Schizophrenic Delusions: A Phenomenological Approach

by Pierre Bovet and Josef Parnas

Abstract

The issue of specificity of delusions in schizophrenia is still a matter of debate. The authors analyze the delusion formation in schizophrenia from a prototypical, phenomenological point of view, focusing on the subject's experience. This perspective links delusion formation to the autistic predisposition, which is considered here as the elementary phenotypic expression of the vulnerability to schizophrenia. Autism is viewed as a defective preconceptual (i.e., before language) attunement to the world. It impedes the individual's sharing of “common sense” with others and impairs the ability to project into the future. The development of delusions is illustrated, in part, by Klaus Conrad's work on the onset of paranoid schizophrenia. Delusions are viewed as transformations of the structure of experiencing. When threatened in future ability to be, the autistic, vulnerable person looks for the clues to becoming by attributing significance to disparate elements of the environment, which become self-referential. The link established between these disparate elements is based on universal characteristics that give the schizophrenic delusion a metaphysical quality. The transitivistic experience in delusions of control and omnipotence points to a specific way of crossing the border between “mine” and “yours” (disturbances of the experiencing “I”). What strikes a clinician in these delusions is that the normally tacit link between the sense of being and the sense of acting becomes quite apparent. The authors also propose a specificity in the themes of schizophrenic delusions. Delusions acquire a schizophrenic quality when ontological (i.e., universal) elements of the discourse between the locutor and the Other dominate at the expense of the worldly elements. It is emphasized that delusional content and form are dialectically related and hardly distinguishable. The authors consider the delusion formation as a phenomenon of emergence, a situation in which a new qualitative order arises from the reorganization of essentially unchanged elements. To consider schizophrenia as an emergent, particular way of experiencing, related to the autistic defect, has important consequences for research and for treatment. A dialectic exchange is needed between prototypical models generated by phenomenological inquiry and empirical, operational validation of testable aspects of such models.

A delusion is usually defined by a set of formal, descriptive criteria, which have been summarized by Oltmanns (1988, p. 5).

The following list includes several features that have been used to describe delusions. They might also be seen as defining characteristics, with none being considered to be either necessary or sufficient conditions [italics added].

a. The balance of evidence for and against the belief is

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such that other people consider it completely incredible.

b. The belief is not shared by others.

c. The belief is held by firm conviction. The person’s statements or behaviors are unresponsive to the presentation of evidence contrary to the belief.

d. The person is preoccupied with (emotionally committed to) the belief and finds it difficult to avoid thinking or talking about it.

e. The belief involves personal reference, rather than unconventional religious, scientific, or political conviction.

f. The belief is a source of subjective distress or interferes with the person’s occupational or social functioning.

g. The person does not report subjective efforts to resist the belief (in contrast to patients with obsessional ideas).

This line of thinking, called “operationalism,” is currently the most accepted approach in psychiatry (Stein 1991). Operational definitions of scientific terms aim at “objectivity” of knowledge, “in the sense of being intersubjectively certifiable, independently of individual opinion or preference” (Hempel 1965).

An operational definition of a term is conceived as a rule to the effect that the term is to apply to a particular case if the performance of specified operations in that case yields a certain characteristic result. [p. 123]

However, delusion is difficult to define operationally. Each of the listed criteria, considered separately, is insufficient. For instance, criterion b, “The belief is not shared by others,” should require the psychiatrist to screen a large sample and would be refuted in cases of folie-a-deux. To improve operationality, each of the criteria should be accompanied by a set of subcriteria, which in turn should be more precisely defined, and so forth. In other words, we can only designate a given statement as delusional within a specific context, encompassing the patient’s and the clinician’s experience.

Moreover, delusion is a non-specific symptom, occurring in many functional and organic mental disorders (Oepen et al. 1988). The issues of objectivity and specificity become more problematic when delusions are included in the diagnostic criteria of schizophrenia. The clinical demarcation of schizophrenia lacks, so far, a specific, independent validation criterion (i.e., biological marker). This lack immediately renders any postulate about specificity of a given clinical feature debatable. Operational diagnostic systems deal with these difficulties by specifying a number of features that should coexist in a given case in order to be included in a diagnostic category (polythetic systems). The DSM-III-R (American Psychiatric Association 1987) requires that delusions either have to be accompanied by specified other symptoms (e.g., incoherence, hallucinations) or exhibit a bizarre quality (sufficient requirement). Unfortunately, Flaum et al. (1991) did not find “bizarreness” to be operationally reliable even among the members of the task force on DSM-IV.

Polythetic systems do not arise out of the blue but derive from prototypical descriptions. “Prototypic categories are organized around prototypical examples (the best examples of the concept) with less prototypical examples forming a continuum away from these central cases” (Livesley 1985, p. 355). The prototypical notions (in the case of schizophrenia, the work of Kraepelin, Bleuler, and Schneider) influence the conceptual guidelines of polythetic operational systems with respect to specificity and pathogenesis. Prototypical cases cannot, by definition, be generalized as true or false (e.g., a sparrow is more prototypical of a bird than a penguin, but all of its own characteristics cannot be generalized to the generic class of birds), and empirical work is necessary to assess the sensitivity and specificity of singular features that are derived from the prototype.

In the absence of external validation, the diagnostic concepts of schizophrenia have to rely on a dynamic exchange between prototypical conceptualizations and empirical validations based on operational definitions. The variety of behavioral phenotypes in schizophrenia results from a long causal chain of increasingly complex interactions between the putative biological etiological factors and environment (Bleuler 1917; Ciompi 1988a). Single symptoms of adult schizophrenia patients are not primary (in the pathogenetic sense) and are only rarely diagnostically specific. However, some of these symptoms may exhibit qualities that reflect basic disturbances, that is, the disturbances that are “midway” between the underlying pathophysiology and overt symptomatology.

We hypothesize that these basic disturbances, which create a vulnerability to schizophrenia, relate to a difficulty in the intersubjective constitution of the sense of a Self. We use a phenomenological approach to explore how delusional transformation in paranoid schizophrenia reflects a particular way of relating to the world, exhibited premorbidly. The ideas presented...
below are based on a prototypical approach and cannot avoid a flavor of generalization. Components of such a prototype still have to face empirical validation. Even though the mechanisms we discuss are not applicable to all phenotypes summarized today as schizophrenia, we think that they illustrate specific aspects of the ontogenic development of schizophrenic symptomatology.

Definitions of Phenomenology

Phenomenology has ambiguous connotations, as was illustrated by a recent debate in the Schizophrenia Bulletin (Andreasen 1991; Rotov 1991). For the sake of clarity, we shall distinguish between three common uses of this term and indicate which of them is used by the present authors.

In Anglo-Saxon psychiatry, phenomenology is synonymous with descriptive psychopathology and refers to the description of symptoms and signs in psychiatric illness. This descriptive process is ideally performed by an impartial, "objectifying" observer.

In continental Europe, Jaspers (1923) considered phenomenology as a branch of psychopathology concerned with the patient's inner world, that is, with "symptoms" rather than "signs." This world is inaccessible to direct observation and can only be grasped through the patient's report. The psychopathologist, then, must faithfully reproduce the patient's experience, preferably by quoting the patient's spontaneous self-descriptions, because these are undistorted by questioning. The observer relies in his investigation on empathy, and the goal of the investigation is to bring to mind as precisely as possible what the patient experiences ("presentification").

Our approach, which may be considered as post-Jaspersian phenomenological psychiatry, has been developed mainly in Germany and France. It is based on phenomenological philosophy (Husserl 1900/1970a, 1936/1970a; Heidegger 1927/1962, 1975/1988; Merleau-Ponty 1945/1962, 1947/1964, 1964/1968), which aims at identifying and describing the essential features of the human being in the world. Phenomenology represents a radical departure from the Cartesian tradition of sharp subject-object, mind-body, affect-cognition dualisms. "Subject and object must be conceived as two abstract 'moments' of a unique structure which is presence" (Merleau-Ponty, 1945/1962, e.t. p. 430).

1 Phenomenological inquiry focuses on the concrete fullness of the subject-object whole as it is lived before the conceptual split between object and subject is introduced by the use of language. Phenomenology considers human knowledge as a dialectic between the object and the subject, implying intentionality of the subject: consciousness is always consciousness of something. Consciousness itself is a projection of the world to which it is perpetually directed. The word phenomenon does not refer to a mere appearance, but, being a correlate of any mental act, phenomenon possesses a certain intrinsic sense of truth (essence). Phenomenological inquiry tries to unearth the meaning of the phenomenon; priority is given to the "evidentness" or "given-ness" of the phenomenon as opposed to its possibilities of being objectified. In the epistemic act, which Husserl (1913/1975) called "originally presenting experience" or "lived experience," the phenomenon unfolds itself to us, and in our mutual involvement with it, we are able to grasp the invariant essence or structure of it by focusing on its variations against a horizon (context or texture). The "lived experience" is always embedded in intersubjectivity, that is, the tacit apprehension that our individual privacy is always constituted and framed by its similarity to (though not identity with) other peoples' privacies.

My awareness of constructing an objective truth would never provide me with anything more than an objective truth for me, and my greatest attempt at impartiality would never enable me to prevail over my subjectivity, if I had not, underlying my judgments, the primordial certainty of being in contact with being itself, if before any voluntary adoption of a position I were not already situated in an intersubjective world. [Merleau-Ponty 1945/1962, e.t. p. 355]

The context of intersubjectivity is designated by Husserl (1936/1970a) as "lived world," that is, the experienced world, which is always there in its concreteness and facticity, as the universal field of all action. What is given in our en-
counter with the world is neither the object perceived nor the perceiving subject, but rather an experience that implies the intertwining of perceiver and perceived and the reversibility of my perception with that of another. The phenomenological maxim "to the things themselves" implies for psychopathology a task of unprejudiced concern with man and man's modes of being-in-the-world as they are directly encountered in experience.

Historically, phenomenological psychiatry in that philosophical line of thought is considered as having been founded in Zurich during the 63rd Assembly of the Swiss Psychiatric Association in 1922 (Schweizerischer Verein für Psychiatrie 1923).

It is clear that there is some overlap between Jaspersian and post-Jaspersian psychiatric phenomenology. Even though "early" Jaspers used concepts like "empathy" and "presentification," he was reluctant to abandon his positivist perspective (Blankenburg 1980). Later, Jaspers moved to an existential philosophical position. Readers interested in philosophical phenomenology are referred to Hammond et al. (1991). A readily accessible account of phenomenological psychopathology can be found in De Koning and Jenner (1982).

**A Phenomenological Approach to Schizophrenic Vulnerability**

Our basic assumption, which is shared by most clinicians and researchers involved in the field of schizophrenia, is to consider schizophrenia as an epigenetic developmental process. Such a model was already sketched by Bleuler and Jung in 1908 and explicitly formulated by Minkowski 20 years later:

The notion of schizophrenia, as a mental disease, can be decomposed into two factors, of different order: first, the schizoidia, which is a constitutional factor, highly specific, and temporally enduring through the individual life; and, second, a noxious factor, of an evolutional nature, and which has the ability to determine a morbid mental process. This latter factor has, for itself, no definite taint, it is of a more unspecific nature, and the clinical picture to which it will lead will depend upon the ground on which it will act. Together with schizoidia, it will transform the latter into a specific morbid process, into schizophrenia. [Minkowski 1927, pp. 50-51]

According to this model, schizophrenia occurs only among vulnerable individuals. There is a consensus among researchers that vulnerability to schizophrenia is formed early in life. Premorbid characteristics may therefore be considered as subtle clinical indicators of such vulnerability. Up to the end of the 1960s, all empirical studies on premorbid characteristics were retrospective (Offord and Cross 1969) and therefore largely unreliable. More recently, studies appeared using data collected during the subjects' childhood before their first schizophrenia episode and recorded by the investigators along the dimensions of their interest (Watt 1972, 1978; Hartmann et al. 1984). Prospective studies of children at risk for schizophrenia used clinical evaluations and other concurrent data sources (Parnas et al. 1982; Parnas and Schulsinger 1986; Parnas and Jergensen 1989; Parnas and Mednick 1991).

The overall picture emerging from these studies is that gross behavioral abnormalities are not identifiable in all preschizophrenia subjects. However, abnormalities can be shown in several behavioral domains with the possibility "that each of the indicators involves information on one or several separate aspects of a single underlying vulnerability that is simply manifested more clearly in some sorts of behavior in one case and other sorts in other cases" (Hartmann et al. 1984, p. 1055).

We hypothesize that premorbid male aggressiveness and female introversion in school (Watt 1972, 1978); difficulties in interpersonal relations, anxiety, neophobia, and flat affect in males (Hartmann et al. 1984); and defective emotional rapport, eccentricity, and formal thought disorder in high-risk preschizophrenia subjects (Parnas et al. 1982; Parnas and Jergensen 1989) are all indicators of a defective attunement between the individual and the outer world. The specificity of this defective attunement is hardly recognizable in any single behavioral disturbance; rather, the overall picture attains some prototypical value. This lack of attunement corresponds to what Minkowski calls "schizoidia." We shall designate this defective rapport between the individual and the outer world as the autistic vulnerability (Parnas and Bovet 1991). It must be emphasized that the term "autistic" does not denote here a withdrawn and shut-in attitude. Autism was originally defined by Bleuler (1911/1950) as a withdrawal from outer reality, accompanied by the predominance of the inner fantasy life. However, both the notion of withdrawal and the notion of rich fantasy life are often contradicted by empirical
data (Bleuler's own descriptions of "latent schizophrenias," 1911/1950; Kraepelin 1919/1921; Minkowski 1927; Zilborg 1941; Dunai and Hoch 1955). In fact, Bleuler was not able to provide a satisfactory symptomatological description of autism and therefore categorized it as a complex fundamental symptom.

For phenomenology, autism is not a symptom in the sense of the medical model; rather, it is a phenomenon that is recognizable in the intersubjective space (Tatossian 1979). It is precisely for that reason that clinicians are sometimes able to make a very quick diagnosis of schizophrenia in the encounter with the patient. In such a diagnostic act, the clinician immediately and preconceptually grasps the sense of the clinical picture (Rümke 1942; Schwartz and Wiggins 1987).

Phenomenology sees autism as a defective expressive-perceptual attunement between the subject and the outer world. The autistic defect is perceivable both in the cognitive and in the affective domains because the attunement to the world is affected at the very elementary, preconceptual level. Expressions used by European phenomenologists, such as "loss of vital contact with reality" (Minkowski 1926, 1927, 1933/1970), "inconsistency of natural experience" (Binswanger 1963), "global crisis of common sense," or "loss of natural evidence" (Blankenburg 1969, 1971), refer precisely to this autistic impairment of the elementary dialogue between the Self and the outer world.

According to Blankenburg (1969), the essential feature of autism is the "lack of common sense" (sensus communis). Common sense is the ability to see things in the proper perspective, to distinguish between what is relevant and irrelevant, likely and improbable, which is a more elementary ability than to distinguish between what is true and what is false. It is "knowing how to negotiate our way through a world that is not fixed and pregiven but that is continually shaped by the types of actions in which we engage" (Varela et al. 1991, p. 144). Common sense reflects our preconceptual attunement to the world. It reveals not so much what is evident but how it is evident, the constantly present and tacit frame of experience (Tatossian 1979; Ferguson 1989).

The defect in common sense can manifest itself in a lack of taste and feeling for what is adequate and a lack of the sense for the "rules of the game" of human behavior. Relatives of patients with schizophrenia often report that, in the initial stages of schizophrenia, the patient asks questions about the most self-evident issues, whereas the ability to solve abstract and intellectual problems remains intact. In such cases, it is sometimes clear that the lack of common sense is compensated by a hypertrophied devotion to logical solutions (Blankenburg 1969).

The view of autism as a "global crisis of common sense" points to the defective core of ontic attunement. (The Greek word "onta" means reality, real being. Throughout this article, we distinguish between the adjectives "ontic," referring to something worldly, and "ontological," referring to general and universal possibilities for something to occur. Ontology is the branch of philosophy concerned with the essence of being.)

Blankenburg (1971) gives the following vignette of a young female patient whose self-descriptions were transcribed as literally as possible.

"I have the need of support in the most trivial everyday matters. I cannot do it by myself.... It is of course the natural evidence, which I am lacking." Sometimes she spoke also of "the evidence of feeling." [What does she mean by that?] "Every human must know how to behave, every human has a track, a way of thinking. His behavior, his humanity, his sociality, all these rules of the game which he uses: until now, I have been unable to recognize it clearly. I lack foundations.... I am precisely lacking that which I know, I would know it also in my encounter with other people—so, evidently.... It was exactly the same in the store [where she had been employed]. How people behave, how they lived correctly! It is not knowledge. One cannot simply see it and understand it. Probably, one must first with parents—it is probably with the parents—one must first have a link with them, a link with a human being that one understands.... If now—just when we have to work together, I cannot stand it for a long time; I am unable. For example washing up: the difficulty, yes what would be the difficulty for me, how to say it, I do not manage it in a self-evident way: it is strange and disconcerting. [pp. 42-44]

These complaints illustrate the "naked," elementary lack of attunement to the world (Minkowski’s "autisme pauvre," i.e., empty autism), which often becomes concealed by withdrawal or by productive psychotic symptoms (Minkowski’s "autisme riche," i.e., rich or florid autism as described by Bleuler).

An essential component of the attunement to the world and of intersubjectivity is their temporal aspect. Minkowski (1926, 1933/
1970) pointed to the temporal dimension in the preconceptual attunement and in intersubjectivity by introducing the term "lived synchronism," which is described as follows:

The faculty of advancing harmoniously with ambient becoming and in the same time of letting us be penetrated by it and of feeling one with it.... [A phenomenon which achieves vital contact with reality in a particularly vibrant way is sympathy, in the etymological sense of the word.... Sympathy cannot be instantaneous, there is always duration in it, and in this duration there are two becomings which flow side by side in perfect harmony.... We find the same phenomenon of vital contact with reality in that feeling of measure and limits which surrounds all of our precepts like a living fringe, rendering them infinitely nuanced and infinitely human. It is a good thing to have rules of conduct, it is better to know how to apply them.... It is intuition, and intuition alone, which lays down our line of conduct and which, in particular cases, let us depart from previously adopted precepts. We just seek by that to be in accord, obviously through feeling and not through reason, with ourselves, and with life. Without ever being able to formulate it, we know what we have to do; and it is this that makes our activity infinitely malleable, infinitely human. [Minkowski 1933/1970, e.t. pp. 65-69]

"Lived synchronism" expresses the possibility of accord and mutuality between temporalization ("lived time") of disparate Selves. Temporality is a phenomenological concept and refers to the dynamic matrix of temporal references in which any concrete life is lived (Heidegger 1927/1962; Merleau-Ponty 1945/1962; Ricoeur 1985/1988). In temporality, future, past, and present are meaningfully and reciprocally interwoven as structuring the referential context of human existence. In this sense, temporality, unlike time, is not unidirectional from past to future but is reversible, continuous, and finite, bound by the wholeness of the human existence, which is completed by death. Temporality is only apprehended preconsciously; our sense of the Self integrates the sediments of our experiences, our past belongs to our present and future, and our projections into the future influence our experience of the past. In temporality, the future is the fundamental element, because this is the temporal dimension on which human beings project themselves. This potential to project into the future is a unique characteristic of human existence.

One can distinguish between two fundamentally different approaches to the future (Heidegger 1927/1962; Minkowski 1933/1970): activity or anticipation, in which we feel ourselves going toward the future, and waiting, in which we feel the future coming toward us. In waiting, the individual feels submerged, experiencing the whole of becoming, concentrated outside himself, as a prearranged destiny.

An essential component of the autistic defect is the impairment of the subject's self-temporalization, that is, a defect in "lived synchronism." (We do not speak here of the disturbances of the subjective perception of time [e.g., time standing still, being discontinuous, time-rushing, etc.] which may be observed both in schizophrenia [Fischer 1929] and in epilepsy.) The subject's potential to project himself into possible futures and anticipate himself is diminished. Autistic subjects seem to live mainly in the waiting mode. This impedes maturation processes; autistic subjects cannot become experienced because their experiencing is not properly incorporated.

One of Minkowski's (1927, p. 100) patients expressed this peculiar waiting attitude in the following way: "I have even less flexibility when I think about the future than I have about the present and the past. There is a kind of routine affecting me which does not allow me to contemplate the future. The creative ability in me has gone. I see the future only as a repetition of the past." In our view, the difficulty of many pre-schizophrenia subjects is a reduced ability to transcend, that is to flexibly change a perspective while still retaining one's autonomy and self-identity. In fact, a defective sense of the continuity of the Self over time is one of the empirically demonstrated indicators of vulnerability (Hartmann et al. 1984).

Our clinical experience indicates that schizophrenia patients tend to act, think, and feel as if their life is congealed in an ahistorical perspective. The word ahistorical means that the dynamic interaction between past, present, and future is deficient. The impact of the past is not hierarchically structured, and events that usually fade away may retain a disproportionate importance. The elements of the past are often relived in a stereotyped way and do not change with circumstances. The future has a limited degree of freedom and is often experienced as a prearranged destiny. Such a fixed outlook is frequently shared by the nuclear family of a schizophrenia patient and is reflected in complex repetitive patterns of attitudes and behaviors that may persist across generations (Bovet and Schmid 1987; Schmid and Bovet 1988).
Case #1. One of our schizophrenia patients was severely inhibited in his everyday obligations by extreme difficulty in getting out of bed in the morning. He would spend hours lying awake in his bed, anticipating the necessary activities before the beginning of the day. At therapy sessions he explained that his reluctance to start the day was related to his awareness of the necessity of washing his hair and shaving himself after getting up. He would then think about thousands of his past, and endless future, washings and shavings. The cumulated image of these repetitive activities acquired a quality of an insurmountable absurdity and prevented him from getting up.

Case #2. A 25-year-old male schizotype, interviewed in the course of a genetic study, reported that his marks dropped when he was finishing his secondary school, and he was about 17 years old. Asked for explanation, he gave the following account: He would have fantasies about some specific future university training, and then try to imagine himself working in a job with this education. For instance, becoming an engineer would involve working in the construction industry. He would then imagine himself endlessly and repeatedly calculating mechanical constraints of the buildings. This “eternal” and senseless image of himself would lead him to drop this particular educational project and change to another one, with similar result. The end consequence was that he withdrew from the school work.

These two cases illustrate Blankenburg’s concept of “global crisis of common sense” and Minkowski’s concept of “loss of vital contact with reality” (the daily routine or the planning of the future career become meaningless by their disconnection with their context) and at the same time point to the corollary of this defective preconceptual attunement, namely the impaired temporalization of the Self.

These three correlated aspects of the autistic defect, that is, defective attunement, weak intersubjective ties, and difficulties in self-temporalization, are fundamental to our view of the development of delusions in schizophrenia. We propose that the normal subject, always immersed in intersubjectivity, searches in himself for the main clues to his future, whereas the preschizophrenia subject, unframed by intersubjective ties, is forced to look for such guiding clues in the “outer world,” rendering the latter potentially self-referential. If such a vulnerable individual finds himself committed to a situation that threatens his autonomy beyond his capacities, the way to escape the threat is to reshape the context of his being-in-the-world, either by an “autoplastic,” delusional reshaping of the experience or by a temporary, senseless “alloplastic” behavior. Such episodes may relieve the tension, and the individual may return to the status quo ante or progress by an autocatalytic process into a long-lasting schizophrenic episode (Ciompi 1982/1988b).

Development of Delusions in Schizophrenia

To illustrate the development of the delusional process, we shall rely partly on vignettes translated from Klaus Conrad (1958), whose work is considered in Europe as fundamental to understanding the onset of paranoid schizophrenia. Conrad described in detail the onset of schizophrenia in a sample of 117 cases, which he collected during World War II when he was working as a psychiatrist in a German military hospital. Conrad distinguishes four stages in the development of delusion: (1) the initial phase, which he calls “das Trema”; (2) the apophantic phase, in which the establishment of a delusion gradually takes place. (The Greek word apophainein means “becoming visible or apparent.”) The word apophasitonic conveys therefore the quality of a revelatory experience. This phase represents an autoplastic reshaping of one’s being-in-the-world; (3) the apocalyptic phase, in which the patient disintegrates; and finally (4) the consolidation phase, which refers to outcome.

Case #3. Born in 1921, the patient had been referred [to Conrad] in 1941. He had a severe delusion of reference. He refused to be examined, as he claimed that everyone had access to his thoughts. He was extremely suspicious, misidentified people, and was in a state of excitement. He improved slowly and was finally able to report the development of his illness, even though he still was deluded.

(1) When he was 18 years old, some months before the beginning of the war, he graduated from a merchants school, but he did not get the diploma that would allow him to enter the University (in Germany: “Abitur”). He was upset by and ambivalent to his parents’ expectations as how to continue his career and about his future financial dependence on them. He decided to leave his parents’ home
and to move to another city, as his father once mentioned the possibility of making a business career without having the “Abitur.” He wanted to be relieved from the awareness of being financially dependent on his parents. After being drafted into the army, he was sent with his company to France in November 1940.

(2) He was the oldest soldier in the company and had a feeling that a particular performance was expected from him. He felt under tension. In the camp, the soldiers spoke of promotions. He felt very inclined to enter the career of an officer. But because he did not have his “Abitur,” he just had to take that idea out of his mind. For some time he dwelled on the possibility of entering a professional career as an under-officer. During that time, he was often reflecting about his future, and his wish of entering a career as an officer regularly came to his mind.

(3) After some time, he got a peculiar feeling that “something was in the air”; what it was, he could not say, but he faced perhaps a special stake. There were rumors that he, and only he, was to be promoted to corporal. No specific names were uttered, but it seemed nevertheless clear, that he had to get the charge. For that reason, he felt hostility and feelings of jealousy from his peers. During a break in an exercise, the haversacks were not in a strict alignment; the sergeant told him: “Put this stuff in order, it will be your responsibility...,” an allusion to his promotion; such allusions were very common.

(4) In the following days, he did not speak to other people, because he feared their jealousy. He felt he was stared at by other people. One forbade him to have a sip from a shared bottle, or the bottle was handed to him with a particular gaze; the atmosphere was all but friendly.

(5) Suddenly, he felt that he was supposed to play some “role” during the night; perhaps his peers would bind him and stamp him with hammer and sickle. So he stayed alert in his bed, watching its immediate surroundings. Suddenly, he heard some cracking in the floor, jumped out of his bed, and waited in a defensive position near the oven. He was hyperalert and sensitive to any noise in the neighborhood. But each time he was up, everything seemed apparently normal, and he concluded that his comrades were taking him. Once, when a guard entered the barrack, he felt that the guard was somehow “instructed.” His odd behavior was noticed by the guard, and he was ordered to dress himself, and to spend the rest of the night in the guards’ room. After returning to his barrack, he felt a hostile atmosphere, and even his best friend asked him, in an “innocent” way, what happened.

(6) Now (at the time of the psychiatric examination), he understands that all these events were preparatory steps to his examination as a candidate officer.

(7) (...)

(8) When he was brought to the medic room, an orderly spoke to him. He then had a feeling that there was a plan to prohibit his promotion. He thought that perhaps he would be caught in some sort of trap and have to scandalize himself in public. He was aware that the decision of his promotion had to come from provincial authorities, and, in case of a scandal, these authorities would withhold promotion. He was confined to bed and given some medication, perhaps in order to artificially raise his temperature.

(9) Suddenly, a physician and medics entered the room. He was carried into a car and immediately got the feeling that he was given a new chance. It was very clear that he had to pass an examination in Germany for becoming an officer. He did not know whether the car was bringing him to the airport or to the hospital. The direction to the airport implied going to Germany and entering the school of officers. He had to interpret the clues under way in order to overcome the uncertainty imposed upon him by the driver’s confusing choice of small country roads.

(10) He was offered a cigarette, which he knew was prepared with a substance which would either paralyze his will or let him have a glimpse of his future.

(11) On the way, they bypassed an infantry troop, which at this very moment took their arms up, which meant that he had to pull himself together. As they bypassed city signs, the names of the villages connected to his past memories. They stopped at a railway crossing, where he noticed the letter “N” on a sign. That meant “No,” and indicated that his hopes for the future were unfounded.

(12) The car set in motion again, and the landscape became more friendly, and his mood improved also. They bypassed the city sign “Gradigan,” and that meant that his career was supposed to “resume its upward direction” (gerade wieder bergan).

(13) (...)

(14) Even when brought to the hospital, he was still hopeful, noticing that the receptionist had a green cover on his desk.
ordered to bed in a room with barred windows, which reminded him of a prison. A lot of people were watching him, and one offered him a cigarette. As soon as he inhaled, his vision became wavering. "And now the true theater begins, all the other has been the foreplay."

(15) "Of course, I did not know that all this was a part of the examination to become an officer." All these people were there to observe him; from the conversation, he was astonished to note that much was known of his private life; allusions were made to his family.

(16) He noticed that there were some cows lowing outside the building, and he suddenly was convinced that he was to be exterminated, that he had to be slaughtered like cattle.

(17) He was brought to the doctor’s office. The doctor resembled his uncle, who is a cashier. This similarity paralyzed him. The doctor’s voice also had the same nice quality as the uncle’s. He began to lose the feeling of the connections of the situation’s elements to each other. Things seemed to go in a supernatural way. He was sure that the doctor was made up in that way in order to test his reactions. The doctor transcribed his utterances, but in a distorting way, which he protested against, but nobody cared. He had to lie on the examination bed and was convinced that he would now be slaughtered, as there were some blood spots on the doctor’s white coat. He considered the medical examination as a simulation. Once brought back to his bed, he was overwhelmed by the thought that the cows’ low signified that he would be converted into an animal through hypnosis.

(18) He sensed that his thoughts were transmissible and that he was hypnotized. They wanted to drain him of everything. Everyone could read his thoughts. Whatever he was thinking, the others made it clear to them that they knew his thoughts (Conrad 1958, pp. 8–11).

During the initial period (1 and 2), there is a longstanding elevation of tension while the patient faces an ambivalent choice of career. He cannot find out whether his parents would encourage or discourage him to take his "Abitur.” A similar ambivalence concerning his future career torments him after he is drafted into the army. This tension is experienced like a pressure that narrows his field of experience into a single expectation of something impending. What is impending is always either positive or negative and always significant for one’s life. The impending narrows the individuals’ experiential field and leads to an increase of tension.

The individual is in a state of "abnormal awareness of significance” (Jaspers 1923). The experienced situation is somehow "made” or "fabricated” (6 and 8).

This turning point, that is the Wahnstimmung (delusional mood), represents, according to Conrad, a transformation of the structure of experiencing and leads to the apophantic (revelatory) phase in which the delusional perception is crystallized.

For a person in a preschizophrenic state, the Trema is experienced as a single modality of future coming to the present. He becomes caught in a situation that he cannot evade because of his inability to transcend.

In the case of the autoplastic, delusional resolution of the Trema, the subject’s awareness of the impending becomes increasingly thematized and self-referent (3 and 4). The preschizophrenia subject has a feeling of being put under some as yet unknown test situation, and phenomena in his field of experience (be it inner or outer) acquire a pregnant significance, which is sometimes indicative of the future theme of the delusions. The individual is in a state of "abnormal awareness of significance” (Jaspers 1923). The experienced situation is somehow "made” or "fabricated” (6 and 8).

This turning point, that is the Wahnstimmung (delusional mood), represents, according to Conrad, a transformation of the structure of experiencing and leads to the apophantic (revelatory) phase in which the delusional perception is crystallized.

In the apophantic phase, the connections between the elements that form the perceptual Gestalt are transformed. Any single element of a Gestalt always has a “cloud” of contextual significance for an individual. For example, a rifle may be associated with military discipline, with the fear of being shot, and with the pleasant memory of a hunting party. Normally, in a total Gestalt, such significance of all elements of experience is in a tacit, mutual equilibrium, preventing any amplified univocal attribution of significance.

In the apophantic phase, how-
ever, the connections between the elements of the experience are based on a single significance, the one that is the same in every element. This common denominator has a sort of ontological quality, that is, it possesses a very general or universal character. “One is much clearer about the relatedness of things, because one can overlook the factuality of things,” as one schizophrenia patient remarked (Matussek 1952, p. 308).

This patient, when successively encountering a dog, a foal, and an old lady, connected these objects with each other, as a sign of a more profound meaning, namely that the whole landscape and environment were rooted in nature and were primordial in character. This feeling was amplified when the patient noticed the names of villages in the neighborhood, “Erding” and “Freising,” which contain the German words “earth” and “free.”

In case #3, the apophantic experience is gradually intensified. In the beginning (5), the context of the situation (an isolated barrack in a dark forest) is coherently expressed in his experience that cracking in the floor means that the whole landscape and environment were rooted in nature and were primordial in character. This feeling was amplified when the patient noticed the names of villages in the neighborhood, “Erding” and “Freising,” which contain the German words “earth” and “free.”

In summary, in the apophantic phase the subject has an experience comparable to the experience of a revelation, in that he now “understands” what was previously only alluded to. The delusional perception, which is the essence of the apophantic phase as described above, may be reported by the patient as an instantaneous event.

Case #4. One of our schizophrenia patients, a 37-year-old male refugee from the formerly Communist part of Europe, described the onset of his psychosis, which began 3 years ago, in the following way. Immediately after Christmas 1988, a PanAm air carrier was terror-bombed when flying over Lockerbie in Scotland. This event attracted an extraordinary interest on the part of the patient. He spent hours listening to various radio stations in order to obtain more details about the accident. He felt increasingly tense.

One day when he was sitting in his bedroom, his gaze fell upon an open pack of his own cigarettes lying on the table. He suddenly realized that the cigarettes were aligned in a different way than when he put his cigarettes on the table, and this signified that he was going to be killed. In the following days, he interpreted various clues in his environment as corroborating his original conviction.

Sometimes, the Trema is not resolved through the formation of delusions, but in an alloplastic way, when the preschizophrenia subject transiently engages in a senseless behavior. Such episodes of senseless behavior may precede the outbreak of delusions by several years.

Case #5. One of our patients, a 50-year-old female with paranoid schizophrenia and delusional ideas, which she in no way enacted, lived peacefully with her mother in a small Swiss town which she had apparently never left, helping with house- and garden-keeping. She expressed her paranoid ideas about her sister, which she maintained for years quietly and without anger. To the astonishment of her psychiatrist, she once revealed that she could speak fluent Italian.

It turned out that in her early twenties, when she was working as a bank clerk, she fell in love with an Italian, an unskilled construction laborer. The possibility of an overt relationship was unthinkable in this very conventional, provincial town. One evening, when leaving the bank, she stole 20,000 Swiss francs and fled to Naples with her lover, where they opened and ran a pizzeria for 2 years. The patient was untraceable by the family and the police dur-
ing that period of time. She then returned upon her own wish, and the money was paid back by her family. Several years later she was diagnosed as having schizophrenia.

What is essential to her situation after falling in love is the conflict with her family and her social network that the enactment of her affair would provoke. A "normal" person would either have faced this conflict or made a deliberate decision to move to Italy and inform the family. Instead, her act overnight commits her to a drastic change in her life and structures her future in a limited and fixed way by making a return difficult. Conrad (1958) offers another example of a similar behavior.

**Case #6.** H.K., 24, a sergeant, was in a "dreadful" state of tension since the beginning of the attack on France, in which he participated. He was an exceptional soldier, much beloved by his superiors and full of ideals, but "deeply" affected by several matters. The dizziness of a victorious advance, punctuated by critical engagements with the enemy, was mixed up with the feelings of deception in relation to his comrades, who could not resist the temptation of plundering, a behavior he despised. In a letter to his mother, he once wrote that he was close to shooting himself. When his troops' advance stopped in the vicinity of Paris, he took his service car and, breaking the strict and explicit orders, drove into Paris with some privates under his command in order to "draw their attention on the cultural values of the enemy." He was condemned to 6 weeks in prison. The psychosis broke out some months later (Conrad 1958, p. 35).

Conrad, of course, feels uneasy in designating this behavior as "crazy," due to its positive human aspect. However, this gross transgression of discipline, which was completely incongruent with the sergeant's former exemplary conduct appeared in its motivation—to approximate his soldiers to the culture of the enemy—as completely "mad" in the eyes of his superiors.

The shared aspect of these two vignettes, at a clinical level, is the outstanding oddity of conduct, which is transient and which is in marked contrast to the individual's habitual behavior. At a phenomenological level, thisreshaping of the context of the situation is related to the autistic defect in the vital contact with reality, expressed in an alloplastic fashion.

For both alloplastic and auto-plastic resolution of Trema, Conrad (1958) emphasizes that what is specific for the schizophrenic world is the transformation of the structure of experiencing. "It is imperative to disattend from what is experienced, i.e., thematic, and to focus upon how, i.e., the modality of experiencing, and to consider the latter as the essence of the change" (p. 54).

Even though a distinction between form and content has practical relevance, form and content are dialectically related to each other (Müller-Suur 1954), and we shall discuss the issue of thematic below.

**Delusion and "Ich-Störungen"**

One of the essential features of schizophrenia is the disturbances of the experiencing "I" (Ich-Störungen). These disturbances overlap more or less the Anglo-Saxon concepts of "depersonalization," "derealization," "loss of control," "disturbed ego-boundaries," "passivity phenomena," and "delusions of reference" (Spitzer 1988). In our view, the concept of Ich-Störungen is more appropriate for the phenomenological understanding of delusion, because it refers directly to the experiencing subject.

We selected two vignettes from Conrad (1958) as examples of delusions that are usually considered specific to schizophrenia and that illustrate the Ich-Störungen in schizophrenia.

**Case #7.** The patient reports his being under the influence of some apparatus for several days. He had been in the city recently. Everything, along the whole way, was prepared anew. All people on the streets were involved, they exchanged signs, and in that manner led him all the way along. This must be in connection with the apparatus, from which everything starts, a kind of wave apparatus, which can be turned on "high" or "low." When it is turned on "very high," he is totally deprived of his own will, has to perform everything that the apparatus suggests, and even the smallest moves are directly piloted and made. Turned on "low" signifies that he may have his own free will. During his excursion in the city, he had been piloted all the way through and was completely deprived of his own will. Sometimes, the influences of the apparatus cross each other contradictorily, and then it is not exactly attuned. But otherwise everything proceeds in a very precise manner, as in a clock, even the smallest matters.

He wrote a letter for his wife's birthday. He noticed immediately...
that his style and content of writing were piloted from outside. It was not his way of arranging the sentences; the formal aspect was not even his own. "I still know my writing." All of his movements when writing, everything was constantly "piloted from a distance" (p. 102).

Case #8. The patient reported, at the very first examination, that he had to shout "faster, faster!" during his transportation by train to the hospital. He had, while shouting, the overwhelming consciousness that he could, by his shouting, influence the course of the war. Some time later, still during his first delusional phase, he said that he felt as if he could influence in some special way the destiny of the whole German army. When he had to get out during the night to urinate, he had the feeling that he could, in that way, let the releasing of bombs on England be executed. It was very clear for him, in that very moment, that his urination was immediately linked with bomb-releasing.... When asked to explicate his experience, he said that in the very moment when the bomber-planes fly over England and release bombs, he is their protector and has the consciousness of being linked to them; he has this ability "as a God," without willing it. He could say in his mind: now I throw bombs, in the moment of urination, and he has the consciousness that, simultaneously, bombs are actually falling on England. Of course, he does not know whether it is really the case, but at the moment of acting (urinating), he has no doubts.... Sometimes he had also seen that, for example, the weather was exactly how he had wanted it to be: "I was looking at a magazine, with pictures showing wonderful weather. And at this very moment, the sun came in the room. And then I looked at a picture of rain, and stormclouds arrived. I thought, I am a little God, and the weather regulates itself following me..." (p. 74).

In most textbooks of psychiatry, as well as in the DSM-III-R, these two vignettes would have two different designations, namely delusion of control and delusion of omnipotence (or grandiose delusion). These designations would be based primarily on the delusional content—the first patient feels that his actions are steered from outside and the second claims divine abilities.

On a more detailed descriptive level, this distinction would probably also touch on certain qualitative aspects of the experience, because in the first case the "mineness" of the experience is absent, and the delusion would be called a delusion of passivity, whereas in the second case the "mineness" is grossly inflated. However, such a view of the issue of "mineness" does not reveal the essential quality of the morbid experience.

In both cases (delusion of omnipotence and delusion of control) the link between I and the environment seems qualitatively changed in a characteristic way. It is not the direction, that is, it is not the question of either I or the environment being experienced as the more powerful, nor is it the unilaterally concerned mineness of experiencing; it is rather the border between "mine" and "yours" (i.e., the outer world), and not the border only, but also the way in which it is overstepped, that is specific for schizophrenia. [Blankenburg 1988, p. 187] Bleuler (1911/1950) called this specific overstepping of the me-not-me boundary "transitivism."

Then, what seems specific for Ich-Störungen in schizophrenia is that the intransitive "to be" is experienced as transitive. This is the shared experience in the delusions of control and omnipotence described above. The former can be epitomized as "The world is I," and the latter as "I is [sic] the world."

The problem of description in the area of Ich-Störungen is closely related to the descriptive problems of what is an "I" and thereby of self-reflection. In some acts of self-reflection, one can describe oneself as an experiencing subject. This kind of self-reflection is partly communicable to others (e.g., "I am sad"). There is, however, another sort of self-reflection pertaining to the very sense of Self as a founding instance (Blankenburg 1971), which is hardly communicable on a verbal level. This latter kind of self-reflection is linked to the relation between the sense of being and the sense of acting. Acting, with its connotations of projecting oneself into many possible futures, is part of the sense of an "I." Being and acting tacitly presuppose each other, and we are tacitly aware of our own "I" and of others' by our own and others' acting. This co-constitution of being and acting, immersed in temporalization, is normally only vaguely grasped in any introspection.

In delusions of control and omnipotence, it is not the strength or weakness of the feeling of activity, nor the sense of power or omnipotence that shows specificity to schizophrenia. Rather, it is the "immediacy" (Unmittelbarkeit) of the access by which the patient
experiences his being and acting that qualifies such experiences as typical for schizophrenia. In the delusions of control and omnipotence, clinicians are struck by the fact that, for the schizophrenia patient, to be and to act fuse with each other. What actually happens is that the normally tacit link between being and acting becomes apparent.

Such delusions are the only way the schizophrenia patient can express the "unthinkable" experience of the dissolution of the Self. This basic disturbance is beyond the scope of variation of normal experience (normal experience cannot vary with regard to the me-not-me differentiation, which we assume is disturbed). The dissolution of the Self is probably experienced by most schizophrenia patients at the onset of psychosis; for some of them, this experience will recur throughout the entire course of their illness. The way in which the me-not-me boundary is overstepped in schizophrenia is, in our view, qualitatively different from the expansive delusions seen in mania and from the complaints of a loss of autonomy encountered in depressive patients. A similar point can be made with respect to transittivistic phenomena of thought-insertion and thought-deprivation. Empirical studies demonstrating these first-rank symptoms of schizophrenia (Schneider 1955/1959) in affective illness (Pope and Lipinski 1978) are most likely not sensitive enough to the complexities of qualitative aspects in the investigated experience. Structured interviews may provoke false positive answers when applied to experiences that are not dichotomously present or absent (Koehler 1979) and that can only be properly evaluated from the patient's spontaneous self-descriptions (Akiskal and Puzantian 1979; Mellor 1982; see also our exposition of Jaspers' view of phenomenology).

**Thematic of Delusions In Schizophrenia**

The content of the schizophrenia patient's statements often reflects the distortions of the experiencing "I." Spitzer (1988) suggests that such statements should not be regarded as delusions but as metaphors used by the patient to describe his "undescribable" experience. We propose that such statements should be regarded as experience-congruent delusions, in which case the content of the delusion apparently qualifies schizophrenia. However, what is characteristic is that we face a Gestalt composed of both structure (form) and content ("matter pregnant with form"; Merleau-Ponty 1945/1962).

**Case #9.** One of our schizophrenia patients claimed that the CIA was responsible for the drug problem, both in the United States and in other countries. In his opinion, the CIA was facilitating the distribution of drugs in order to weaken people's resistance and pacify them. Another idea of this patient was that farmers were mistaken in their way of cultivating the soil. He considered that ploughing the soil after the harvest was, in fact, diminishing the soil's organic resources, because it let these resources evaporate into the air, rather than letting them dissolve down into the soil.

These statements, regarded at the purely contentual level, would not be considered diagnostic of schizophrenia. They seem to be, at first glance, very impersonal and do not transmit a "bizarre" message, although they are definitely unconventional. However, closer examination revealed that these statements reflected severe transittivistic experiences of the patient. In fact, he was a marijuana user and felt that his will was paralyzed. On other occasions, he felt vibrations in unison with the cycles of nature. Consequently, the unveiling of the transittivistic quality of his experiences, to which these delusions were linked, qualified the latter as schizophrenia. A comparable situation can sometimes be encountered in the apparently "normal" utterances of a schizophrenia patient.

The patient never omitted to begin the session by some, usually pertinent, remark on today's weather. Each time we tried to scratch beneath the surface of such remark, it turned out that these meteorological utterances were concealing some delusional connotations. For example, "it is hot today" meant "the sun's heat is today too intense for me to move close to you and shake hands with you." And, in fact, while she uttered her "it is hot today," she froze on the doorstep, without giving any explanation to her attitude. [De Waelhens 1972, pp. 137-138]

Kepinski (1974) claims that there is a certain metaphysical taint to the thematic of the delusions in schizophrenia that helps us to distinguish them from nonschizophrenia delusions. Kepinski divides this metaphysical taint into three interrelated trends.

The ontological trend, which concerns the essence of Being and the concept of existence in the cosmos.

The main characteristic of schizophrenic cosmology is its fantastic and magic character....
The schizophrenic world is filled with secret energies, rays, good and evil forces or waves which penetrate human thoughts and direct human behavior. Even though the cultural changes throughout history have influenced the thematic of the schizophrenic world, there are, nevertheless, certain motifs which repeat themselves: a struggle of contradictory forces, the possibility of action per distance, and the pretended character of the perceived world. The world is a place of struggle between forces with moral connotation: good and evil, beauty and ugliness, wisdom and stupidity. It seems as if the patient discovers the essence of reality—Kant's "Ding an sich" (noumenon). According to the patient, other people are ignorant and only aware of the Kantian phenomenon (appearance). The world becomes a caricature of causal connections: there are no independent events—one event is always dependent on another and interacts with the other. [pp. 118-119]

The eschatological trend, which concerns the ultimate issues ("eschatos" means ultimate), such as the end of the world.

The feeling of impending disaster is not rare for a human being. It is usually connected with depressed mood (e.g., depression in which the future is black and one has feelings of total self-insufficiency). However, such moods never reach the apocalyptic intensity of schizophrenia. In the latter case, the impending disaster is preceded by a mood of apprehension: the color of the world darkens, everything becomes ambiguous and threatening. The anxiety increases crescendo; at the climax, there is an explosion: end of the world, wars, cataclysms, chaos, the Last Judgment Day, separation between devils and angels, condemned and saved, good and evil, compatriots and enemies, living and dead, etc. Gradually, this storm calms down, and what is left is heaven or hell, which often are presented in a secular way: ideal political system, concentration camp, life on another planet, etc. The catastrophic atmosphere makes the schizophrenic delusions different from nonschizophrenic delusions. The fact of being spied upon, persecuted, poisoned, etc., acquires a universal quality; if such events are possible, the whole world is against the patient, the whole world has changed. [pp. 120-121]

The charismatic trend, which contains issues concerning the meaning and sense of human life, its true purpose and goal ("charisma" means gift).

The patient is not inactive when the world is exposed to apocalyptic events. He is in the central position of that world. He may feel immortal, immaterial, almighty, as God or devil; the fate of the world depends upon him. The world is threatened by annihilation, and the patient wants to warm mankind, offer himself for the sake of humanity. The meaning of his life reveals itself to the patient: a great mission, an act of heroism, martyrdom. [pp. 121-122]

We would also consider delusions of affiliation as belonging to the metaphysical type of schizophrenia delusions described by Kepinski. Delusions of affiliation confront us with the paradox of continuity or discontinuity in our own history as a human being. Every individual, as a child of two parents, is an original being, provided with unique characteristics both at the biological level and as a member of human society. Therefore, an essential discontinuity exists in the sequence of generations, and no individual can be considered as the pure extension of one of his lineage. Heredity in its broad sense (the transmission of both genes and cultural values and goals) has to face this discontinuity, which delusions of affiliation (e.g., parthenogenetic or of grandiose affiliation) deny (Schmid and Bovet 1988). In summary, Kepinski (1974) states

The presented metaphysical aspects of the schizophrenic world, despite variable details due to cultural influences, remain the same in their essential pattern. This pattern can be found in the oldest descriptions of schizophrenia. To a great extent, this pattern allows us to identify a given case as suffering from schizophrenia. [p. 122]

Müller-Suur (1954) arrives at a very similar conclusion, but his perspective takes into account both the content and the form of experience. Considering content and form as cocontributors, he emphasizes that formal aspects of experience often influence its content.

According to the DSM-III-R, many of those examples from the schizophrenic world would be considered bizarre delusions, on the face of their implausible or, as Jaspers would have said, false content. (Spitzer [1990] notes that this criterion is usually referred to as "impossibility of content," but it is clear from the context in Jaspers' original publication that he is referring to falsity.) However, what Kepinski is denoting as the invariant metaphysical taint of such utterances is, phenomenologically speaking, not only reflected in the content, but also related to the intersubjective apprehension of the speaker’s experience. When De Waelhens’ patient says "The sun’s heat is today too intense for me to come close to you and shake hands with you," it is not the pure content of the utterance that has a delusional quality, because the patient could, in fact, be hesitant to approach the therapist.
because of her sweating and smel-
ing. What constitutes the delu-
sional quality of this meteorologi-
cal statement is its place in the
context of the entire interaction
with the therapist. It is therefore
essential to recognize that the dis-
tinction between content and form
(structure) is only possible to some
degree, and that every item of lan-
guage is embedded in a total Ge-
stalt which communicates to the
Other something of the speaker’s
experience of the world. The co-
stitution of form and content
generally has been neglected by
psychopathology (Müller-Suur
1954).

We propose that the invariant
metaphysical taint in the delusions
of schizophrenia patients conveys
something about the nature of the
dialog between the schizophrenia
individual’s Self and the outer
world. It informs us about the na-
ture of the subject’s being-in-the-
world. It is therefore not the per-
ception per se of the outer world,
nor the conviction per se of the
subject that qualifies these delu-
sional statements as schizophrenic,
but the disturbance of the “Self as
a founding instance,” which is
perceivable in both the subject’s
perception and conviction. The
schizophrenia patient’s autistic de-
fect impedes his ontic tie to the
world and to the Other. Conse-
quently, schizophrenic utterances
become characterized by two inter-
related features: first, the Other in
the dialog is not considered as an-
other ontic being, and, second, the
ontological elements of the com-
munication become quite apparent
and dominating because they lack
ontic embodiment. What we, as
listeners, are confronted with in
such communications is a sort of
“empty ontological matrix.”

As an example, a normal or a
depressed person would convey
his feeling of guilt embedded in a
personal statement, accompanied
by paraverbal signals indicating
guilt feelings, but without any re-
course to the general concept of
guilt. On the other hand, a schizo-
phrenia patient, claiming, for in-
stance, that his breathing is re-
sponsible for the famine in the
Third World, is presenting to us,
through this delusional amplifica-
tion, the very idea of guilt. Due to
a lack of common sense sharing
with others of the notion of guilt,
the schizophrenia patient expresses
feelings in a way that points to
the ontological essence of guilt.

One of Minkowski’s (1927) pa-
tients expressed it very precisely:
“I feel that I can reason quite
well, but only in the absolute, be-
cause I have lost contact with
life.” These ontological qualities
of schizophrenic discourse may also
be perceivable in the way the pa-
ient reveals his conviction:
Whereas a paranoid (i.e., non-
schizophrenic delusional) patient
would eagerly corroborate his de-
lusions by post hoc arguments and
even by presenting some “empiri-
cal” pseudo-evidence, a schizo-
phrenia patient would have diffi-
culty comprehending why any
evidence should be needed at all
(Müller-Suur 1950).

What we are confronted with in
the schizophrenic delusional trans-
formation is a phenomenon of
emergence—the emergence of a
new paradigm, the transformation
of the patient’s being-in-the-world.

Delusional Transformation as
an Instance of Emergence

The phenomenon of emergence is
familiar to all natural sciences and
denotes a situation where a new
qualitative order arises from the
reorganization of essentially un-
changed elements. Clear examples
of emergence are the appearance
of life on earth (molecular compo-
ents of living beings must fulfill
all physical laws, but the phe-
nomena they generate in function-
ing as living organisms depend
on their organization) and the
origin of consciousness in human
phylogeny.

The phenomenon of emergence
makes sense only when the objects
studied are considered as systems,
that is, as unities defined by the
relationships among their different
components.

As human beings, we interact
with other human beings in a way
that can be described as a high-
order coupled system in the
affective–cognitive and linguistic
domains. Such a situation creates
a new coherence in which, though
the participating beings preserve
their individual limits, a new phe-
nomenological domain of abilities
emerges, comprising consciousness
and intersubjectivity (Maturana
and Varela 1988). Self-consciousness
and the sense of the Self as a
found ing instance can emerge only
in the context of intersubjectivity
and historicity (Varela et al. 1991).
The phenomenological notions
of life-world (Husserl 1936/1970a)
and of being-in-the-world (Heide-
ger 1927/1962) and Stern’s (1985)
views on the emergence of Self all
point to the coconstitution of the
Self and the interpersonal world.
The autistic defect is related to an
impairment in this coconstitution.

Delusion formation can be re-
garded as the emergence of a new
structure comprising the deluded
person and his transformed world.
This new structure comprises the
intentional attributions of the pa-
tient and their universal (ontologi-
cal) counterparts in his world. My perception of the world is usually tripartite, comprising me, the Other with whom I interact, and the objects that I perceive and that I know that the Other perceives (or at least could perceive) in a way with which I am familiar. It is an everyday experience that, in our interactions with the world, we attribute some anthropomorphic intentions to other people, animals, and objects with which we are interacting (e.g., if my car “refuses” to start when I am in a hurry). These attributions of intentions are always framed by our intersubjective ties with the Other, by the fact that “we know how the Other knows.” The extent of this framing or limitation of attribution of intentions to the world is highly dependent on the prevalent culture.

Delusion formation begins when such framing dissipates. The major problems of a predelusional, autistic person, as described above, are his weakened intersubjective anchoring and difficulties in self-evident discrimination of the world’s signs. According to Wiggins et al. (1990) the primordial certainty in the invariant, fundamental features of the Self and the world becomes shaken in the early stages of schizophrenia.

In the delusional transformation a disinhibition of attribution of intentions occurs. In the first stage (delusional mood and other initial phases of delusional perception), the disinhibited attribution of intentions to the outer world relates to the patient’s defective self-temporalization, in the sense that he can now “read” from the world indications of his future. The patient, in search of the meaning of his predetermined future, suddenly understands his being-in-the-world by attributing to the elements of his experience some common intention. As we said before, such common intention (“common denominator”) has necessarily ontological qualities.

The phenomena of emergence in the cognitive domain are currently studied within the framework of Prigogine’s theory of “order through fluctuation” (Prigogine and Stengers 1984). Prigogine’s model deals with the thermodynamics of open systems, which are supplied with energy from outside. A trivial example of such a system is the phase transition between the liquid and the gaseous state. In such an open system some of the internal fluctuations can acquire a localized new structure called nucleation (e.g., the formation of droplets of condensation in a gas). Under certain necessary conditions, which are co-determined by the environment and by the system, these fluctuations can amplify and “inform” the whole system. Correlations between normally independent events may appear, letting the latter jump into a new regimen of functioning, into an entirely new structure.

Within this model, the Trema phase can be viewed as a system in a certain field of force, the initial delusional hints as nucleations, and the apophantic phase as a new order through fluctuation.

Conclusions

Phenomenology is a specific way of understanding human consciousness and its world. Phenomenological inquiry is best fit to generate conceptual models derived from an investigation into subjective experience. Such models can both pertain to the essential characteristics of the observable and also point to the existence of nonlinear processes in human consciousness. To be fruitful, phenomenology must keep up a dialectic exchange with the empirical approach. The current situation in psychopathology is that, unfortunately, this dialectic hardly exists. Such a dialectic should strive for a more balanced emphasis on reliability and on meaning (validity). Operationalized criteria are necessary for empirical research, mainly for reasons of reliability. However, even this approach uses data saturated by subjective experiences of the patients. The quest for reliability attempts to reduce this subjective component. In phenomenological inquiry it is precisely this component that generates heuristic models.

From the phenomenological perspective, the development of delusions in schizophrenia can be viewed as the emergence of a new “order of being,” intimately related to the autistic vulnerability. Such a view has both research and clinical consequences for schizophrenia. With respect to research, the issue at stake is the psychopathological demarcation of schizophrenia. In etiological research, we are interested in phenotypic features that can be expected to relate as closely as possible to the underlying pathophysiology. The contemporary descriptive psychopathology focuses on symptoms that seem fairly distant from the putative pathophysiology, and even these symptoms, regarded at the purely descriptive level, lose their diagnostic specificity. The autistic vulnerability, as viewed by phenomenological psychiatry, may be potentially closer to the pathophysiology and more specific to schizophrenia.
With respect to clinical issues, a phenomenological approach has some implications for the conceptualization of schizophrenia as a disease and for its treatment. If we consider the delusional state in schizophrenia as a special form of existence (being-in-the-world), we add a further dimension to the concept of schizophrenia. This new dimension enables the clinician to adopt a multidisciplinary treatment approach. In some cases, one would abstain from treating delusions with neuroleptics, so as not to interfere with the equilibrium of the restructured being-in-the-world. Autism is not amenable to neuroleptic treatment, but can perhaps be modified if the therapist, through his or her personal involvement, amplifies the schizophrenia patient's intersubjective ties.

References


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