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Commentary **Open Access**

Self-disorders: A promising Candidate for Early Detection

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Early intervention for patients with psychosis has attracted an enormous amount of attention during recent decades. Research has shown that the duration of untreated psychosis has a significant effect on a patient's long-term prognosis (1,2). Findings have also highlighted the importance of detecting individuals who are at high risk for the development of psychosis with the purpose of preventing the later transitioning of their conditions into psychosis or schizophrenia (3-6). The current approach that has been applied to detect these vulnerable individuals is the clinical high-risk (CHR) approach. The CHR approach includes the following: brief, limited, intermittent psychotic symptoms (BLIPS); attenuated psychotic symptoms (APS); genetic risk and functional deterioration (GRFD); and basic symptoms (BS).

However, reliable identification of individuals who are at high risk for the development of psychosis has proved challenging. A recent meta-analysis of the prognostic accuracy of the CHR approach emphasized the need to further improve its predictive value (8). In brief, the prognostic value of the CHR approach seems to depend on the examined sample. For example, its utility for a non–help-seeking sample was low, but it was excellent for a sample of help-seeking individuals who had been referred to specialized services (i.e., an enriched sample) (8). In our view, part of the problem is that both BLIPS and APS include near-psychotic or brief psychotic features, so the samples tend to center on individuals in the late prodromal pre-psychotic phase. This renders the CHR approach vulnerable to being criticized for being tautological: it is not surprising that milder psychosis predicts more severe psychosis. Furthermore, the meta-analysis demonstrated that the excellent prognostic value of the CHR approach was mainly mediated by its ability to rule out psychosis (as compared with its ability to rule in psychosis) (8).

A novel and highly promising candidate for improving the early identification of individuals with mental states that have the propensity to unfold into schizotypal disorders or schizophrenia is the concept of *self-disorders* (SDs). SDs are non-psychotic experiential phenomena. During the last two decades, an accumulating amount of empirical studies have shown that SDs constitute a specific experiential vulnerability phenotype of the schizophrenia spectrum (9,10). The idea that SDs form core features of schizophrenia is not new; explicit references to a variety of abnormal self-experiences can be found in nearly all of the foundational texts that address schizophrenia (e.g., Kraepelin, Bleuler, Jaspers, Berze, Minkowski, Schneider). It is important to note, however, that SDs affect the "core" or "minimal" experiential self (11-13). The idea of the *core self* refers to a first-person articulation of experience that is typically thought of as ipseity, selfhood, or "mineness," "myness," or "for-me-ness" (14). It is a sense of self-presence and self-intimacy that implicitly or pre-reflectively permeates an individual's consciousness across the flux of time and changing experiential modalities (e.g., perceiving, thinking, feeling). This sense of self-presence may be described as a feeling of being a self-coinciding subject of awareness and action. This self-presence generally saturates our experiential life, and thus we never wonder if our thoughts, feelings, and bodily movements are in fact *ours;* the question

simply does not arise. Among individuals with schizophrenia spectrum disorders, however, this sense of self-presence is threatened and unstable, which allows a profound form of self-alienation to grow from within the disturbed subjectivity and result in a multiplicity of SDs. SDs include feelings of being ephemeral, of lacking an inner core or nucleus, of not feeling truly present or alive, of not being spontaneously immersed in the shared social world, of perplexity, and of thought pressure or block (15).

Today, SDs are assessed with the Examination of Anomalous Self-Experience (EASE) scale (16). It is notable that certain SDs overlap with BSs; see Appendix C of the EASE scale for details. However, the definitions of the overlapping items are not completely identical. BSs are conceptualized as phenomena that first emerge during the stage that occurs before the onset of manifest illness (17). By contrast, SDs are considered mainly trait phenomena that typically have been present for years before the onset of psychosis and that tend to persist during remission after a frank psychotic episode. From patients' self-reports, we have learned that SDs usually date back to childhood or early adolescence.

Follow-up studies of help-seeking, prodromal, and first-admission patients have shown that the presence of SDs predicts a subsequent schizophrenia spectrum diagnosis (18,19). One study examined a non-clinical population at high risk for schizophrenia and found that premorbid SDs significantly predicted lifetime schizophrenia spectrum diagnoses (20). Another study examined 87 help-seeking, non-psychotic adolescents between 14 and 18 years for SDs and prodromal symptoms; 22% of the participants reported the presence of SDs at clinically meaningful levels. This study lends preliminary support to SDs as relevant and clinically useful tools that can be used to supplement and refine the methods of early detection (21). In our view, SDs offer great promise for the identification of some of the most vulnerable adolescents years before the full and often disabling crystallization of the schizophrenia syndrome. Screening for SDs in help-seeking individuals may contribute significantly to improving the early detection, diagnosis, and treatment of our younger patients. Therefore, we suggest including examination of SDs with the use of the EASE scale as a part of the psychopathological assessment of adolescent patients.

References

1. Hegelstad WT, Larsen TK, Auestad B, et al. Long-term follow-up of the TIPS early detection in psychosis study: effects on 10-year outcome. Am J Psychiatry 2012;169(4):374-80.
2. Penttila M, Jaaskelainen E, Hirvonen N, Isohanni M, Miettunen J. Duration of untreated psychosis as predictor of long-term outcome in schizophrenia: systematic review and meta-analysis. Br J Psychiatry: 2014;205(2):88-94.
3. O'Donoghue B, Lyne J, Madigan K, et al. Environmental factors and the age at onset in first episode psychosis. Schizophr Res 2015;168(1-2):106-12.
4. O'Donoghue B, Nelson B, Yuen HP, et al. Social environmental risk factors for transition to psychosis in an ultra-high risk population. Schizophr Res. 2015;161(2-3):150-5.
5. Schultze-Lutter F, Michel C, Schmidt SJ, et al. EPA guidance on the early detection of clinical high risk states of psychoses. Eur Psychiatry 2015;30(3):405-16.
6. Stilo SA, Di Forti M, Mondelli V, et al. Social disadvantage: cause or consequence of impending psychosis? Schizophr Bull 2013;39(6):1288-95.
7. Fusar-Poli P, Borgwardt S, Bechdolf A, et al. The psychosis high-risk state: a comprehensive state-of-the-art review. JAMA Psychiatry 2013;70(1):107-20.
8. Fusar-Poli P, Cappucciati M, Rutigliano G, et al. At risk or not at risk? A meta-analysis of the prognostic accuracy of psychometric interviews for psychosis prediction. World Psychiatry 2015;14(3):322-32.
9. Nordgaard J, Parnas J. Self-disorders and the schizophrenia spectrum: a study of 100 first hospital admissions. Schizophr Bull 2014;40(6):1300-7.
10. Parnas J, Henriksen MG. Disordered self in the schizophrenia spectrum: a clinical and research perspective. Harv Rev Psychiatry 2014;22(5):251-65.
11. Henriksen MG, Parnas J. Clinical manifestations of self-disorders and the gestalt of schizophrenia. Schizophr Bull 2012;38(4):657-60.
12. Parnas J. A disappearing heritage: the clinical core of schizophrenia. Schizophr Bull 2011;37(6):1121-30.
13. Skodlar B, Henriksen MG, Sass LA, Nelson B, Parnas J. Cognitive-behavioral therapy for schizophrenia: a critical evaluation of its theoretical framework from a clinical-phenomenological perspective. Psychopathology 2013;46(4):249-65.
14. Sass LA, Parnas J. Schizophrenia, consciousness, and the self. Schizophr Bull 2003;29(3):427-44.
15. Henriksen MG, Nordgaard J. Schizophrenia as a disorder of the self. J Psychopathol 2014;20:435-41.
16. Parnas J, Moller P, Kircher T, et al. EASE: Examination of Anomalous Self-Experience. Psychopathology 2005;38(5):236-58.
17. Gross G, Huber G, Klosterkötter J, Linz M. Bonner Skala Für die Beurteilung von Basissymptomen [Bonn scale for the assessment of basic symptoms manual]. Springer Verlag; 1987.
18. Nelson B, Thompson A, Yung AR. Basic self-disturbance predicts psychosis onset in the ultra high risk for psychosis "prodromal" population. Schizophr Bull 2012;38(6):1277-87.
19. Parnas J, Raballo A, Handest P, Jansson L, Vollmer-Larsen A, Saebye D. Self-experience in the early phases of schizophrenia: 5-year follow-up of the Copenhagen Prodromal Study. World Psychiatry 2011;10(3):200-4.
20. Parnas J, Carter J, Nordgaard J. Premorbid self-disorders and lifetime diagnosis in the schizophrenia spectrum: a prospective high-risk study. Early Interv Psychiatry 2014. doi: 10.1111/eip.12140
21. Koren D, Reznik N, Adres M, et al. Disturbances of basic self and prodromal symptoms among non-psychotic help-seeking adolescents. Psychol Med 2013;43(7):1365-76.