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Space, Time, and Atmosphere

A Comparative Phenomenology of Melancholia, Mania, and Schizophrenia, Part II

Abstract: *This paper offers a comparative study of abnormalities in the experience of space, time, and general atmosphere in three psychiatric conditions: schizophrenia, melancholia, and mania. It is a companion piece to our previous article entitled 'Varieties of Self-Experience'; here we focus on experiences of the world rather than of the self. As before, we are especially interested in similarities but also in some subtle distinctions in the forms of subjectivity associated with these three conditions. As before, we survey phenomenologically-oriented clinical and theoretical accounts as well as patient reports. Experiences involving forms of alienation from the practical and social world and a sense of uncanniness seem to be common in both schizophrenia and affective disorders. But despite some significant similarities, changes in schizophrenic subjectivity appear to be more pervasive and profound, involving experiences of fragmentation, meaninglessness, and ineffable strangeness that are rare or absent in the affective disorders.*

1. Introduction

In this paper, 'Space, Time, and Atmosphere', we continue the project begun in a previous contribution (Sass and Pienkos, 2013). This is to compare the phenomenology of severe forms of melancholia and mania with the phenomenology of schizophrenia, paying particular

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attention to areas of overlap in which experiences in these disorders can seem to converge. The previous article ('Varieties of Self-Experience', this issue) focused on disturbances of the *self*. Now we turn to anomalous experiences of the *world*, addressing changes in these various psychiatric conditions in the experience of objects and space, of time and events, and of pervasive atmospheric qualities.

Phenomenology has long recognized the inseparability of self and world. Husserl (1931/1962) noted that all consciousness is a consciousness of *something*, suggesting that cognition and subjectivity are intrinsically tied to world-oriented experiences; Heidegger (1962) spoke of human existence as being-in-the-world or *Dasein*. While much current phenomenological psychopathology has focused on disturbances of self in schizophrenia, patients often describe concurrent changes in their perception of and engagement with events, things, and the overall 'feel' of the world. Such transformations in schizophrenia and affective disorders have been classically described by Jaspers (1946/1963), Minkowski (1933/1970), and Matussek (1987), among others. More recently, these sorts of changes have been highlighted by the Bonn Scale for the Assessment of Basic Symptoms (an assessment tool that catalogues subjective disturbances in schizophrenia) (Gross *et al.*, 2008), and by such writers as Fuchs (2005; 2007), Ratcliffe (2010), Stanghellini (2004), and Sass (1992). Here we consider three particular domains of world experience: space, time, and atmosphere. These domains have frequently been described as essential components of subjective experience of the world in classic phenomenological research (e.g. Jaspers, 1946/1963; Ellenberger, 1958; Tatossian, 1997). They represent what we consider to be the major dimensions of world experience, with the significant exception of those that have a more explicitly interpersonal focus (the latter to be treated, for reasons of length, in later papers on interpersonal experience and the experience of language).

Like the previous article, this paper is exploratory, drawing its conclusions and speculations from a survey of work coming largely from phenomenological psychiatrists and psychologists as well as from first-person accounts of patients diagnosed as suffering from schizophrenia or affective disorder. This paper has the same ambitions, and suffers from the same limitations, as were described in the two introductory sections of 'Varieties of Self-Experience' (this issue); these points will not be discussed again in detail here. As explained there in more detail, our ambition is to contribute to both the diagnostic differential and general psychopathological understanding of the disorders at issue. Just as in our previous paper, our focus is not on the traditionally

described symptoms of schizophrenia and severe affective disorders (such as hallucinations and delusions), but on more subtle, experiential anomalies. By considering these subtle alterations of world experience, we hope to illuminate a more general underlying orientation to experience.

As in the previous paper, here we survey a considerable array of clinical, theoretical, and empirical work in psychopathology, and we present illustrative patient reports of subjective experience. Our approach is fairly speculative and anecdotal, and obviously needs to be corroborated by empirical research — to which it should serve as a necessary theoretical preliminary. Once again, discussion of each domain of experience is separated into three parts in a dialectical structure: I. obvious and traditionally recognized differences between subjective experience of time, space, and atmosphere in schizophrenia and affective disorders; II. experiences that seem particularly similar between these two domains of disorder; and III. subtler ways in which the disorders seem nevertheless distinct. We remind the reader that we are pursuing a kind of ‘ideal-type’ analysis. We seek broad generalizations about tendencies and dominant characteristics, without claiming to uncover sharp boundary lines or address all subtypes or internal complexities.

2. Objects and Space

I: Changes in the perception of objects and space are not infrequent in schizophrenia. The Bonn Scale (Gross *et al.*, 2008) lists the experiences of micropsia, macropsia, and dysmegalopsia, disruptions of normal spatial properties (the relative size or shape of objects) that, presumably, are *not* as commonly described in affective illness. In *General Psychopathology*, Jaspers (1946/1963) remarks on these changes in schizophrenia, and also notes the experience of infinite space, citing one schizophrenia patient who said: ‘Space seemed to stretch and go on into infinity, completely empty. I felt lost, abandoned to the infinities of space, which in spite of my insignificance somehow threatened me’ (*ibid.*, p. 81). Jaspers also describes ‘space with an atmosphere’ (a phrase taken from Binswanger): the sense that space is charged with a special meaning or mood-like significance. One schizophrenia patient described this in the following terms:

Suddenly the landscape was removed from me by a strange power. In my mind’s eye I thought I saw below the pale blue evening sky a black sky of horrible intensity. Everything became limitless, engulfing... I

knew that the autumn landscape was pervaded by a second space, so fine, so invisible, though it was dark, empty, and ghastly. (*Ibid.*, p. 82)

Schizophrenia patients may also describe how they are drawn to notice the empty space surrounding objects or in a scene, rather than the people and things within it:

[A] schizophrenic reported: 'when he looked at objects, things often seemed so empty. The air was still between things, but the things themselves were not there'. Another patient said: He only saw the space between things; the things were there in a fashion but not so clear; the completely empty space was what struck him. (*Ibid.*, pp. 81f)

Schizophrenia patients may also report an experience in which objects appear fragmented, flat and unrelated, arrayed in space as on a vast, even infinite plane, or reduced to their pure geometrical qualities. 'My perception of the world seemed to sharpen the sense of the strangeness of things', states Renee, author of the *Autobiography of a Schizophrenic Girl* (Secheyay, 1962, p. 83). 'In the silence and immensity, each object was cut off by a knife, detached in the emptiness, in the boundlessness, spaced off from other things' (*ibid.*, p. 83). Here everything seems somehow equally distant, as if Renee were detached from any normal subjective standpoint.

II: Significant transformations in the experience of space and objects may, however, also occur in the affective disorders, and sometimes in ways that can seem similar to schizophrenia. Ellenberger (1958) describes how space may feel full or empty, that it may be experienced as expanding or constricting, depending on the state of mind of an individual. Similarly, in mania everything may appear to be more near or readily available than would usually be the case. Consistent with the mania patient's general sense of grandiosity, his belief that he can do or be anything he desires, such a person may feel that all objects are somehow within reach, as if space and distance no longer presented any obstacle and everything lay at one's fingertips.

Melancholic patients, by contrast, may experience everything as being somehow unreachable and far away, with objects seeming duller, smaller, and somehow insignificant. Straus (1958) speaks of how the experience of distance reflects the degree that one feels able to 'reach' or act upon objects, describing how the feeling of passivity (frequently found in depression) 'removes the reachable to a limitless remoteness' (*ibid.*, p. 165). Furthermore, with the dimming down of emotional life, everything loses the intensity of its motivational valence and consequently appears both dull and distant. Some of these melancholic reports can seem difficult to differentiate from experi-

ences of limitless space and meaningless objects that are found in schizophrenia. For example, Cutting (2002) describes an encounter with a melancholic patient as follows: ‘When I wanted to weigh him... he got on the scale, shifted the weights, and correctly found his weight. However, he was no sooner finished than he began, “What use is all that? This scale is only a lot of iron and wood”’ (p. 155). This description suggests a focus on the material rather than the affordance quality of objects, which may be associated with a more general, alienated perspective on the value of human activities; such a perspective can, at times, erode the ready familiarity of the world (Toulous, 1893, in Cutting, 2002).

III: We suggest, however, that there may be an important albeit subtle difference to be discerned: the difference between a spatial world that is experienced as if from no place in particular versus one that, though distant and deadened, is nevertheless viewed from a *particular* standpoint, and is still imbued with recognizable (though less salient) affordance-meanings.

It may be useful to recall the geometer’s distinction between anisotropic space, meaning space that is imbued with a point of view, versus isotropic space — the latter implying an objective view that is not grounded anywhere in particular and allows for uniformity in all directions (Ellenberger, 1958), a sort of alienated ‘view from nowhere’ (phrase from Nagel, 1986). While patients with mania and melancholia are trapped *within* their point of view, unable to escape from its affective colouring and adopt a more objective perspective, schizophrenia patients seem at times almost to lose the sense of having any subjective centre at all. This can be coordinated with a perception of the world as flat, geometrically oriented, meaningless, and at times bizarre and uncanny. The affective colouring in melancholia or mania reflects an internal feeling state, either duller for the melancholia patient or brighter and more vibrant for the patient with mania. In these affective disorders we do not, however, seem to find the sort of evenly distributed infinitude described by the schizophrenia patient Renee.

3. Time and Events

Now we turn to disturbances of time and the experience of events. The Examination of Anomalous Self-Experiences (EASE; Parnas *et al.*, 2005), which targets experience in the schizophrenia spectrum, devotes but one, rather heterogeneous item to these disturbances: *Disturbance in Experience of Time*, where it is noted that time may seem to be moving more slowly or quickly than usual, to be standing still, or

to be fragmented. It also describes disruption in existential time, such that 'life appears to be restricted to the present, without guiding future projects, or the present is overwhelmed by stereotyped/repetitive reliving of congealed past, or the experience towards the future is felt as blocked or not available at all' (*ibid.*, p. 243).¹ Several phenomenological texts, both classic and contemporary, have explored these disturbances and how they might relate to the fundamental disturbance of schizophrenia and affective disorders. We focus first on the theoretical writing of Minkowski, especially *Le Temps Vecu* (1933/1970), then on more recent writings by Thomas Fuchs.

I: Minkowski's analysis of time and its disorders was greatly influenced by the work of Henri Bergson. Bergson considered human subjectivity to be composed of two contrasting but complementary principles, space and lived time, which also reflected the contrast between 'intelligence and intuition, the dead and the living, the immobile and the flowing, being and becoming' (Minkowski, 1933/1970, p. 272). Minkowski describes the fundamental disorder or *trouble générateur* in schizophrenia as a 'loss of vital contact with reality', a profound disturbance of the patient's sense of vitality and of his dynamic relationship between self and world: 'The schizophrenic not only seems completely immobilized in himself but seems as if deprived of the necessary organ to assimilate anything dynamic' (*ibid.*, p. 276). Instead such a person manifests a kind of 'morbid rationalization' or 'morbid geometrism', with emphasis on the spatial and the static such that 'everything spontaneous, everything unforeseen, is excluded from his life [which] is transformed into a shapeless mosaic composed of logical precepts and scraps of thought' (*ibid.*, p. 278).

In comparing affective disorders to schizophrenia, Minkowski first suggests that the former should be characterized by a *hypertrophy* of vitality, movement, and harmony between self and world (*ibid.*, p. 290). This follows Krestchmer's distinction of schizoid versus cycloid personality traits, such that 'the schizoid is rather unaffected by his surroundings and remains in merely superficial contact with it' while 'the cycloid [associated with affective disorders] always retains his contact with the surrounding world' (Urfer, 2001, p. 283). Bleuler too has suggested that schizophrenia is characterized by a loss of 'syntony', the ability to remain in contact with the environment, while affective disorders involve increase in this trait (Bleuler, 1911).

[1] Temporality can be conceived of as a feature of either the lived world or self-experience, as both Husserl and Heidegger make clear. Here we treat it (somewhat arbitrarily) as an aspect of the lived world.

II: However, Minkowski goes on to question the simplicity of this opposition between schizophrenia and affective disorder. Although the affective patient maintains closer ‘contact with ambient life’ than does the schizoid or schizophrenic individual, this contact is nevertheless instantaneous and superficial, not ‘a fully developed contact’ but one that is ‘degraded, deformed, in comparison to true syntony’ (Minkowski, 1933/1970, p. 291).

According to Minkowski, the patient with mania loses the capacity for ‘unfolding in time’ or *durée*, and his vital contact with reality necessarily shrinks as a result, ‘absorb[ing the world] so avidly... that he does not penetrate it at all’ (*ibid.*, p. 294). This is apparent in manic distractibility, for such patients typically ‘perceive only in a fugitive and imprecise manner, seeming scarcely to care very much about what goes on around them’ (Kraepelin, in Minkowski, 1933/1970, p. 295) or to grasp ambient events in a deeply meaningful way. The melancholic patient also experiences profound temporal disturbance in which ‘ego-time seems slower than world-time’ (Minkowski, 1933/1970, p. 297). This causes such a patient to lose future-orientation and to fall out of sync with the environment.

This experience can appear quite similar to some time disturbances in schizophrenia. One schizophrenia patient states, ‘There is no more present, only a backward reference to the past; the future goes on shrinking — the past is so intrusive, it envelops me, it pulls me back’ (Jaspers, 1946/1963, p. 84), suggesting an experience of the past as dangerously engulfing. Minkowski (1933/1970) notes that in melancholic patients this inhibition and slowing-down result in a feeling of passivity and impotence, and even in a loss of the normal connectedness and meaningful continuity of time and events. ‘I live in instantaneousness’, states one severely depressed patient. ‘I don’t have the feeling of continuity any more... At every new instant that I live, I have the feeling that I have just fallen from the sky’ (*ibid.*, p. 333). He continued: ‘I am incapable of assimilating either movement or the speed of events that occur around me... When someone does something beside me, I am completely disoriented because I am incapable of following the movement... I see a tree, but I cannot see an automobile that is moving at all’ (*ibid.*, p. 333). These reports certainly resemble the ‘morbid geometrism’ and alienated disturbance with spontaneous and dynamic aspects of life that is characteristic of schizophrenia, as reported by a schizophrenia patient also quoted by Minkowski: ‘I have a tendency to immobilize life around me... Stone is immobile. The earth, on the contrary, moves; it doesn’t inspire any confidence in me... A train passes by an embankment; the train does

not exist for me; I wish only to construct the embankment' (*ibid.*, p. 279).

It seems, then, that both melancholic and schizophrenic patients can lose the ability to 'assimilate anything dynamic', perhaps feeling their life to be transformed into something like a 'shapeless mosaic' (*ibid.*, pp. 276, 278).

III: One possible way of distinguishing between these disorders is insightfully developed in recent work by Thomas Fuchs. Fuchs (2007) suggests that the disturbances in schizophrenia can be attributed to a fundamental fragmentation of the 'intentional arc', a phrase from Merleau-Ponty that describes the underlying temporal continuity that permits the seamless connection, via 'passive synthesis', of the present with the immediate past and immediate future. Edmund Husserl referred to this temporal synthesis (we will call it the 'temporal arc') as involving 'retention' and 'protention', which he distinguished from the more thematic and less automatic processes of 'recollection' and 'expectation' (Zahavi, 2005). Retention and protention are intrinsic elements of the 'now', of what William James called the 'specious present' and likened to 'a saddleback and not a knife edge' (James, 1898). As Fuchs (2005; 2013) notes, his views are congruent with the ipseity-disturbance hypothesis (Sass and Parnas, 2003). One might say, in fact, that the microstructure of minimal self or first-person givenness just *is* the structure of inner time-consciousness (Zahavi, 2005): the minimal self can only exist as a temporal flux, yet this flux also *depends* on the minimal self as the medium through which it is manifested.²

The intimate connection between basic temporality and minimal self is clear in Elyn Saks' account of her schizophrenic experience:

This experience is much harder, and weirder, to describe than extreme fear or terror. But explaining what I've come to call 'disorganization' is a different challenge altogether. Consciousness gradually loses its coherence. One's center gives way. The center cannot hold. The 'me' becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a sturdy vantage point from which to look out, take things in, assess what's happening. No core holds things together, providing the lens through which to see the world, to make judgments and comprehend risk. Random moments of time follow one another. Sights, sounds, thoughts, and feelings don't

[2] According to Zahavi: '...inner time consciousness simply *is* the pre-reflective self-awareness of the stream of consciousness, and Husserl's account of the structure of inner time-consciousness (protention–primal representation–retention) should consequently be appreciated as an analysis of the microstructure of first-personal givenness' or 'pre-reflective self-awareness' (Zahavi, 2005, p. 65, also p. 54).

go together. No organizing principle takes successive moments in time and puts them together in a coherent way from which sense can be made. And it's all taking place in slow motion. (Saks, 2007, p. 13)

This foundering of the temporal arc has numerous implications or *sequelae*, including the feeling that there are gaps between one moment and the next, and difficulty anticipating and integrating future events. The patient is left experiencing worldly events as though seen under a strobe light, or perhaps like a series of photographs shown one after another in no clear order. Sequences of events, even of the patient's *own* actions, can lose their automatic flow; and the patient may have to make effortful attempts to put them together into a meaningful sense of sequence.³

Disruption in the temporal arc will also have implications for higher-order or more reflective/thematic aspects of temporality that are founded on this more basic sense of existing in time. The schizophrenia patient who states, 'You are dying from moment to moment and living from moment to moment, and you're different each time' (Fuchs, 2013, p. 84) seems to be experiencing a basic disturbance of ipseity/temporality. But this, in turn, will have reverberations at the more reflective and temporally extended level of narrative continuity over larger stretches of time, and involving recollection and expectation rather than the more basic retention and protention.

By contrast, in his analysis of temporality in *melancholia*, Fuchs (2007; 2013) emphasizes not the very *structure* of the temporal arc, with its protention and retention, but the loss of drive, motivation, or vitality and an associated slowing down of physiological processes. These are manifestations of a 'loss of conation': diminution of 'the basic energetic momentum of everyday life', of the drive, appetites, or desires that makes one pursue various goals, and which are inextricably linked to the basic sense of 'aliveness' or fundamental self-affection. Such persons also tend to feel rigid in comparison to the world around them and to lose their affective resonance with others and even themselves, resulting in the experience of 'affective depersonalization'.

As the melancholic mood takes over, there is the feeling of being oppressed by an inescapable past, and a loss of orientation to the future. The future may in fact come to seem like yet another manifestation of the past, so predetermined and inevitable is its feel. The overarching mood tone of this melancholic lived world is one of guilt, of

[3] An interesting demonstration of this mutation of basic temporal anticipation is the schizophrenia patient's ability to tickle herself, apparently because she can lose the ability to own or predict the consequences of her own hand and finger movements (Blakemore, Wolpert and Frith, 2000).

being tied to one's past transgressions against others whose consequences will be forever repeated in the future. As Binswanger notes, melancholic thoughts are overwhelmingly characterized by empty possibility: 'If only I had done/not done this' (in Fuchs, 2013), where the patient is completely stuck in his futile regret of the past. Sarah Kane, the playwright who so vividly evokes her psychotic depression in her play *4.48 Psychosis*, described this boundless shame, guilt, and regret, in which 'a wound from two years ago opens like a cadaver and a long buried shame roars its foul decaying grief' (Kane, 2001, p. 209). The transgressions at issue may be more imaginary than real, but they are typically felt to reside in an unchangeable past. 'I gassed the Jews', writes Sarah Kane. 'I killed the Kurds, I bombed the Arabs, I fucked small children while they begged for mercy, the killing fields are mine' (*ibid.*, p. 227). And elsewhere in Kane's play, she writes: 'Victim. Perpetrator. Bystander' (*ibid.*, p. 231).

We may summarize this distinction as follows: schizophrenia patients can certainly experience many of the temporal distortions associated with melancholia; some, for example, may be consumed by the past. But what is more distinctive of persons with schizophrenia is their propensity to experience a disturbance of time at the very level of ipseity and basic temporality, that is, in the disruption of the temporal arc, of the 'coupling or mutual relation of conscious moments creating a span of lived time which is necessary for the continuity of self-awareness' (Fuchs, 2013, p. 98). This disruption has a multitude of consequences, including loss of fundamental dynamism and diminished contact between oneself and the world. In melancholia, by contrast, the core disturbance has more to do with motivational drive, and it affects primarily the social and narrative dimensions of experience rather than ipseity itself. The melancholic is not driven to the pursuit of any need, desire, or goal, and in this sense lacks propulsion toward the future. However, he or she still experiences what William James called 'the specious present' and what Husserl termed 'width of presence', or the 'duration-block' (Husserl, in Zahavi, 2005). In melancholia, the past becomes more determining, and the future less open; in mania it is the reverse. The relative *weighting* of past, present, and future can also change in schizophrenia, but this is not the most fundamental change. In schizophrenia the very vector-like nature of the present moment, understood as James's specious present or the Husserlian now, can actually collapse or disappear. And as a result, rather than merely slowing or speeding the flow, life itself can turn into a series of stills as time turns wholly strange and unpredictable.

'[T]he play of time was so uncanny... an *alien time* seemed to dawn', said one patient with schizophrenia (Jaspers, 1946/1963, p. 86).

These are subtle but profound differences. Consider the difference between the following two reports. On the one hand, a melancholic patient says, 'I cannot see the future, just as if there were none. I think everything is going to stop now and tomorrow there will be nothing at all' (*ibid.*, p. 86). On the other hand, a schizophrenia patient states, 'While watching TV it becomes even stranger. Though I can see every scene, I don't understand the plot. Every scene jumps to the next, there is no connection. The course of time is strange, too. Time splits up and doesn't run forward anymore. There arise uncountable disparate now, now, now, all crazy and without rule or order' (Kimura, in Fuchs, 2007, p. 233).

These temporal alterations have implications for the patients' overall experience of the general causal structure of events. In melancholia and mania the dominant causal structures of interpretation are fairly straightforward: in depression, inexorable causal determinism (e.g. preoccupation with bodily aging; impossibility of escaping consequences of past events); in mania, an exaggerated sense of the power of one's own will, implying that events are largely under one's control. Both modes of experience can and do occur in schizophrenia, sometimes in extreme form, as when the patient experiences the self as a machine or a god-like entity. But in schizophrenia one may also find a profound and confusing sense of the sheer randomness of events, as if all causal linkages are destroyed or were effaced. The difference can be summarized as follows: in schizophrenia, a mode of temporality (perhaps better, of *a*-temporality) that, together with collapse of protention and retention, loses all organization and meaning; in melancholia, a foundering of drive and associated projection of the self into the future, that leaves one dominated by the past, futility, and fatigue.

4. Atmosphere

We turn now to the topic of atmosphere, of aspects of experience or subjective life that seem to concern the feel of everything and cannot readily be ascribed to any particular domain, such as space, time, persons, or language. Some psychiatrists have suggested that such holistic changes can be sensed from without, as when Tellenbach spoke of 'atmospheric diagnosis' and Rümke of the 'praecox feeling' (Cermolacce, Sass and Parnas, 2010). Here we consider the subjective side of these changes in mood or atmosphere as they may occur in both schizophrenia and affective psychoses.

I: The atmosphere of the depressive and the manic worlds are typically described either as grim and deadened or as abnormally bright and vibrant, respectively. By contrast, schizophrenic persons are often described as manifesting ‘flat affect’ — a term that refers primarily to diminished affective *expression*, but is frequently assumed to be associated with an underlying diminishment of emotional or affective *experience*. As mentioned in the introduction, according to Jaspers (1946/1963) the alterations typical of affective illnesses can be ‘comprehend[ed] vividly enough as an exaggeration or diminution of known phenomena’, such as intense emotion (p. 578). By contrast, the key features of the typically schizophrenic ambiance do not seem comprehensible in such obviously emotion-related terms. This would include several aspects of the oft-discussed ‘delusional mood’ or ‘delusional atmosphere’, the atmospheric feeling state that precedes or accompanies the development of delusions in schizophrenia (though perhaps not exclusively in schizophrenia), as well as of forms of ‘perplexity’ and ‘derealization’ considered to be fairly specific to this illness.

A crucial feature of the ‘delusional mood’ is a quality of disconcerting and suggestive specificity. In this state of what might be termed ‘uncanny particularity’ (Sass, 1994), objects or events can appear as though they were special in some way, commanding one’s attention and jumping out with a strange significance: ‘Every detail and event takes on an excruciating distinctness, specialness, and peculiarity — some definite meaning that always lies just out of reach, however, where it eludes all attempts to grasp or specify it’ (Sass, 1992, p. 52). This change can be quite subtle: ‘The environment is somehow different — not to a gross degree — perception is unaltered in itself but there is some change which envelops everything with a subtle, pervasive and strangely uncertain light’ (Jaspers, 1946/1963, p. 98).

Often there is a ‘just so’ quality (‘I noticed particularly’, the patient will say; *ibid.*, p. 100), with everything seeming to exist or somehow to be placed in a specific rather than random way. Given this felt specificity, the subject will sense that such an experience *must* refer to or mean something, but is typically unable to determine what that meaning might be. Experiences may also be imbued with a *déjà-vu* quality or can take on Capgras-like qualities in which everything seems like a copy or clone of something now absent. For example, schizophrenia patients will describe ‘so-called’ things or ‘so-called’ people, as when Daniel Paul Schreber spoke of the ‘supposed patients’ and a man ‘who was supposed to be the Medical Director of the Institute’ (in Sass, 1994, pp. 104f). The subject may also feel that such experiences have

a certain 'for-me-ness' to them, namely, that they are somehow targeting the subject and intentionally eliciting his attention for some unknown reason having either cosmic or more mundane, paranoid significance.

Other atmospheric features characteristic of schizophrenia pertain more directly to the reality-feeling itself, which is perhaps the most foundational of all issues and one that can be felt in very pervasive yet concrete terms. The entire fabric of space and time may seem subtly yet utterly transformed, with 'the feeling of reality... either heightened, pulsing with a mysterious, unnameable force, or else oddly diminished or undermined — or, paradoxically, things may seem... both "unreal and extra-real at the same time"' (Sass, 1992, p. 44). The world may, for instance, seem intensified yet somehow artificial, as is suggested by one schizophrenia patient's description of the world as a 'puppet theatre' (Fuchs, 2005).

In a previous article we have discussed how, in schizophrenia, the world may seem merely a solipsistic extension, without separate reality of its own. Another crucial feature of the schizophrenic world is captured by the notion of 'double or multiple bookkeeping', the quality whereby persons with schizophrenia seem able to live in two or more realities, at the same time or in quick succession and sometimes without confusion between the two. This is most obvious in the case of certain chronic deluded patients, who though preoccupied with their fantasies nevertheless comport themselves in perfect accord with intersubjective reality. It can also appear in more subtle, quasi-perceptual forms, as when patients are aware of two distinct ways of seeing another person, in a kind of 'seeing-as' whereby, for example, they may see the therapist as both dead and yet not-dead (Sass, in press; Sass and Pienkos, 2013). The sort of wavering or equivocation regarding the nature of external reality seems much less common in affective psychosis, whether melancholia or mania.

As a result of these overall perceptual and more general, experiential changes, normal objects and events shed their common-sense meanings. The classic psychopathological literature speaks of a specifically schizophrenic 'perplexity' and 'loss of natural self-evidence' (Blankenburg, 1986; Stoerring, 1987), a feeling of confronting a world that is, by turns, fragmented, meaningless, or unreal, yet often insinuating. Maldiney (in Raballo and Nelson, 2010) speaks of a loss of 'transpassibility' in schizophrenia, by which he means loss of the spontaneous attunement or fluid understanding of the world whereby new things become spontaneously incorporated into one's worldview as comprehensible and meaningful. Instead of a 'familiar space

of naturally given saliences, [the world becomes] enigmatic and impenetrable; the very feeling of self-coherence [may] blur and eventually fall apart' (Raballo and Nelson, 2010, p. 251).

II: But there are a number of features of affective psychosis that bear striking resemblance to these 'atmospheric' changes that are often assumed to be specific to schizophrenia. Paranoia, with its sense of being at the centre of a threatening or insinuating world, is especially common in mania but also in depression. Indeed, as noted earlier, some psychiatrists have even argued that many or most cases of supposed *paranoid* schizophrenia are really forms of affective psychosis (Lake, 2008).

One of the most distinctive features of *melancholic* forms of depression is the *unfamiliar* nature of the sadness or dysphoria that occurs (DSM-IV-TR, 2000, p. 491). Since this unfamiliarity or strangeness is not merely quantitative, it appears to conflict with Jaspers' talk (see above) of mere 'exaggeration or diminution of [such] known phenomena' as sadness or grief. On the other side, the supposed diminishment of affective intensity that is sometimes ascribed to schizophrenia in particular (i.e. the internal or subjective dimension of 'flat affect') has been contradicted by recent research, involving both self-report and physiological measures, which suggests that schizophrenia patients actually react just as intensely as do normal individuals (Kring *et al.*, 1993; Kring, Kerr and Earnst, 1999).

Forms of derealization certainly occur in severe melancholia. As one depressed patient states, 'I feel miserable and ill; instead of a heightened sense of reality I seem "to move among a world of ghosts and feel myself the shadow of a dream"' (Custance, 1952, p. 61). Another described living 'in a Plutonian psychical twilight. Even the sun was off-color to me' (Kaplan, 1964, p. 83). Many studies have also noted the frequency of depersonalization and derealization experiences at the onset of depression, and as contributors to the formation of depressive delusions (see Sierra, 2009). Like schizophrenia patients, melancholic persons also describe fears and delusions related to death, annihilation, and even a kind of world catastrophe. One melancholic patient reports: '...the room opened on to... space, blank, void. I could never get back, never find myself or anything. The room moved a little as if it were gradually slipping into that all-enveloping nothingness...' (Kaplan, 1964, p. 162). Others say: 'I conceived the delusion that I was about to be buried alive, not in the earth but walled in a small chamber; and I believed that "they" were coming for me' (*ibid.*, p. 86). '...I had a sudden vision of the end of the world, a catastrophe caused solely by my fate' (*ibid.*, p. 86).

Patients with mania often describe the other side of this kind of atmospheric change, namely, an *increase* in liveliness or a *heightened* sense of reality, sometimes involving *jamais-vu* experiences. As one patient states,

I seem to merge into everything. [There was] an intense consciousness of power and absolute ecstasy... Things appear more real, as if you were just becoming alive and had never lived before. The whole being expands... Everything is more intense... Everything is absolutely new, every minute is as if everything has just started. (Landis, 1964, p. 290)

The bipolar patient John Custance describes a ‘heightened sense of reality’ in his manic phases, when ‘the outer world makes a much more vivid and intense impression on me than usual’ (Custance, 1952, p. 31). ‘At present,’ he writes, ‘faces seem to glow with a sort of inner light which shows up the characteristic lines extremely vividly’ (*ibid.*, p. 31). This report is at least reminiscent of ‘mere being’ experiences in schizophrenia, where things can seem ‘illuminated and tense’, ‘alive... in their existence itself’ (Sechehaye, 1962, pp. 40, 41), oddly unfamiliar, or otherwise hyper-real.

It is not surprising that these experiences of paranoia and derealization will often be accompanied by forms of cognitive confusion, in affective disorder as in schizophrenia. The altered feel and significance of the world makes it difficult either to assess reality or to cope with it in standard ways. One depressed patient described this experience as follows: ‘I seemed to catch out of the tail of my eye a cold black draughty void, with a feeling that I stood on the brink of it in peril of my reason...’ (Kaplan, 1964, p. 88). Such subtle changes in the surrounding environment can cause a feeling that one no longer knows how to *be* in the world, and the sense that one is going crazy.

III: Closer analysis suggests some subtle yet significant differences that can sometimes distinguish these experiences in schizophrenic versus affective conditions. In schizophrenia, paranoid interpretations will often be closely associated with certain cognitive/perceptual changes by which they seem to be inspired and that they often serve to rationalize or justify. These changes — including uncanny particularity, doubling, and *déjà vu* — do not seem common (or perhaps even present) in either melancholia or mania. In the latter conditions, paranoid trends appear to be more directly related to the projection of negative self-evaluations or some combination of grandiosity with irritability (and, perhaps, submerged feelings of inferiority). Although the latter motivations can certainly be present in schizo-

phrenia, they seem less dominant or decisive than in the affective conditions.

Furthermore, although the derealization that is common in melancholia can certainly be profound, it seems to lack the extremely uncanny quality characteristic of schizophrenia. Instead of entering into a new and bizarre universe where objects are stripped of all meaning, there is a more straightforward sense that everything is imbued with sadness, guilt, heaviness, or lack of vitality. 'Everything I saw seemed to be a burden to me,' said one melancholic patient, 'the earth seemed accursed for my sake: all trees, plants, rocks, hills, and vales seemed to be dressed in mourning and groaning, under the weight of the curse, and everything around me seemed to be conspiring my ruin' (Landis, 1964, p. 272). Objects may lose meaning and interest, becoming symbols of depression or losing all imaginable appeal. Although things may no longer matter in melancholia, they maintain their basic meaning as things: a tree is still a tree, a face is still a face. This contrasts with the loss of affordances and fragmentation that sometimes prevails in the schizophrenic world — where, as one patient put it, one can feel 'surrounded by a multitude of meaningless details' (Sass, 1992, p. 50) or in which even a human face may lose its coherence: 'I saw the individual features of her face', writes the schizophrenia patient Renee, 'separated from each other: the teeth, then the nose, then the cheeks, then one eye and the other' (quoted in Sass, 1992, p. 50).

The loss of meaning and vital significance found in both schizophrenia and melancholia may be associated with a preoccupation with death, annihilation, and ultimate catastrophe. In melancholia, however, death and destruction appear to be more closely related to guilt, pain, and deprivation, including the feeling of having lost enlivening appetites or the sense that one no longer deserves to live or has been passed up by life, creating a sense of deadness. The Cotard delusion of being dead is common in severe depression as well as in certain organic conditions. Similar experiences of catastrophe and annihilation can certainly occur in schizophrenia patients — indeed 'world catastrophe' is one of their classic delusional themes; but here one often finds a solipsistic element that imbues things with a different accent. 'If you do not keep in touch with me, you will perish', said one schizophrenia patient. And two others: 'Once I am dead, you will all lose your minds'; 'They have to have someone to support the world; the world must be represented or the world will disappear' (in Sass, 1992, p. 303). This solipsistic feeling — that if one desisted from

creating everything, the world would cease to exist — seems absent or very rare in melancholia.

As noted, schizophrenia patients can also experience a *heightening* of reality that can seem reminiscent of mania. But in mania there seems a greater emphasis on the sensory qualities of an object, such as aesthetic aspects of colours or shape, and a more distinctly ecstatic vision of the world. In schizophrenia the focus may be more on ontological qualities; the mere existence of a thing may jump forward as practical meanings in the world recede from awareness. A similar experience is described in the famous scene from Sartre's *Nausea* in which the narrator Roquentin stares at the roots of a chestnut tree until they lose all functional qualities and seem to manifest the sheer fact of being there before him in space (discussed in Sass, 1992, p. 187). Another such instance occurs in a classic account from the schizophrenia patient Renee, who describes objects as becoming detached from their normal usages and looming forth in the sheer fact of their existence:

When, for example, I looked at a chair or a jug, I thought not of their use or function — a jug not as something to hold water and milk, a chair not as something to sit in — but as having lost their names, their functions and their meanings; they became 'things' and began to take on life, to exist... Their life consisted uniquely in the fact that they were there, in their existence itself. (Sechehaye, 1962, pp. 40f)

The 'mere being' of such objects or people can make them seem, in a disconcerting way, both unreal and hyper-real, both dead and alive. Melancholia can involve similar forms of uncertainty. But schizophrenic individuals often seem to inhabit, we might say, an even deeper region of the 'uncanny valley' — which is a term that virtual reality and video game designers use to refer to that unsettling, liminal realm (much to be avoided in computer graphic design) in which one is uncertain of whether something or someone is alive or dead, real or unreal (Mori, 1970).

Residing deep in the uncanny valley seems to be a disconcerting experience, a source of anxiety and ontological uncertainty. Such reactions can certainly be intense. They are, however, distinct from the more standard, emotional reactions that, at the extreme, are termed the 'passions'. Here we encounter one of the most misunderstood features of schizophrenia: the fact that, although such persons may well have diminished *emotional* experience, this does not mean that their *affective* life is any less intense. As Sass (2004; 2007) has pointed out, emotions can be understood as a subset of the more general category

of affective reactions: namely, as those affective reactions that are targeted at specific persons or events that are experienced by the subject as existing independently of him or her (in the 'external' or 'objective' world) and that are felt to have real but unpredictable consequences for the subject's survival or flourishing. Various aspects of schizophrenic experience seem liable to detach the patient from this mode of experience. These include the tendency for bodily experiences, kin-aesthetic or proprioceptive, to replace external objects as the focus of attention; for external objects to lose the coherence or affordance-qualities that make them emotionally relevant; and finally, for some patients to withdraw into what they experience as a subjectivistic or even solipsistic world. Although all these experiences undermine one or another requirement for truly *emotional* experience, they are often associated with highly charged yet non-emotional (in the above sense of 'emotional') *affective* responses, such as awe, amazement, or general ontological insecurity about the very existence of the world or the self. These latter responses, affective yet non-emotional, seem to be far more characteristic of schizophrenia than of melancholia or mania. Such an interpretation is consistent with both subjective reports and neurophysiological findings (e.g. re electrodermal response) concerning so-called 'flat affect' in schizophrenia (Sass, 2007).

Still another crucial aspect of schizophrenic experience pertains to the general sense of presence, reality, or substantiality that the objects of experience are felt to have. The overall feel of the schizophrenic world has been aptly described as 'peculiarly insubstantial, evanescent, and hovering' (in Schmidt, 1987, p. 115). Persons with schizophrenia may seem to be open to a variety of ways of experiencing even the same events or set of objects, and may slide all too readily between perspectives on the world, or even experience two or more perspectives simultaneously (as indicated by 'fluidity' and 'contamination' codes on the Rorschach test; Solovay *et al.*, 1986). This contrasts sharply with the fatal certitude so characteristic of psychotic depression, in which the feeling of absolute and incontrovertible finality (usually involving guilt and a sense of doom) can be so dominant.

5. Conclusion

In our previous article, 'Varieties of Self-Experience' (this issue), we discussed a range of features of self-disturbance in schizophrenia and affective psychosis. These included disturbances of a person's relationship to thoughts and thinking, feelings of alienation from the body, changes in emotional experience, and distortions of the basic

sense of existing as a subjective presence. We concluded by describing the difference between schizophrenia and melancholia as akin to the distinction between the ‘the feeling that I cannot feel’ (melancholia) and the sense of being ‘unable to feel that I feel’ (or even to *feel* that I *don't* feel: schizophrenia) — the latter involving a more profound disturbance that is closer to the innermost kernel or zero point of self-experience.

In this article we focused on the perception of and engagement with the outside world, including space and objects, events and time, and general atmosphere. Most of these experiences can be described as involving forms of alienation and experiences of strangeness and the uncanny. Both schizophrenic and melancholic patients may experience a sense of being cut off from the world around them. Melancholic patients may feel out of sync with the world, or they may feel a significant decrease in motivation that renders them incapable of engaging with people and objects, thus creating an unbridgeable gap between themselves and the world. Schizophrenic patients, on the other hand, may have always felt separate or distant from people and things; and their experience of alienation may be bound up with a hyperreflexive scrutiny of the strangeness of the world. Such experiences may also be accompanied by loss of common-sense meanings of objects and fragmentation of time and space.

Experiences of the background sense of reality, or atmosphere, may also be transformed in these disorders. The world may seem unreal or hyper-real. It may seem void of all meaning, or else as though it contains special, even paranoid, meaning for the patient alone. However, whereas these changes will typically occur as a result of emotional disturbances in melancholia and mania, and will thus typically be tinged with either a depressive or an excited mood state, such experiences in schizophrenia are often notable for their sheer uncanniness, which seems both to result from and to augment the difficulty of existing in the world. In schizophrenia the general atmospheric qualities seem subtly and ineffably strange, as in the experiences of uncanny particularity and *déjà-vu*, even to the point of fragmentation or meaninglessness.

In both papers, we have focused on similarities that can complicate differential diagnosis of schizophrenia versus affective disorder, and that may also suggest some shared psychopathological processes or mechanisms. But we have also suggested that a nuanced understanding of underlying structural changes can help to differentiate the two disorders, and perhaps ultimately contribute to a more precise grasp of the different pathogenetic pathways they may involve. For example,

hallucinations in a patient with mania may not imply the same type or degree of foundational alteration in cognitive and experiential orientation as occurs in schizophrenia. Such differences may be crucial in understanding the greater chronicity of schizophrenia, and its propensity to place the patient more profoundly at odds with common-sense, practical reality and the social world. As stated in ‘Varieties of Self-Experience’, the ability to make such distinctions is essential for both treatment and research into these disorders. We hope that our exploratory forays will spur further, empirical research on both the affinities and differences of subjective experience in schizophrenia and severe affective disorders.

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