Abstract: This paper provides a critical survey of some subtle and often overlooked disturbances of self-experience that can occur in schizophrenia, melancholia, and mania. The goal is to better understand both similarities and differences between these conditions. We present classical and contemporary studies, mostly from the phenomenological tradition, and illustrate these with patient reports. Experiential changes in five domains of selfhood (following Parnas et al., 2005) are considered: Cognition, Self-Awareness, Bodily Experiences, Demarcation/Transitivism, and Existential Reorientation. We discuss: I. major differences involving self-experience between schizophrenia and affective disorders; II. experiences in which these conditions nevertheless resemble each other; III. suggestions on how these experiences may still differ on a more subtle, phenomenological plane. While affective patients may undergo significant changes in self-experience, their underlying sense of basic or minimal selfhood (‘ipseity’) remains intact. In schizophrenia, basic self is disturbed, and this may help to account for many characteristic disturbances of this disorder.

1. Introduction

The difference between affective and schizophrenic forms of disorder is one of the classic issues in psychopathology. Ludwig Binswanger even called it ‘the central problem of clinical psychiatry’ (Tatossian, 1997). In a famous passage, Karl Jaspers (1946/1963) describes the
‘most profound distinction in psychic life [as] that between what is meaningful and allows empathy’, and what ‘in its particular way is ununderstandable, “mad” in the literal sense, schizophrenic psychic life’ (p. 577). This, in his view, distinguishes affective illnesses, which ‘we can comprehend vividly enough as an exaggeration or diminution of known phenomena’, such as intense emotion, from the supposedly more incomprehensible disorder of schizophrenia. But Jaspers also recognized that this distinction, though fundamental, was extremely difficult to conceptualize: he speaks of ‘a basic difference… which even today we cannot formulate clearly and precisely’ (ibid., p. 578).

The present article (together with its sequel) is an attempt to explore this distinction from a phenomenological standpoint, that is, to examine both differences and affinities in the subjective experiences characteristic of these two major groups of psychopathology.

Despite some important work (e.g. Minkowski, 1933/1970; Tellenbach, 1980; Kraus, 1991; Tatossian, 1997; Fuchs, 2001; 2005; Stanghellini, 2004), affective conditions have been relatively neglected in phenomenological psychopathology, with far less attention directed to subjective life in affective disorders than in the schizophrenia spectrum. More common have been empirical studies enquiring into symptoms and signs that can be objectively observed or operationalized. While such studies benefit from their ability to compare objectively measurable dimensions, they typically neglect subjective experiences, and so may miss some of the subtle changes patients undergo. In this paper we shall give equal emphasis to subjectivity in the affective conditions and in schizophrenia, with each serving as the foil to the other. One of our purposes is to offer a preliminary mapping or synopsis of key features of subjective experience in psychotic forms of affective disorder, especially melancholia but also mania — something that is not available in the recent psychopathological literature.

Our attempt is exploratory. We offer a critical survey of what has been said in the phenomenological tradition about subjective life in these conditions, with an eye toward both contrasts and affinities. We present, whenever possible, patient reports that either illustrate the relevant theoretical claims or suggest their limitations (mostly taken from the published literature, but occasionally coming from our own patients or informants). We are obviously interested in fundamental differences that distinguish typical affective (melancholic or manic) phenomenology from what is found in schizophrenia. These differences can be both profound and striking. They are, however, quite well known. We therefore pay special attention to phenomenological
domains in which the characteristic experiences can appear rather similar, and where the differential may be difficult to achieve. These difficult instances, we believe, are especially worthy of study both as potential aids for differential diagnosis and for furthering our theoretical understanding of both psychopathological conditions; by probing these affinities, subtle distinctions may become more apparent.

In order to survey the inner landscape of these disorders, it is necessary to divide it into separable domains, even while recognizing that these domains are likely to be overlapping and interdependent in various ways. In this first article, ‘Varieties of Self-Experience’, we will borrow the mapping of domains offered in a recently developed research tool of phenomenological psychopathology: the Examination of Anomalous Self-Experience or EASE (Parnas et al., 2005). The EASE distinguishes five experiential domains of self-experience: Cognition and Stream of Consciousness, Self-Awareness and Presence, Bodily Experiences, Demarcation/Transitivism, and Existential Reorientation.

The EASE was developed as a technique for carrying out in-depth, qualitative interviews with live subjects; it targets experiences that are thought to be highly characteristic of schizophrenia-spectrum illnesses. Research with the EASE and related instruments has shown that self-disturbances, as there defined, are, in fact, far more common in schizophrenia-spectrum disorders than in either depression or bipolar disorder (Parnas et al., 2003; Handest and Parnas, 2005; Raballo, Saebye and Parnas, 2011). The EASE can, however, also be viewed as an exceptionally clear and detailed delineation of major domains of psychopathology from a phenomenological standpoint. Its specific items provide an excellent set of definitions and also of key schizophrenic or schizotypal examples with which to compare experiential reports in affective disorders. Whereas the EASE focuses on sub-psychotic phenomena, here we are interested both in sub-psychotic and psychotic experiences associated with melancholia, mania, and schizophrenia. Also, although our discussion follows the general EASE mapping, it is not restricted to the particular items included in the EASE, which are primarily directed toward schizophrenia-spectrum self-experience. Here we take a broader approach to the possibility of anomalies in each of these domains of self-experience, so as to include anomalies found in affective illness but possibly not in schizophrenia.

The EASE focuses on anomalies of self-disturbance. In a companion article, we supplement these five domains with three others that
target anomalies not of self but of world experience: *Objects and Space, Events and Time, and Aspects of General Atmosphere.*

We wish, then, to offer three perspectives in these papers: I. a review of some major differences in anomalous self-experience between affective and schizophrenic conditions; II. a consideration of experiences in which the two conditions may nevertheless resemble each other, thus undermining the clarity of the distinction between the two domains; III. suggestions, some quite speculative, about how these apparently similar phenomena might nevertheless be distinct, and perhaps are distinguishable in clinical and research settings.

As noted, the psychiatric understanding of the affective/schizophrenic border has been characterized by various ambiguities and vacillations. We shall suggest that there are various explanations for this. One reason is that affective disorders (contrary to what Jaspers says) may not, in fact, always be fully understandable as ‘exaggeration or diminishment of known phenomena’ of emotional life. This is particularly apparent in severe states of psychotic depression (melancholia), when the patient seems to move beyond any recognizable emotional or affective state into what can seem an utterly remote and void-like condition. Mania at the extreme can bring on forms of cognitive or behavioural disorganization and self-disorder that may be sharply at odds with the classic manic experiences of increased vigour, euphoria, and flight of ideas. Distinguishing these experiences from schizophrenic depersonalization, derealization, disorganization, and self-alienation can pose a special challenge for phenomenological investigation. It may, however, help to sharpen our grasp of both conditions.

2. Diagnostic Controversies
   and Other Complicating Factors

The EASE interview, like much phenomenological psychiatry, is meant to reveal an underlying *trouble génératrice*, an organizational matrix or structure of experience; as such, it focuses on the subtle mutations of experience that may or may not be directly reflected in symptoms such as hallucinations or delusions. There is, of course, controversy about the very existence of these matrices of experience. Currently it is common to question the validity of the traditional psychiatric distinction between schizophrenia and the affective disorders

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[1] A full survey of important world-disturbances in psychopathology would need to address some additional domains, including the experience of other human beings (persons) and of language. For reasons of length, we deal with these latter issues in two further articles, now under preparation.
(Allerdyce et al., 2007; van Os, 2012). Some contemporary empirical research suggests that many symptoms, or even groups of symptoms, are insufficient for distinguishing between these disorders (e.g. Taylor, 1992; Kendell and Jablensky, 2003; Dutta et al., 2007; van Os, 2009). This is not, of course, a new issue: both the location and existence of boundaries between these disorders have been disputed for over one hundred years. Still, Kraepelin’s (1913) basic distinction — whether framed as a dichotomy or as a continuum between schizophrenic and affective types — continues to be the dominant view in contemporary psychiatry and psychology. It is well to bear in mind Karl Jaspers’ (1946/1963) assessment of this long-running debate: ‘for many years the border between manic-depressive insanity and dementia praecox [the older term for schizophrenia] has vacillated considerably in a kind of pendulum movement without anything new emerging’ (p. 567). Jaspers recognized the difficulty of precisely defining the border between these conditions; he also acknowledged the near impossibility of deciding on a diagnosis in certain cases. He did not, however, doubt that there is something valid about this distinction to which we seem always to return, writing that ‘there must be some kernel of lasting truth not present with previous groupings’ (ibid., p. 568).

This paper contributes to this debate by exploring the possibility that there may indeed be underlying differences that require more sensitive and detailed forms of exploration. In this sense, the very idea that such distinctions exist operates as a working hypothesis, one that is, however, highly congruent with traditional views in psychopathology for the past century (Bleuler, 1911; Kraepelin, 1913; Minkowski, 1927; Jaspers, 1946/1963). Even if it were the case that key pathogenetic processes are shared across these disorders (e.g. salience dysregulation; van Os, 2009; 2012), it may nevertheless be true that the consequences of these processes are moulded differently in accord with distinct underlying experiential orientations or troubles générateurs.

In this article, we do not seek to determine whether or not such categories should be retained — the latter is obviously an issue that can be debated on a variety of different grounds. Rather, we seek to explore whether certain distinctive kinds of experience can be reliably associated with each of these disorders as traditionally defined. We

[2] Recent studies employing phenomenological methods have, however, been capable of distinguishing schizophrenia-spectrum disorders from bipolar disorder (Parnas et al., 2003; Haug et al., 2012) and have been able to predict transition to schizophrenia psychosis in ultra high-risk populations (Nelson, Thompson and Yung, 2012).
acknowledge that a certain confirmation bias may prejudice us in the direction of finding differences. This and the following article are, however, exploratory, meant to provide hypotheses for future confirmation or disconfirmation. The subtler differences we explore concern levels of experience that are not addressed in the literature critical of these diagnostic entities. Future research may need to take these into account.

We would not argue, of course, that particular experiences in these different conditions can always be distinguished in phenomenological terms. One perennial issue, in fact, is whether the distinction between schizophrenia and affective psychosis is sharp or qualitative, or whether there is a continuum, and whether ‘schizoaffective’ psychosis is a legitimate category (Tsuang and Simpson, 1984; Dutta et al., 2007). Here we take no position on these questions. We have tried, however, to focus on clear-cut examples of the forms of psychosis we consider, and to the extent possible have avoided using examples or analyses of intermediate cases.

One limitation of our study, as with all phenomenological research, is that we must rely largely on patients who are able to describe their experiences; this can involve a selection bias in favour of patients who may not be typical of the entire diagnostic group at issue. Although this issue must be borne in mind, it must also be recognized that this is an essential feature of phenomenological work, one that can only be avoided at the risk of ignoring the subtle features of a patient’s subjectivity.

We must recall, as well, that manifest forms of psychopathology are typically the joint products of numerous factors and processes — not merely of some inherent psychopathological kernel (if such exists), but also of various sequela, including both consequential and compensatory reactions. Consider how very common, and how varied in its manifestations, depression can be in schizophrenia: although the depression of a schizophrenia patient may sometimes have a rather different quality than that of a pure affective patient, in other instances it may be much the same (e.g. the secondary depression elicited by isolation and problems in living). Paranoia is common in schizophrenia, melancholia, and mania, as are certain forms of depersonalization in schizophrenia and melancholia. Indeed such defence reactions are universal or near-universal processes, part of the general human condition. Yet it is true, as well, that the choice of these mechanisms, and also the way they are inflected in particular cases, can reflect something deeper or more distinctive about the individual or disorder in question.
All this is related to the overlapping issues of co-morbidity and internal complexity. We note, for instance, that some patients with paranoid forms of schizophrenia may lack the more extreme forms of self-disorder and world-transformation found in disorganized cases. The melancholia of patients with manic or hypomanic phases may differ from those patients who lack these phases. Schizophrenia patients with predominantly positive versus negative versus disorganized symptoms obviously differ from each other in various ways. There are also significant differences between patients with affective reactions (manic or melancholic) who are prone to psychosis versus those who are not.

It would be impossible to take all these potential subtleties and distinctions fully into account in a brief survey and report such as ours. The play of sameness and difference is virtually kaleidoscopic in nature; it would result in cognitive paralysis. Although we do not ignore all such nuances and qualifications, here we opt for a kind of (Weberian) ideal-type analysis. As Max Weber (1904/1949) noted with regard to such notions as ‘charisma’ and ‘capitalism’, such phenomena never exist as ‘pure’ entities in the real world, yet it is essential to employ such abstractions when analysing empirical reality. This ideal-type analysis emphasizes features that are ‘typical’ of the phenomenon studied, but without applying equally well, or in just the same way, to all instances of the type. We do not claim that all of the distinctions we suggest will hold invariably, in a truly pathognomonic sense, nor that the feature will be constantly present in any particular patient. Here we have the more modest — and more realistic — goal of discerning features of melancholia, mania, or schizophrenia that are highly distinctive of the disorder in question.

In this paper, we have chosen to focus specifically on the experiences of ‘melancholia’ and ‘mania’. ‘Melancholia’, a term employed since classical times (Radden, 2009), has recently been used to specify severe, endogenous, or psychotic depression (Sierra, 2009). DSM-IV-TR (2000) uses the specifier ‘With Melancholic Features’ to describe a Major Depressive Episode that is more severe and qualitatively distinct: with ‘a near-complete absence of the capacity for pleasure, not merely a diminution’ and with a ‘distinct quality of mood… qualitatively different from the sadness experienced during bereavement or a non-melancholic depressive episode’ (ibid., p. 419). Our use of ‘melancholia’ reflects the severity of the disturbance and its likelihood of generating striking experiential anomalies. We use ‘mania’ to

refer to particular experiences that can occur in someone diagnosed with Bipolar Disorder. Here, however, we are specifically interested in these manic experiences themselves, rather than in the diagnostic entity as a whole.

A famous line from the psychiatrist Harry Stack Sullivan states that people with schizophrenia, like all people, are ‘more simply human than otherwise’ (1953). This reminds us that the structure and pathogenesis of schizophrenia, like all forms of psychopathology, will involve some psychological mechanisms found elsewhere as well — e.g. in affective psychosis, depersonalization disorder, etc. But this does not mean that there is not also an ‘otherwise’, to use Sullivan’s term. The comparative phenomenological method is, we believe, an indispensable tool in isolating this core that, without explaining the totality of schizophrenic pathology, may well contribute to giving schizophrenia a unique, Gestalt-like essence. And perhaps it can make a similar contribution in the cases of melancholia and mania. It is worth noting, however, that there does seem to be something more unique or at least ‘otherwise’ about schizophrenia: whereas most of the phenomena found in melancholia and mania can occur in schizophrenic patients, though less prominently, there do seem to be certain features, often having a certain bizarre or uncanny quality, that seem to be quite distinctive of schizophrenia in particular (Rümke and Neeleman, 1942/1990; Jaspers, 1946/1963; Mellor, 1970).

As noted, our study is exploratory, an exercise in generating hypotheses for further investigation. It has several weaknesses that are perhaps inevitable in this sort of project.

Although some of our generalizations are corroborated by controlled empirical research (e.g. by EASE interviews comparing schizophrenia with affective patients), many are supported only by anecdotal reports and theoretical rationales. These would need to be tested in various ways, not only with in-depth qualitative interviews with carefully diagnosed patients, but also through various forms of experimental research.

We are aware of the inherent difficulty of operationalizing some of our more speculative claims, which can refer to subtle features of experience that are not likely to be spontaneously or readily described by individuals untrained in phenomenology, and that may, in some instances, even verge on ineffability. We believe, however, that an empiricist-oriented restriction of theoretical speculation would not be appropriate at this stage of research, when it is difficult to know precisely what can and what cannot be operationalized. Perhaps the major lesson of the modern philosophy of science, since the rejection
of the logical-positivist programme, is the complexity of the relationship between theory and observation. Work that is highly theoretical, speculative, clinically oriented, and anecdotal — such as ours — is certainly not opposed to empirical study, but should play a role in the formulation of its hypotheses and particular methods. For as we know from Kant, experience without theory is blind, just as theory without experience would be mere intellectual play.

3. Cognition and Stream of Consciousness
(EASE Domain 1)

We begin with Domain 1 of the EASE (Examination of Anomalous Self-Experience; Parnas et al., 2005), which contains experiences of anomalous Cognition and Stream of Consciousness. Items in this domain — which are thought to be characteristic of schizophrenia-spectrum disorders in particular — generally involve disturbances of the normal process of thinking or related processes such as memory, attention, and language.

I: Thought disorder has, of course, been traditionally associated with schizophrenia, and is often thought to distinguish schizophrenia from the affect- or emotion-related disturbances characteristic of mood disorders. So-called formal thought disorder is largely manifest in verbal output, but can clearly be suggestive of cognitive and experiential anomalies as well. Schneider’s first-rank symptoms of schizophrenia specify several forms of disturbed experiences of thinking that are explicitly subjective in nature, including audible thoughts, thought withdrawal, and thought diffusion (Schneider, 1959). Such disturbances seem to contrast sharply with the cognitive disturbances typically noted in affective disorders, viz. slowed thinking in depression and racing thoughts in mania. Although schizophrenia patients may also experience change in the speed or quantity of their thoughts, what is more distinctive is the qualitative change such as described in EASE items Loss of Thought Ipseity and Spatialization of Experience.

II: However, in more severe forms of affective disturbance, some of these distinctions may not be so clear. Indeed, formal thought disorder has been noted in both psychotic and non-psychotic patients with mania. A study by Holzman, Shenton and Solovay (1986) using the Rorschach Thought Disorder Index examined patients with mania, schizoaffective disorder, and schizophrenia, and noted high levels of

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[4] Kant’s famous line from the Critique of Pure Reason (1855), ‘Thoughts without content are empty, intuitions without concepts are blind’ (A51, B75), has been glossed more or less as paraphrased above in General Systems (1962).
thought disorder in all groups, including non-psychotic patients with mania. Common factors among the various diagnoses included vagueness, loss of set, inappropriate distance, and incongruous ideas. Such characteristics echo Binswanger’s (1964) earlier description of manic thought, in which he noted that manic ‘flight of ideas’ involved not merely a simple increase in thought quantity or speed, but was also frequently disordered and confused, jumping from one idea to the next with little goal-directedness or respect for the rules of grammar or logic. DSM-IV-TR (2000) describes manic thinking as like ‘watching two or three television programs simultaneously. Frequently there is flight of ideas evidenced by a nearly continuous flow of accelerated speech, which abruptly changes from one thought to another’ (p. 358). This mode of thinking bears some similarity to the description of Thought Pressure found in the EASE, which describes thoughts that arise ‘in quick sequences’, and that ‘lack… a common theme and hence… coherence or meaning for the client’ (Parnas et al., 2005, p. 240).

This form of disordered thought is illustrated in the following statement by a patient with mania: ‘I can write up or down. I can call the jolly folks or the sad folks. I have one church on Madison Avenue, another in downtown. You don’t go messing around with churches. No I wasn’t asleep. I just disappeared…’ (Akiskal and Puzantian, 1979). These utterances seem to demonstrate a lack of common meaning or theme similar to what can characterize schizophrenic thinking.

A study by Silber et al. (1980) observed several features of their depressed patients that shared commonalities with schizophrenic thought disturbances: 1. ‘cognitive rigidity’ and ‘preoccupation with certain repetitive thoughts’, similar to the EASE item Ruminations/Obsessions; 2. poverty of speech that seems to resemble schizophrenic Thought Block (an EASE item); 3. difficulty focusing that might resemble Attentional Disorders (also an EASE item), such as one patient who noted, ‘I could not follow conversation, could not pretend any interest. There was no talking with anybody’ (Smith, 1999). Sarah Kane, a British playwright known to be severely and psychotically depressed, described her experiences in the play 4.48 Psychosis (published posthumously after her suicide at age 28). Her statement ‘Behold the Eunuch/ of castrated thought’ (Kane, 2001) suggests a similar feeling of the inadequacy of her thinking.

In addition, Piguet et al. (2010) noted that, in contrast to the typical notion of slowed or decreased thinking in melancholia, many depressed patients in fact experience an increase in the number of thoughts. These are experienced as coexisting simultaneously in an
unpleasant continuous flooding, in which earlier thoughts linger in the mind instead of being replaced by subsequent ones — something that has been called ‘thought crowding’. One patient described it as though ‘all the problems of the universe came crowding into my mind’ (ibid., p. 192). Such ‘thought crowding’ might not be easily distinguished from schizophrenic ‘thought pressure’, in which ‘many thoughts (or images) with different, unrelated or remotely related meaning content… pop up and disappear or… seem to the patient to occur at the same time (simultaneously)’ (Parnas et al., 2005, p. 240). This similarity between crowded thoughts and thought pressure is highlighted in Les Murray’s account of depression in his book Killing the Black Dog: ‘…now my mind became congested, jammed with ideas I couldn’t formulate clearly or nimbly enough, so that they tumbled over each other and made me incoherent’ (Murray, 2009, p. 3).

The following quotation from Sarah Kane’s grueling account of psychotic depression suggests another way in which depressive thinking can become strange and even object-like:

[A] consolidated consciousness resides in a darkened banqueting hall near the ceiling of a mind whose floor shifts as ten thousand cockroaches when a shaft of light enters as all thoughts unite in an instant of accord body no longer expellent as the cockroaches comprise a truth which no one ever utters. (Kane, 2001, p. 205)

Such statements suggest a sense of alienation from one’s thoughts, to the point that they may feel creepy, thing-like, and not completely under one’s control. This appears similar to the EASE item Spatialization of Experience, where ‘thoughts, feelings, or other experiences or mental processes are… described in spatialized terms (e.g. location, spatial relation or movement)’ (Parnas et al., 2005, p. 242).

Furthermore, it has often been claimed that the first-rank symptoms (FRSs) — which involve severe abnormalities of the sense of possession or control over one’s own experience or behaviour, or of one’s separation from other minds — are pathognomonic of schizophrenia; but this claim has also been contested on the grounds that similar experiences can be found (though perhaps less frequently) in affective psychosis or PTSD (Taylor and Abrams, 1973; Abrams, Taylor and Gaztanaga, 1974; Carpenter and Strauss, 1974; Abrams and Taylor, 1981).

III: However, a review of the concept of first-rank symptoms by Koehler (1979) provides one way again to differentiate schizophrenic from severe affective symptoms; he suggests that many of the aforementioned overlaps may stem from ambiguities in the definitions of
the FRSs. According to some experts, only the more narrowly defined symptoms are specific to schizophrenia as opposed to affective psychosis. Thus for Taylor and Heiser (1971), Mellor (1970), and Wing, Cooper and Sartorius (1974), one must distinguish between ‘influenced experiences’ in which the patient experiences his own thoughts or feelings as imposed upon him by some outside agency, versus the more distinctive alienated experiences, in which thoughts or feelings that were not his own somehow come from or belong to an outside force. Of related interest is the observation that, whereas thought diffusion (the sense that one’s thoughts are spreading out from one’s head) is found in both affective psychosis and schizophrenia, thought broadcasting (the sense that others are participating in one’s thoughts) is unique to schizophrenia (Fish, in Wing, Cooper and Sartorius, 1974; Hamilton, 1984).

Such a view is consistent with that of Alfred Kraus (1991), who states that although the I-sense may indeed be weakened in melancholia, such patients do not experience the frank loss of mineness (Meinhaftigkeit) that does occur in schizophrenia (p. 73). It seems that extreme forms of melancholia and perhaps also mania can indeed involve various forms of alienation from thoughts and feelings, but not the extreme loss of minimal self, of existing as a distinct subjective point of view. By contrast, this disturbance of the core or minimal dimension of selfhood, or ipseity, seems to be a key aspect of a disturbed experience of thoughts and cognition for many schizophrenia patients. Clear instances of what the EASE (Parnas et al., 2005, p. 240) terms ‘loss of thought ipseity’ — where the patient feels that ‘certain thoughts [are] deprived of the tag of mineness’ — are very rare if not absent outside the schizophrenic spectrum. Even the above quotation from Sarah Kane (‘a consolidated consciousness… near the ceiling of a mind’) appears to lack the extreme degree of reification and loss of mineness that can be described in schizophrenic spatialization of experience.

This may be related to a difference in the kind of confusion that is felt in schizophrenia versus mania. The mania patient’s rapidly shifting attention in flight-of-ideas is a form of distraction — an inability to ignore environmental stimuli that are capable of arousing lively but ephemeral interest in the patient, but that, in a normal individual, would remain on the margin of awareness, outside the focus of attention. The distinctive schizophrenic ‘perplexity’ (Ratlosigkeit, as it was called in classical German psychopathology, a term that means helplessness, not knowing what to do, being at a loss) seems less a matter of being distracted by the outside world than of lacking an orienting
centre or vital core, the sense of relevancy (of having a thematic field at all) that requires an organizing motivational perspective (Sass, 2004).

It is all a matter of mattering, we might say, or rather of how things matter. Whereas for the individual with mania, with his intensified emotional reactivity, there are too many things that matter, and that come to matter too quickly and fleetingly, for the individual with schizophrenia, it is rather that nothing may matter, or at least matter in a normal fashion. This may be related to a certain emotional flattening that can occur in schizophrenia. Things, after all, normally matter to a person and within a distinct point of view, and the subjective loss of self-affection (of minimal or core self), which is normally bound up with emotion and grounds one’s sense of having an orienting project, tends to undermine one’s orientation to the external world. This is not a dimming-down but a qualitative transformation of subjective life.

Sophie, a young woman with schizophrenia, reported to us that in schizophrenia a particular object may attract attention because of what is experienced as its strangeness or unfamiliarity, or, alternatively, there may be a ‘global sense that everything is strange and unfamiliar/ineffably “off”… [resulting in] an inability to attend to anything in particular [and a tendency] to flit from object to object, unsure of why they are all so disturbing’. In either case the object or objects-in-general appear to have lost their normal affordance qualities, which are generally correlated with normal emotional reactions and practical concerns, and instead loom up as objects of a disconcerting fascinating or detached scrutiny.

Distinguishing schizophrenic perplexity from melancholic confusion is somewhat more difficult, however. In the latter condition we encounter, if not a loss of minimal self, at least an ebbing of its vital dynamism and orienting appetites — all of which obviously diminish the significance things can be felt to have in subjective life, often resulting in a general sense of confusion. For example, one melancholic patient remarked, ‘I saw his lips moving, but his words were lost on me… Some other voice held my ear, and my mind was a tangle, a welter of confusion and overwhelm’ (Smith, 1999, p. 4). Les Murray, who suffers from depression, describes ‘my brain [as] boiling with a confusion of stuff not worth calling thought or imagery: it was more like shredded mental kelp marinated in pure pain’ (Murray, 2009, p. 7). ‘I can’t make decisions… I can’t think’, writes Sarah Kane (2001, p. 206), and later, ‘tongue out / thought stalled / the piece-meal crumple of my mind’ (ibid., p. 225). The subjective experience of depressive inadequacy and schizophrenic perplexity may in fact
approach each other very closely, at least in some instances. Given the limitations and general vagueness of much verbal report, one should expect to find many indistinguishable descriptions.

We believe, however, that there are some subtle yet profound differences; and that in depression the experience will be more bound up with issues of vitality or fatigue, whereas in schizophrenia there is an even more fundamental disturbance of ipseity or minimal self, manifest both as an exacerbation of hyperreflexivity (exaggerated and dysfunctional forms of self-consciousness) and as an undermining of basic self-affection (of mine-ness, or first-personhood) (Sass and Parnas, 2003; 2007). Consider the following quotation from Antonin Artaud, who suffered from schizophrenia, in which he describes his own experience of mental confusion and related thought blocking:

[T]he thought, the expression stops because the flow is too violent, because the brain wants to say too many things which it thinks of all at once, ten thoughts instead of one rush toward the exit, the brain sees the whole thought at once with all its circumstances, and it also sees all the points of view it could take and all the forms with which it could invest them, a vast juxtaposition of concepts, each of which seems more necessary and also more dubious than the others, which all the complexities of syntax would never suffice to express and expound. (In Sass, 2003, p. 173)

This sort of hyperreflexivity, in which one’s own ongoing mental life comes to be objectified and treated as a thing, can be manifest as the ‘spatialization of experience’ described above. Schizophrenic patients have described this in various ways: ‘Thoughts are encapsulated.’ ‘Thoughts “spiral around” inside his head.’ ‘Thoughts always pass down obliquely into the very same spot’ (Parnas et al., 2005).

Consider, by contrast, the following account from a depressed patient, which does contain some superficial resemblances:

I was seized with an unspeakable physical weariness. There was a tired feeling in the muscles unlike anything I had ever experienced. A peculiar sensation appeared to travel up my spine to my brain. I had an indescribable nervous feeling. My nerves seemed like live wires charged with electricity… The most trivial duty became a formidable task. Finally mental and physical exercises became impossible; the tired muscles refused to respond, my ‘thinking apparatus’ refused to work, ambition was gone. (Landis, 1964, p. 272)

Here the patient’s description of her nerves as like ‘live wires’ and of her brain as a ‘thinking apparatus’ do suggest some alienation from her body and mind. Similarly, Sarah Kane’s (2001) description of ‘the ceiling of a mind whose floor shifts as ten thousand cockroaches when
a shaft of light enters’ evokes a yet more extreme degree of the psychophysical alienation. Still, these patients describe what they felt: each is always the subject of consciousness, never questioning that her nerves or brain or thoughts are integral parts of her subjectivity. The depressive experience described here is related to a loss of ‘vital impulse’, a diminished engagement with the world that decreases motivation and desire, making thoughts, emotions, and body seem nervously charged or dark and creepy, but also sluggish, closed up, and unresponsive. Such experience appears to be subtly but distinctly different from the particular kind of confusion that can be felt in schizophrenia (perplexity/Ratlosigkeit), and also from the feeling of thoughts being fully autonomous and alien that can occur with the loss of ipseity or minimal self typical of schizophrenia.

4. Self-awareness and Presence
(EASE Domain 2)

The second EASE domain is the one most directly concerned with self-awareness and presence, with what, in the normal case, could be described as ‘automatic un-reflected self-presence and immersion in the world’ (Parnas et al., 2005, p. 243). This includes a sense of being at one with one’s own experience in its full immanence as well as a feeling of immediate engagement with the outside world. Disturbances in this domain clearly reflect what is meant by the concept of schizophrenia as a ‘self disorder’ in the sense of disordered ipseity or minimal self.

I: A particularly clear description of an experience of ipseity disturbance comes from the autobiography of Elyn Saks, who suffers from schizophrenia:

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. What’s happening to me? This is scary, please let it be over! I think maybe if I stand very still and quiet, it will stop. (Saks, 2007, p. 12)

Affective disorder can also involve disturbance of some aspects of the self, but it is important here to clarify which aspects of self are affected. Various authors make a clear distinction between a core or minimal dimension of selfhood — what we call ipseity — and another layer, built upon this foundation, that concerns one’s sense of continuity over time (Ricoeur, 1992; Zahavi, 2005). In schizophrenia what seems to be disrupted is the most basic level of self-consciousness, the
pre-reflective consciousness that is the source and anchor of all our experience: as Ellen Saks says, ‘there’s no center to take things in and process them and view the world’ (in Sachs, 2007). In melancholia, the disturbance may often occur more at the level of narrative identity — at the level of ‘the self as a construction, the product of conceiving oneself in a certain way’ (Stanghellini, 2004, p. 23). The understanding of who I am and how I relate to others, and of my continuity over time, will be disturbed, but the person nevertheless preserves the minimal sense of existing as a living, subjective point of view distinct from the external world.

II: It should be noted, however, that there are experiences in severe melancholia that can look very similar to schizophrenia. Silber et al. (1980) describe a state of ‘affective inaccessibility’ in which one moves well beyond sadness or any recognizable form of dysphoria: the melancholic loses ‘the ability to experience and recognize affects’ (ibid., p. 161), to the point that one may wonder whether it even makes sense of speak of ‘depression’. As Sarah Kane wrote, ‘I used to be able to cry, but now I am beyond tears’ (Kane, 2001, p. 206). Something similar may occur in mania, when the patient seems to lose all capacity to rejoice, because there is no longer an authentic self that can experience the state of joy. Von Gebsattel (in Tatossian, 1997) goes even further, speaking of the possibility of a complete loss of feeling in melancholia, and alongside it, loss of the capacity for meaningful action in the world. This evokes a kind of fundamental emptiness of the self and loss of meaning in the world, which is perhaps what Sarah Kane meant when she wrote, ‘corrosive doubt / futile despair… nothing can fill this void in my heart’ (Kane, 2001, p. 219).

In the following quotation from by John Custance, a bipolar patient with psychotic features, we see some of the above themes, together with a suggestion that selfhood simply disappears:

…the material world seemed less and less real… the whole universe of space and time, of my own senses, was really an illusion… There I was, shut in my own private universe, as it were, with no contact with real people at all, only with phantasmagoria who could at any moment turn into devils. I and all around me were utterly unreal… My soul was finally turned into nothingness — except unending pain. (Custance, 1952, pp. 72f)

III: One might doubt, then, whether it is possible to distinguish the above-mentioned disruptions of self and world from what is found in schizophrenia.

One distinction can perhaps be drawn from the psychoanalytically-oriented account of McGlashan (1982), who discusses ‘aphanisis’, a
term he uses to describe experiencing a sort of ‘pseudo-depression’ or ‘psychic blankness’ common to many chronic schizophrenics. Many of its traits look similar to the melancholic affective inaccessibility described above, such as ‘motivational inertia, interpersonal isolation, anhedonia, and reports of feeling empty, stuck or blank’ (ibid., p. 120). McGlashan maintains, however, that there is a fundamental difference between these two. He argues that the *aphanisis* of schizophrenia is, at its foundation, an autistic, object-less state, a stance of isolated ‘blankness’ that occurs as a defence against vague and undifferentiated feelings of discomfort. In severe depression, by contrast, even the shutting down of feeling is always permeated with a sense of interpersonal loss, and this gives these experiences a less autistic quality.

Silber *et al.* (1980) take a similar view, suggesting that in severe depression even the experience of affective inaccessibility occurs as a defence against the pain associated with object loss, certain deprivations, or the experience of failure. The implication is that these painful feelings are still present in severely melancholic patients, though relegated to a level of consciousness or background awareness no longer available to normal focal awareness. This is perhaps the unending pain of which John Custance (1952) complains, despite his sense of unreality and of being a ‘soul… turned into nothingness’. But not just object loss; also the *loss of feeling itself* is a source of pain in severe depression, as such patients are painfully aware of this loss (Stanghellini, 2004).

It would clearly be wrong, however, to portray the schizophrenic condition as one that is devoid of pain. Here it might be better to resort to a way of describing this distinction that is stated in Jaspers (1946/1963) and brought insightfully into relief by Stanghellini (2004): namely, that between the *feeling that one is unable to feel*, which is itself a source of pain in severe melancholia, and the *inability (at times) even to feel that one feels or exists*, which can be a source of somewhat paradoxical misery for many persons with schizophrenia. Borrowing this formulation, we might say that the melancholic still possesses a fairly robust, basic sense of ipseity or self-possession; this, in fact, provides the position *from which* he can recognize his diminished vitality or affective response. The schizophrenia patient, by contrast, lacks something closer to the core — the sense of inhabiting his own, first-person perspective. But we should not think that the latter condition is devoid of suffering or any kind of subjective response. As Sophie, the young schizophrenic referred to earlier, wrote in response to precisely this point: ‘So there is perhaps [in schizophrenia—
nia] a sense in which one cannot feel that one feels, but also an almost fully externalized cognition of precisely how (non-affectively) agonizing it is to not be able to feel.’

A further source of anguish for both schizophrenia and affective disorders may be the experience of excessive self-consciousness. However, while melancholic patients may experience a largely social self-consciousness (a consciousness of self as object of other consciousnesses), patients with schizophrenia may more often experience what the Japanese phenomenological psychiatrist Kimura Bin refers to as ‘simultaneous reflection’, namely, a self-consciousness of the self as consciousness, and in the very act of being conscious. This experience of hyperreflexivity (described in Sass, 1992) might be described as involving a split from within, in which consciousness itself becomes divided and self-aware in unusual ways by virtue of taking itself as its own object. Most auditory verbal hallucinations in schizophrenia appear to involve this form of hyperreflexivity, possibly due to a kind of self-conscious externalization of ‘inner speech’, which normally serves as the very medium of thought itself (Lang, 1938; Sass, 1992; Morrison and Haddock, 1997). More general, and even more profound, than this experience of hyperreflexivity is the experience of the complete collapse of minimal self and related feeling of fragmentation that can occur in schizophrenia — of the kind that is implicit in Elyn Saks’ report mentioned earlier, where she feels like she is dissolving, like ‘a sand castle with all the sand sliding away in the receding surf’. Antonin Artaud’s description of his own ‘central collapse of the mind’ and ‘erosion, both essential and fleeting, of my thinking’ (Artaud, 1965, pp. 10–11), more than relating to a disturbance merely of cognitive thought, describes a feeling that the coherent self, the centre from which all organized thought arises, has begun to disintegrate or collapse. Although melancholic patients may at times describe a certain deadness of the self or feeling of void, the latter sort of fragmentation, with all its implications for thought, feeling, and experience of the world, seems to be specific to schizophrenia.

5. Bodily Experiences
(EASE Domain 3)

I: Domain 3 of the EASE describes various disturbed Bodily Experiences, typical of schizophrenia, which are said to deviate from a ‘normal sense of psychophysical unity and coherence, [from] a normal interplay or oscillation of the body as “lived from within” as a subject or soul…and of the body as an object’ (Parnas et al., 2005, p. 252).
The items in this domain involve feelings of bizarre estrangement: the body may no longer seem fully to belong to the patient; physiological processes may be felt as strangely concrete or objectified; one’s physical movements may become confused with those of external objects or other persons.

Various phenomenological authors have described schizophrenia as involving extreme disembodiment, a sense of radical separation from one’s own being as a physical entity (Sass, 1992; Stanghellini, 2004; Fuchs, 2005). As we have seen, the very experience of the minimal self can seem dubious for such persons; yet it often tends to be identified more with a mental or spiritual than with a corporeal presence (Laing, 1965). For example, one schizophrenic patient was described as having ‘difficulty in realizing that she is in her body, and she may be thinking “it’s strange that I am here”’. Another spoke of ‘a lack of coherence’ or split between his physical part, visible to others, and himself, i.e. all that happens in his mind. He feels that his body is a shared property, something anonymous, distanced from him’ (Parnas et al., 2005, p. 253).

This does not mean, however, that the body simply disappears, as if it could be simply or persistently ignored. Rather, the body may become the object of a kind of alienating or objectifying, hyper-reflexive gaze that turns what might have been implicitly experienced sensations into objectified quasi-entities that are witnessed rather than lived. The body may also be experienced as an alien, controlling entity that subjects the experiential self to its demands or commands. A classic example of the ‘influencing machine delusion’ illustrates these developments (see Sass, 1992). Here the patient Natalija’s earlier experiences of alienation from body sensations led eventually to the delusion that a machine-like version of her own body lay in another room, and that all her own actions, feelings, and perceptions were but copies or epiphenomena of what was happening to the distant Natalija-machine.

Stanghellini (2004) has described these two aspects of schizophrenic disembodiment as those of being either (or both) a ‘disembodied spirit’ or a ‘de-animated body’. Both Sass (2007) and Fuchs (2005) have described how, in schizophrenia, somatic sensations that would normally ground emotional response can become detached and object-like, leading to a sense of distance and artificiality, and losing their usual emotional significance or resonance. Similarly, other physiological drives like hunger and sexual desire may lose their contextual meaning and come to be experienced as object-like states of tension.
In melancholia and mania, bodily experience is also frequently disturbed, though in ways that tend to look different from the more alienated or objectified experiences in schizophrenia. Stanghellini (2004) aptly described the melancholic experience of feeling ‘confined within a body that has lost its own fluidity, mobility, and flexibility’ and now acts less as a medium of openness than as ‘an obstacle between the self and the world’ (p. 139). There is a key difference here, though it is easier to state than always to discern: whereas the person with schizophrenia feels detached from his body, the melancholic feels somehow over-identified with it. Rather than being disembodied, the melancholic individual is overly embodied or corporealized (Fuchs, 2005). As in the case of extreme fatigue, one can feel that one is nothing but one’s body, into which one sinks and which also sinks into itself. One has come to feel incapable of the animated activity whereby the healthy lived body, without leaving itself behind, nevertheless transcends itself toward the external world. The melancholic body has become solid and heavy; it resists any attempt at reaching out to touch the external world [and] closes itself up, thus taking on the aspect of a corpse. The fluid body coagulates either into a single part of itself, or into an organ, which is then felt to be heavy, weighty, oppressive, and suffocating. (Stanghellini, 2004, p. 139)

In losing the normal sense of feeling, the melancholic body is no longer imbued with the ‘spirit’ that animates it and drives it forward. Such a body turns inflexible, heavy, and burdensome, taking on aspects of a corpse. Fuchs (2005) speaks of ‘corporealization’, stating that such patients feel detached from their emotions and their environment. The lived body no longer provides access to the world, as in Merleau-Ponty’s (1945/1962) embodied being, but rather blocks any kind of meaningful action in the manner of an obstacle.

II: In practice, however, the boundary between schizophrenic and melancholic experiences of the body can seem to blur. Although melancholic patients may most frequently experience a kind of debilitating fatigue, stasis, heaviness, and lack of motivation, they sometimes undergo stranger experiences that suggest something more like a basic disturbance of ipseity. ‘Body and soul can never be married’, writes Sarah Kane (2001, p. 212) in describing body-alienation experiences reminiscent of schizophrenia. Kane writes: ‘I am deadlocked by the smooth psychiatric voice of reason which tells me there is an objective reality in which my body and mind are one. But I am not here and never have been’ (ibid., p. 209). Another depressed patient recalls:
There in the parking lot I was standing at attention. I was being made to move; there was nothing for it but to move. My legs snapped out stiffly, one by one, in sidelong kicks... My arms traced long stiff arcs through the sky; my elbows dropped woodenly into my ribs. Then, apparently, it was time for some choreography. My arms and legs began to move together, then alternately. I must have resembled some short-circuited windshield wiper, or some marionette gone awry. But who — where — was the puppeteer? Who was in control of this body? (Smith, 1999, p. 18)

Here we see how the body in melancholia can be an obstacle, preventing the person from engaging meaningfully in the world. With its suggestion that someone else is controlling the body, this report takes us beyond typical melancholic corporealization and appears to overlap with schizophrenic disembodiment.

III: Still, we suggest that these experiences can be differentiated. It is noteworthy that in the report from the depressed patient just above, the experience described pertains more to control of one’s body than to a basic sense of alienation from it: it is always, and still, my legs, my arms, and my elbows to which the patient refers, as if basic Meinhaftigkeit were retained.

Another way of distinguishing between melancholia and schizophrenia would move beyond discrete complaints of disturbed embodiment to consider how these might be related to other aspects of the patient’s life, such as temporality and intersubjectivity. The intense feeling of guilt and inability to transcend the past that Fuchs relates to melancholic corporealization does not appear so prominent in the types of descriptions provided by schizophrenia patients. Also, the melancholic experiences are perhaps more closely related to an implicit sense of disturbed relationship to others: it is other people who will see me as guilty; other people to whom I am no longer able to relate as I feel stuck in my own body.

Schizophrenic disembodiment, by contrast, seems to involve — at least in many cases — a disturbance of self-experience that is somewhat less related to others or the actual external world. Such experiences in schizophrenia may certainly affect how one engages with one’s external situation; but the initial disruption seems more intrinsically internal, involving the body’s role in the constitution of minimal selfhood.
6. Demarcation/Transitivism; Existential Reorientation (EASE Domains 4 and 5)

In this final section we briefly discuss some of the outstanding experiences described in two EASE domains: 4. Demarcation/Transitivism, and 5. Existential Reorientation. We combine discussion of these domains because of an overlap in themes. Domain 4 describes the ‘loss or permeability of the self-world boundary’ (Parnas et al., 2005, p. 254), and suggests confusion between the self and another, or the feeling of being overwhelmed due to being somehow ‘too open or transparent’ (ibid., p. 255). Domain 5 refers to ‘a fundamental reorientation with respect to [the patient’s] general metaphysical worldview and/or hierarchy of values, projects, and interests’ (ibid., p. 255), and relates to solipsistic beliefs or experiences, such as feeling that the world is illusory, or that one has extraordinary creative or telepathic powers. Both these domains seem largely to involve a diminution of the usual sense of separation between inner and outer or between subjective and objective reality.

I: Regarding transitivism, experiences of actual confusion between self and other do not seem to be characteristic of patients with mood disorders, whether depressed or manic. Often, in fact, depressed patients describe a painful increase in the boundaries between self and other, as in this report:

Gradually that barrier became like a thing of stone or wood in my mind and although it was intangible it was the most real thing in my life. I could see people through that invisible wall, I could speak to them and they to me, but the mental and spiritual I, the essence of me, could not reach them… (In Landis, 1964, p. 151)

II: But some psychotic patients with mania do describe experiencing a kind of ‘mystic union’ with others or the universe that suggests considerable diminishment of normal ego boundaries. During one manic phase, for instance, John Custance felt a ‘breach in the barriers of individuality’:

It is actually a sense of communion, in the first place with God, and in the second place with all of mankind, indeed with all of creation… I have on occasion noticed a curious sympathy between my own mind and those of others in an excited mental states… There have been times… when other patients have said things to me without any prompting which corresponded in a very remarkable way with what was in my own mind at the time, as though some sort of telepathy was involved. (Custance, 1952, p. 37)
Other patients with mania stated, ‘You just have a feeling you’re part of the earth, not a person on your own, sort of melt into it’ (Landis, 1964, p. 281) and ‘I seem to merge into everything’ (Parnas et al., 2005, p. 290). But there also seem to be some subtle difference that may distinguish the merger experiences typical of mania versus schizophrenia.

III: One difference is that patients with mania do not seem to report any sense of confusion about their own point of view, in the sense of losing track of who one is. Perhaps associated with this is the presence of a mood-tone that is ecstatic or benign, or at least not frightening or unpleasant. Landis (1964) has related such experiences to a kind of religious or spiritual ecstasy, as is implied by Custance’s use of the term ‘communion’ to describe his relation to ‘mankind’ and the universe. Typically the manic experience seems to involve an enjoyable feeling of expansion such that one’s experience touches and mingles with others. There is little indication of a disorganization of fundamental selfhood, and these patients do not seem at all confused about who they are.

By contrast, the feeling of uncertainty about boundaries often has a dysphoric quality in schizophrenia patients. The patient seems to become anxious about not knowing who he is, or feels threatened and invaded by other people or external stimuli, as in the EASE item Threatening Bodily Contact, where ‘bodily contact feels threatening to one’s autonomy and existence’ (Parnas et al., 2005, p. 254). An additional difference seems to be that the schizophrenic experience of union frequently has a more distinctively solipsistic tone, with the world felt to be merely an extension of the self and having no separate reality of its own. This is reflected in many items in Domain 5 of the EASE, Existential Reorientation. For example, one former doctor described in the EASE had Feelings of Centrality: ‘a transient “as if” sentiment that he was the only true doctor in the entire world and the fate of humanity depended on him’ (ibid., p. 255). The psychiatrist Hilfiker (in Jaspers, 1946/1963) describes experiences in his schizophrenia patients that are congruent with this item of the EASE: e.g. patients who believe that ‘their death would be the death of the world; if they die, everyone else dies’. Other patients made such remarks as, ‘When my eyes are bright blue, the sky gets blue’; ‘My eyes and the sun are the same’; and ‘My body bears fruit… it is a world-body… they have to have someone to support the world; the world must be represented or the world will disappear’ (ibid., p. 296). Such quotes strongly suggest the solipsistic quality that can lie behind schizophrenic feelings of union. ‘The self is identified with the All’, writes
Jaspers (ibid.) of schizophrenia. ‘The patient is not just someone else (Christ, Napoleon, etc.) but simply the All. His own life is experienced as the life of whole world, his strength is world-sustaining and world-vitalizing. He is the seat of this supra-personal power’ (ibid., p. 296).

In mania, by contrast, the dominant experience seems more a feeling of resonating or being at one with the All. If in mania there is a sense of merging with the Godhead, in schizophrenic solipsism it is more a matter of being the only Godhead, the creator of all things in the experiential field. Whereas the manic experience involves merger with the world, schizophrenic solipsism seems more a matter of reducing the world to one’s own consciousness or ken. The following report, from a grandiose patient with mania, does put some pressure on the distinction just drawn. We would argue, however, that it falls short of identifying the self with God or the constituting centre of the universe; also there is no denial of the reality of the external universe: ‘I feel so close to God, so inspired by His Spirit that in a sense I am God. I see the future, plan the Universe, save mankind; I am utterly and completely immortal; I am even male and female’ (Custance, 1952, p. 51).

7. Conclusion

Throughout this paper, we have considered various ways in which subjective life in affective disorders and in schizophrenia, in particular self-experience, can be similar, in spite of what psychiatry has traditionally recognized as a profound and basic distinction between the two. But we have also attempted to show how, on closer examination, the two can probably be distinguished, albeit in some ways that are more subtle and elusive than those traditionally proposed. Perhaps the best way of summarizing this distinction across all the domains we have reviewed is by returning to Jaspers’ (1946/1963, pp. 111, 122) formulations of the melancholic’s ‘feeling of having no feeling’ vs. the schizophrenic experience of being ‘no longer able to feel he exists’. It is true that affective patients can experience profound change in the way they experience themselves and the world around them. We suggest, however, that they will typically maintain the sense of basic self that generates or underlies all experience, including that particular experience which involves recognizing the deadening of one’s experience. In schizophrenia, by contrast, the most essential disturbance seems to affect minimal or core self in a more fundamental way, undermining of the most intimate and foundational ‘I’ (Sass and Parnas, 2003). It may be that this fragmentation and collapse of basic
ipseity is the *trouble générateur* which the most distinctive disturbances of schizophrenia will reflect.

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**References**


