the normal person his *feeling of individuality, uniqueness, and self-direction*" (my additions in square brackets).

The phenomenological, experiential, notion of the self signifies that we live our (conscious) life in the first person perspective, as a self-present, single, temporally persistent, embodied, and bounded entity, who is the subject of his experiences. A stable sense of this basic selfhood and identity always goes together with an automatic, un-reflected immersion in the shared (social) world. The world is pre-given, i.e. always tacitly grasped as a real, taken-for-granted, self-evident background of all experiencing and all meaning (9).

Recent empirical studies confirm more classic observations that this basic and foundational self-world structure of subjectivity is unstable or failing in schizophrenia, constituting its core vulnerability (2,10). This often results in alarming and alienating experiences, typically already occurring in childhood or early adolescence. This structural alteration marks the nosological extension of the schizophrenia spectrum disorders: it occurs in schizophrenia, schizotypy (11-15) and in pre-onset vulnerability (16,17).

The patients feel ephemeral, lacking a core identity, profoundly (often ineffably) different from others and alienated from the social world. There is a diminished sense of existing as an embodied subject, self-present and present to the world, distortions of first person perspective with anonymization or deficient sense of "mineness" of the field of awareness ("my thoughts are strange and have no respect for me"), spatialization of experiential contents (e.g., thoughts being experienced as spatially located extended objects) and failing sense of privacy of the inner world. There is a significant lack of attunement and immersion in the world and pervasive perplexity, i.e. inadequate pre-reflective grasp of self-evident meaning ("why is the grass green?") and hyper-reflectivity ("I only live in my head", "I always observe myself"). Social isolation and loneliness are more solipsistic, arising "from within", rather than functioning solely as a psychological defense or a simple deprivative consequence of the illness. The basic disorder often translates into altered and strange existential patterns, e.g. solipsistic grandiosity, bizarre attitudes and actions, "double book-keeping", mannerist behaviors, or searching for new existential or metaphysical meaning (e.g., adherence to sectarian political or religious groups).

What is diagnostically significant at the level of the core Gestalt is the sense of confronting a condition marked by a *fundamentally changed subjectivity* that may manifest itself across all mental domains: affect, expression, motivation, mood, cognition, willing and action. The core Gestalt transpires through the illness' polymorphic picture in *how* the patients experience themselves, others, and the world, and not merely in *what* they experience. The core Gestalt possesses a generative status, making the clinical picture less enigmatic, because endowed with certain static (synchronic) and developmental coherence of its symptomatic elements. The delusions, passivity phenomena and hallucinations of the psychotic phases often appear as thematic elaborations of the more primary features of the altered structure of self-world experience (18).

CONCLUSIONS

An unintended consequence of the operational remake of the diagnostic systems was a decline of psychopathological competence and scholarship (19), coupled with reification of diagnostic categories and the associated explosion of the phenomenon of comorbidity. Schizophrenia became largely reshaped into a psychosis with chronic delusions and hallucinations, depleted of affective features. The diagnoses of schizotypal disorder and disorganized schizophrenia (more broadly, non-paranoid schizophrenia) have become a clinical rarity, yielding space for a variety of other, alternative (typically, checklist-derived) diagnoses, e.g., borderline personality disorder, social phobia, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder, etc. (20).

There is no other way forward than reviving and prioritizing teaching of psychopathology, including peer-shared assessments of psychopathology, accompanied by theoretical and interdisciplinary studies and discussions. A reinvigorated investigation of trait features of schizophrenia is today urgently needed to achieve a significant progress in pathogenetic and therapeutic research and for improvements in clinical practice, which includes early diagnosis and intervention. A sophistication of psychopathology is a necessary condition for a fruitful match with the scientific and technological possibilities offered by the rapidly advancing basic neuroscience.

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