

What Is It like to Be a Person with Schizophrenia in the Social World? A First-Person Perspective Study on Schizophrenic Dissociality – Part 1: State of the Art

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Key Words

Cognitivism · Phenomenology · Schizophrenic autism · Social dysfunction · Subjective experience · Theory of Mind

Abstract

This is a critical review of research on the subjective experience of social dysfunction in persons with schizophrenia. Studies from the phenomenological and cognitive paradigms are examined, and significant outcomes and shortcomings are pointed out. Clinical phenomenologists have mainly interpreted schizophrenic dissociality as an anomaly of prereflexive attunement. The main shortcoming of phenomenological research is that it lacks adequate methodology to collect reliable data since most studies are based on the analysis of a few typical cases. Cognitivism has reliably documented disorders of social functioning in large-scale experimental studies. The main shortcoming of most cognitive paradigms is that they do not properly investigate the personal level of experience in real-world functioning. We conclude that there is a need to reliably collect data through quantitative as well as qualitative methodology as established and accepted by the scientific community in the area of schizophrenic dissociality, reflecting the subjective experiences of people with schizophrenia in the real world.

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Introduction

Social dysfunction in persons with schizophrenia is a multifaceted phenomenon encompassing many domains of life, e.g. difficulty with everyday functioning, lack of social contacts, unemployment and consequences of stigmatization [1–4]. A large number of empirical studies have contributed to our knowledge on the features and causes of social dysfunction, providing several instruments to evaluate them, albeit with some inconsistent results [5–9]. These studies have mainly focused on social performance, restricting the phenomenon of social dysfunction to what patients are unable to do, such as behaviours inappropriate for circumstances, lack of affective contact and detachment from social life [10]. As compared with the majority of research on social dysfunction, there is a paucity of empirical reports on the way persons with schizophrenia experience others and sociality. Overlooking subjective states entails two major risks. Exclusively focussing on social *performance* may lead to a strictly behavioural-functionalistic way of conceptualizing the social life of persons with schizophrenia, ignoring reasons and motivations to behave in that given way. Moreover, entirely concentrating on *deficits* in performance may increase stigmatization [11]. In the current literature, the subjective perspective in persons with

schizophrenia is usually assessed as a feature of 'quality of life', a construct that mainly addresses the self-evaluation of well-being and participation or satisfaction in daily activities [12–14]. What will be referred to here as the abnormal subjective experience of sociality is, however, a wider concept than quality of life since it also includes lack of common sense, disorders of inferential perspective-taking, abnormalities of attunement, the tendency to rumination not oriented towards reality, rigid and non-adaptive adherence to idiosyncratic ideas, and the emergence of a deviant hierarchy of values, scopes and ambitions. Studies focussing on patients' self-reports regarding their own social functioning may be inconsistent with information provided by caregivers [12]. To explain these discrepancies, lack of insight, cognitive impairment and depressive symptomatology have been invoked: patients who underestimate their social functioning tend to be more depressed and less impaired in cognitive domains, whereas patients with greater cognitive deficits tend to overestimate their social abilities [12, 14]. This critical review of research on the subjective experience of social dysfunction in persons with schizophrenia is meant to set the stage for an empirical study focussing on the personal level of analysis, on the experiential matrix from which criterion B features arise. Our aim is to improve our understanding of the life-world inhabited by persons with schizophrenia. By doing so we hope to reduce stigmatization and enhance the specificity and validity of the DSM-IV 'social and occupational dysfunction' criterion [15].

The Subjective Side of Social Dysfunction: The Background – Phenomenology and Cognitivism

In classical psychopathology, *autism* is the most famous construct depicting both the schizophrenic patients' detachment from social milieu and their constitution of a private world either filled out by efflorescent imaginative inner life or emptied in a cold rarefaction leaving behind only odd and aloof simulacra. Introduced by Eugen Bleuler [16], *autism* is conceived as a defence mechanism for avoiding the conflicts between desires and reality testing, promoting disengagement from everyday activities, emotional indifference, inappropriate behaviours and dereistic and overinclusive thinking. Kretschmer [17] depicted schizophrenic autism as an *emotional paradox*: a kind of emotional ataxia whose main features are coldness, lack of affective contact with other persons mixed up with irritability and hypersensitivity to social stimuli, social anxiety and avoidant behav-

iour. Kretschmer also introduced autism as the essential psychopathological core of the *schizothymic-schizoid-schizophrenic continuum*, anticipating the notion of schizophrenic spectrum.

Two main paradigms of psychopathological research – phenomenology and cognitivism – investigate the subjective features of the impairments of social life in schizophrenia.

Phenomenology

From the angle of clinical phenomenology, autism implies a disturbance of attunement, i.e. of the ability to perceive the existence of others and to see their mental structure as similar to one's own; make emotional contact and establish mutual relationships; intuitively understand the manifestations of mental life of other persons, and communicate with others using the shared meaning structures in a context-relevant manner [18].

Modern phenomenological accounts of autism mainly draw on Minkowski's [19] and Blankenburg's [20] ideas. Minkowski assumed that schizophrenic autism is a loss of vital contact with reality, including morbid rationalism and the so-called 'antithetic attitude'. Vital contact with reality provides a latent awareness of reality 'making us adjust and modify our behaviour in a contextually relevant manner but without distorting our overall goals, standards and identity' [21, p. 282]. Morbid rationalism is an intellectualistic attitude that consists in governing one's own life according to abstract principles and renouncing the non-rational feelings of harmony with oneself and the outer world. By 'antithetical attitude' Minkowski designates the attempt to avoid all perturbations coming from without the self, feared as an attack to one's own fragile sense of selfhood. Blankenburg characterized autism as a crisis of 'common sense': the lack of an implicit understanding of the axioms of everyday life (the background of tacit knowledge shared by a social group, through which its members conceptualize objects, situations, and other persons' behaviours) and of the natural attitude (being attuned to the world as it appears in everyday experience). These concepts address a pragmatic impairment where what is actually impaired is not just the possession of a sufficient stock of knowledge of the rules of the game of human sociality. Rather, the fundamental disorder is understood to be in our preconceptual and precognitive grip on social situations, a kind of pre-reflexive 'indwelling' in the social world [22]. This basic disorder was described by Mundt [23] as an anomaly of intentionality, i.e. of the capacity to constitute social reality in the dialectics of emotional reciprocity and empiri-

cally investigated in its psychopathological as well as neuropathological features.

Eccentric values in persons with schizophrenia are another aspect of an overall crisis of common sense [24]. The outcome of this has been designated as antagonomia and idionomia. Antagonomia reflects the choice to distance oneself from common sense rules and take an eccentric stand in the face of commonly shared assumptions and the here and now 'other'. Idionomia reflects the sentiment of the radical uniqueness and exceptionality of one's own internal law (*nomos*) with respect to common sense or the other human beings. This may go together with an appreciation of one's own radical exceptionality, which is felt as a 'gift', often in view of an eschatological mission or a vocation to a superior, novel, metaphysical understanding of the world.

Recently, detachment from the lived body has been regarded by clinical phenomenologists as a fundamental phenomenon of schizophrenia, relevant to understanding the patient's existential standpoint and clinical symptoms [25–29].

Since the beginning, phenomenology has developed a distinction [30] between lived body (*Leib*) and physical body (*Körper*), the first being the body experienced from within, my own direct experience of my body in the first-person perspective, myself as a spatiotemporal embodied agent in the world; the second (body-object), the body thematically investigated from without, as for example by natural sciences as anatomy and physiology. Phenomenology conceives of the lived body as the centre of three main dimensions of experience [28]: (a) the experience of my self, and especially of the most primitive form of self-awareness emerging from the basic kinesthetic and proprioceptive experience of one's own body. I experience myself as the perspectival origin of my experiences (i.e. perceptions or emotions), actions and thoughts. This primordial access to myself, or primitive form of egocentricity, must be distinguished from any explicit and thematic form of I-awareness, since it is tacit and implicit although experientially present. Henry [31] uses the term 'ipseity' to express this basic or minimal form of self-awareness. (b) Object-experience and meaning-bestowing; the lived body is not only the perspectival origin of my perceptions and the locus of their integration: it structures and organizes the field of experience, being silently at work whatever I do. I understand my environment as I inhabit it, and the meaningful organization of the field of experience is possible because the active and receptive potentials of my own body are constantly projected into it [32]. (c) The experience of other people, i.e. intersub-

jectivity. Philosopher Merleau-Ponty [33] placed the lived body at the centre of the problem of body-to-body attunement, setting the stage for the understanding of intersubjectivity as intercorporeality, i.e. the immediate, prepredicative, prereflexive perceptual linkage between my own and the other's body – or transfer of corporeal schema – through which I recognize another being as an alter ego and make sense of his actions. Intercorporeality is never fully evident, but it is the bearing support of all interaction connected with behaviour, already active and present ahead of any explicit communication. The perceptive bond between myself and another person is based on my capacity to identify with the other's body by means of a primary perceptive tie. Developmental psychologists support the hypothesis that proprioception is involved in understanding other persons through body-to-body attunement [34]. Empirical evidence from neuroimaging also seems to corroborate this view [35].

Clinical phenomenology has described a list of anomalous experiences coming out from disorder of embodiment: the disembodiment of the self, of interpersonal relationships, and also of the cognitive-categorical schema with respect to its extensional references situated in the social world, and lastly the assertion of goodness (in the ethical sense), and of the need (in the epistemic sense) for principles and morals far detached from the warmth of the flesh (their own and other people's), and of emotions. All these phenomena lead to the hypothesis that the autistic schizophrenic person lives and behaves like a deanimated body or a disembodied spirit [26–28].

In this light, the basic features of autism can be understood as the fragility of the tacit dimension of self-coherence that is at the basis of both subjectivity and intersubjectivity and of the disturbance of emotional participation in the social world. The former is the agonizing feeling of fogginess, of imploding internally, of being unable to cope with social confrontation as a face-to-face relationship with another person – all these leading to social withdrawal. The latter consists in the loss of emotional, prereflexive and prelinguistic attunement with other persons [25–27, 36].

Criticisms of Phenomenological Studies

The main shortcoming of phenomenological research on autism is that it lacks adequate methodology to collect reliable data. The issue of collecting and interpreting data through rigorous methodology, as established and accepted by the scientific community, is generally overlooked [with few significant exceptions, e.g. 23, 37–40]. There are four main features to this:

Idiographism. Most studies are idiographic. They report one or a few paradigmatic or typical cases and look for their essential feature(s). The scientific community is usually sceptical towards this kind of generalization of idiographic data. The outcome of this is that, normally, phenomenological constructs are neither incorporated into the ‘big picture’ of evidence-based science, nor do they generate hypotheses that are received and tested by evidence-based research.

Lack of Operationalized Constructs. Unfortunately, few clinical phenomenologists are interested in operationalizing their generalizations. This is an obstacle to comparing one’s own findings with those of other researchers, and to cumulating data and concepts coming from different researchers. Findings are seldom summarized in clearly defined constructs to promote improvement of operational criteria and standardized assessment instruments.

Lack of Established Procedural Criteria. The main aim of phenomenological research in psychopathology is seeking for the invariances in anomalous experiences and attempting to disclose the essential feature(s) of a given type of phenomenon. The standard way to obtain this is by means of imaginative variations [41], a method whereby the researcher attempts to imagine a phenomenon as being different from what it actually is in order to discover which features cannot be varied without preventing that phenomenon to be the *type* of phenomenon it actually is. Although this kind of conceptual analysis may be shared among investigators and its outcomes are therefore open to rejections and refutations [42], the community of researchers does not share rigorous procedural criteria to check the appropriateness of this process.

Lack of Established Validity Criteria. Another problem, closely related to the previous one, concerns the kind of ‘truth’ clinical phenomenology seeks. This phenomenological kind of truth has its own criteria, different from those of standard quantitative research. These criteria include construct validity, rather than reliability, such as vividness, connectedness, depth and complexity [43]. As with procedural criteria, there is no consensus in the scientific community on which criteria should be included in the list of validity criteria and how should they be operationalized [44, 45].

Cognitivism

Today, cognitivism is the dominant approach to empirical research on social dysfunction in schizophrenia. Its contribution has been developed following two major streams: *neurocognition* and *social cognition*. The first is

a set of abilities for processing abstract clues (words, numbers and symbols) and the second, for elaborating social stimuli (intentions, feelings and behaviour of self and others in diverse social contexts). Neurocognition is a polythetic construct encompassing several subcomponents, the most relevant of which for schizophrenia research are speed of processing, working memory, attention/vigilance, verbal learning and memory, visual learning and memory, reasoning and problem solving [46]. Neurocognitive impairments are well documented in patients with schizophrenia [47–49]. They have been described in early stages of the disease [50, 51], in the prodromic phases [52, 53] and in unaffected relatives [54, 55]. They have been considered the ‘rate limiting factor’ for social recovery [56–58]. It is still under debate whether patients are globally impaired or whether there are specific domains of deficits [46, 59–63].

Social cognition includes various and still debated psychological constructs [64–67], including emotion perception (EP) – the capacity to decipher emotions as they emerge from facial expressions, vocal prosody and bodily gestures – and Theory of Mind (ToM). ToM implies seeing others as possessing intentional states such as beliefs and desires and using these to explain and predict the others’ behaviours. There are two main versions of ToM [68]: *theory theory* (TT) and *simulation theory* (ST). TT [69] postulates that one understands other persons by implicitly employing a theoretical stance, a folk theory of the mind, akin to a scientific theory, consisting in a set of causal-explanatory laws enabling one to infer others’ mental states from the observation of their behaviours. ST [70] by contrast claims that other people’s mental states are represented and understood through imaginatively adopting their perspective and matching these states with resonant states of one’s own. According to ST, the source for one’s understanding of others is not a theory, but one’s own mind that is used to run simulations of the other persons’ behaviours and by so doing understand their mental state. Whilst TT depicts mindreading as a thoroughly detached theoretical activity, ST incorporates an attempt to mimic or impersonate the mental life of others [71]. A version of ST is so-called *embodied simulation* [72]. According to embodied simulation theory, the intentions of the observed person (as well as his/her emotions and sensations) are mirrored in the observer’s body, as if he/she did a similar action.

Patients with schizophrenia display compromised sociocognitive processes, particularly EP and ToM abilities as reported by recent robust meta-analyses [73–75]. These impairments have been documented in at-risk popula-

tions, early stages of disease and in patients' unaffected relatives [76–81]. EP and ToM impairments are correlated with worse functional outcome [82–90].

A list of the main impairments of Social Cognition in persons with schizophrenia, as described by cognitive scientists, includes impairment in Social Perception [91–94], i.e. the ability to get 'the big picture' of the social game (e.g. to infer 'precipitating events' or to correctly appreciate contextually relevant information), in Attributional Style [95, 96] and Social Knowledge [97, 98]. Also, the ToM mechanism has been considered a preeminent feature of the entire Social Cognition constructs [99–102] and has been invoked to mirror all empathic abilities in humans [103, 104]. Broadly defined, empathy in this research context is considered to be multidimensional in nature, involving cognitive and emotional processes (perspective taking or inferential thinking and concerns for others or emotional sharing) [105, 106]. Inferential perspective taking and pure affective empathy have appeared to be associated with overlapping but distinct neuronal networks [65, 107] and are currently evaluated with different laboratory paradigms, e.g. Hinting Task and Eyes Test [108, 109].

In contrast to the view that the affective facet of ToM 'may be in fact an empathic response' [104, pp. 19], Bora et al. [103] argued that empathy is not evaluable via emotion recognition tasks like the Eyes Test. What is really evaluated through these tasks is the cognitive side of empathy, or some specific forms of mentalizing (mental state decoding and mental state reasoning), the affective side of empathy, the immediate emotional sharing, being very difficult to assess via direct objective measures.

Some researchers [110–112] have emphasized the importance of the cognitive facet of empathy to explain social deficits in terms of ToM. Many of these accounts, however, do not say enough about the role of emotions in social cognition processes [104]. As mental states are inseparable from emotional processes and 'in many if not all cases, human social and emotional behaviors are highly intertwined' [113, p. 48] any account of social impairments in persons with schizophrenia should include the role of emotions [104]. Emotion processing is a major determinant of social outcome in schizophrenia such as Emotion Recognition [83–89], anhedonia [114, 115] and particularly the anticipatory pleasure experience [116], motivation [117, 118], recently regarded as the critical feature of negative syndrome [119] with respect to functional outcome. To note, persons with schizophrenia display relevant impairment in the integration of affective and cognitive ToM skills [120], and affective ToM tasks have

appeared to be more predictive of social functioning in people with schizophrenia [84].

Criticisms of Cognitive Studies

The main shortcoming of the ToM paradigm is perhaps that, since it is mainly based on laboratory assessment of social performance, it does not properly investigate real-world functioning [121–123]. The following is a list of criticisms that can be addressed to the cognitive paradigm in the study of schizophrenic dysociality, organized along three main topics: inconsistent results, methodological problems and problems with research design.

Inconsistent Results

- Different studies show inconsistent results. It is debated whether social dysfunction in schizophrenia is better predicted by symptomatology or by cognitive impairments [124–129]. It is still unclear which cognitive impairments are more relevant, neurocognitive or social cognitive variables [82, 84, 102, 130–132]. The extent to which social cognition is independent of neurocognition is also unresolved [102, 133–136].
- Which neurocognitive subcomponents correlate best with functional outcome is also a matter of debate. The candidates are verbal memory, executive function and verbal fluency [137]; sustained attention and speed of processing [138], and single subcomponents such as verbal memory [139], attention [140, 141] and speed of processing [142].
- Although with some exceptions [143], the variance explained by cognitive paradigms (neurocognitive and sociocognitive) is relatively small [86, 92, 138, 144, 145]. Correlations between individual neurocognitive abilities and functional outcomes are generally moderate, and even composite measures of neuropsychological performance rarely account for more than 25–50% of the variance in real-world functional outcomes [125]. Similar evidence emerges from a review of correlations between sociocognitive constructs and social outcome [102].
- It is still debated to what extent the relationship between neurocognition and functional outcome may be a linear causative process that leads from disorders of neurocognition to social dysfunction or to what extent it may be mediated by a supervening set of social cognitive abilities [57, 85–89, 92, 93, 142–146].
- Finally cognitive paradigms (neurocognitive and sociocognitive) have been unable to maintain a clear-cut Kraepelinian dichotomy of psychoses. Neurocogni-

tive deficits have also been documented (although to a lesser grade) in bipolar patients. Also, bipolar patients display impairments in ToM and EP similar to those reported in patients with schizophrenia [147–157].

Methodological Problems

- With respect to Social Cognition constructs, diverse tasks have been produced whose psychometric properties have not been adequately investigated [67, 73, 76].
- Also, instruments to assess neurocognitive performances produce variables that have overlapping features, for example attention and processing speed are critical to performance on tasks of verbal memory or executive skills [142].
- Classical tasks used to assess impaired ToM ability are considered too complex. These tasks are often considered developmentally inappropriate since they make large demands on verbal abilities and explicit problem-solving skills, and involve after-the-fact reflection as opposed to spontaneous mentalizing [123, 158, 159].
- It is documented that Social Cognition tasks are correlated with neurocognitive abilities such as IQ, working memory, executive functions and attention [73], executive functions and IQ [160], episodic and working memory [85, 89], early visual processing [93], executive functions [161] and vigilance [162]. Thus Social Cognition tasks require neurocognitive abilities. The question here is to what degree social cognition tests account for neurocognitive abilities, and not just for social cognitive ones.

Problems with Research Design

Social Cognition research designs are conducted by recreating real-world social interactions in laboratory settings; as such, it is a matter of debate whether they properly investigate real-world functioning and personal and ‘embedded’ coping strategies to perform real-life tasks. Indeed *in clinical settings*, but not in laboratory settings, patients with schizophrenia seem to exhibit intact ToM skills in conversational interactions, appropriately report first- and second-order mental states of others, and design their contributions to conversations on the basis of what they think their communicative partners know and intend [121]. Thus, in a clinical setting, patients can use ToM abundantly and appropriately [121]. This ‘makes clear that a simple ToM deficit account of schizophrenia is inadequate. Actively psychotic patients retain subtle interactional abilities that depend on their ability to reason about their own and others’ mental states’ [121, p. 412].

Recently, using social stimuli via videotaped realistic social scenarios, patients with schizophrenia displayed specific, rather than general, ToM impairment, limited to sarcastic and insincere social exchanges [163]. Also, clinical studies demonstrate that persons with schizophrenia are aware to be impaired in empathic abilities, and recognize the others as intentional agents: self-report measures show that they are able to admit general (affective and cognitive) impairments [103, 104, 163], impairments limited to the cognitive (perspective-taking) facet of empathy [164].

In conclusion, people with schizophrenia seem to have no general difficulties in recognizing other people as intentional agents whose behaviour is subtended by intentional mental states – that is the core supposed disturbance in childhood autism [165]. Whatever ToM deficit there may be in schizophrenia, this appears to be very different from the one occurring in childhood autism as also documented by the marked differences in the clinical pictures.

Conclusions

Studies on Social Cognition usually sidestep the experiential quality of conscious mental life and are committed to an idea of cognitive functioning depicted as an input-output device based only on its processing properties. Also, they sometimes seem to endorse a disembodied and disembedded conception of mental processes that are neither taking place within the lived body (especially the emotional body) nor interacting with the environment. In the last two decades, cognitivism has contributed robust and well-replicated data on disorders of Social Cognition in persons with schizophrenia, documenting disorders of emotion recognition and of the ability to get ‘the big picture’ of the social game – although different studies may show divergent results. As we have seen, the main shortcoming of cognitive paradigms is perhaps that, since they are mainly based on laboratory assessment of social performance, they do not properly investigate real-world functioning and the personal level of experience – *what it is like* to be a person with schizophrenia in the social world. Social and neurocognition research designs are mainly interested in bridging social behaviour (e.g. mindreading or mindblindness for ToM paradigms) with the working of a subpersonal mechanism (e.g. a module), rather than depicting the personal-level of experience. The ToM paradigm encourages the assessment of social *performances* but does little to frame the investigation of

the *personal experience* one has of such performance. For instance, it measures the accuracy in attributing mental states to other persons in a task of false beliefs but does not describe the person's experience in attributing mental states to others. As recently stated by Montag et al. [164, p. 87], 'subjective perception of social cognitive, i.e. empathic abilities in schizophrenia deserves further research'.

Since the works of Eugen Bleuler and his followers, this has been the task of phenomenological psychopathology. As recently stated by Andreasen et al. [166, p. 708], 'having been 'lost' or ignored for a number of years, several features of Bleuler's thinking are now reemerging (...) Bleuler believed that the inability to relate empathically to others [autism] was one of the primary or fundamental symptoms of schizophrenia. He considered this symptom to be far more important than the delusions and hallucinations given so much emphasis in current diagnostic criteria'. For almost one century, phenomenology has argued that sociality is chiefly an embodied and embedded practice. Clinical phenomenology has always considered autism an essential, defining feature of schizophrenic disorders, and has studied the subjective experience of persons with schizophrenic autism. It has mainly interpreted autism as an anomaly of immediate, prepredicative, prereflexive attunement. This complex phenomenon

is not easily amenable to a rigorous operational definition and it is difficult to be investigated via purely quantitative empirical methods. Also, its subjective side – *what it is like* to be affected by poor prereflexive attunement – is still inadequately investigated. In addition to this lack of a richly detailed and operationalized construct for schizophrenic autism, phenomenological research on schizophrenia suffers from serious methodological inadequacies: idiographism, lack of established procedural criteria and lack of established validity criteria.

Thus, there is a need to collect data, through quantitative as well as qualitative methodology as established and accepted by the scientific community, reflecting the subjective experiences of dissociality in people with schizophrenia in the real world. Reconsidering the concept and the multifaceted aspects of schizophrenic autism by improving the methodology of phenomenological research may represent a way to grasp the core feature of schizophrenia [167], thus establishing links between the persons' subjective experience and experimental measures of core mental dysfunctions [168]. This has obvious ethical implications – reducing stigmatization by improving our understanding of the world persons with schizophrenia live in – and epistemological ones – enhancing the specificity and validity of the construct 'social and occupational dysfunction'.

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