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Minimal Self Disorders in Schizophrenia

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SUMMARY

In recent years we have witnessed a rebirth of interest in the field of subjectivity and its disorders, particularly the severity and quality of non-psychotic abnormal subjective experience. Contemporary research on abnormal subjective experiences in schizophrenia has used several different theoretical frameworks. The most common of these is the phenomenological approach. A prominent example of the phenomenological approach is the minimal self disorder model. In this article, first of all, prominent theories about the self and the historical background of the minimal self disorder model in schizophrenia and then the current approach to this model is discussed. According to this model self disorders have been hypothesized to be an underlying and trait-like core feature of schizophrenia. The model suggests that this minimal self is disturbed in three ways in people with schizophrenia: hyperreflexivity, diminished self-affection (diminished self-presence) and disturbed grip or hold on the cognitive-perceptual world. Hyperreflexivity is an excessive attention to processes that would ordinarily be implicitly experienced. Diminished self-affection (diminished self-presence) refers to an experience of a loss of self-agency. Disturbed grip or hold on the cognitive-perceptual world refers to disturbances of spatio-temporal structuring of the experiential field. The three aspects are intimately interlinked, and should be understood more as aspects of a single whole. Finally, clinical symptoms that may indicate minimal self disorder and the abnormal self experiences of two patients with a diagnosis of schizophrenia are discussed.

Keywords: Schizophrenia, phenomenology, self-disorders, hyperreflexivity, diminished self-affection

INTRODUCTION

Schizophrenia is a heterogenous clinical syndrome and it shows significant psychopathological differences and changes both during a patient's illness and among different patients (Silveira et al. 2012, Silverstein et al 2014, Tandon 2014). While current diagnostic classifications examine this complex phenomenon a diagnostic approach based on the presence or absence of a limited set of signs or symptoms that have been selected by consensus from field professionals is adopted. Especially since DSM-III, this approach has started to become dominant, interrater reliability has begun to be emphasized more, and the more complex and evidence-based assessment of mental or experiential life has been replaced by the definition of operational symptoms and diagnostic criteria (Andreasen 2007, de Leon 2013, Kendler 2009, Stanghellini 2009, Marková and Berrios 2009). However, this approach, which was expected to eliminate the problems in research and treatment, could not fully solve these problems, and caused patients with different clinical symptoms and appearances to be included in the same diagnostic categories and raised questions about validity (Insel 2010, Kendall 2011, Naber and Lambert 2009, Parnas et al.2013, Tandon 2012, Tyrer and Kendall 2009). Despite the long history of debate about the diagnosis of schizophrenia, an approach whose consistency and applicability are unquestionably accepted has yet to emerge (Borda and Sass 2015).

In terms of philosophy of knowledge (epistemology), mental symptoms in psychiatry have a more important quality and meaning than "medical symptoms" in medicine. In the process of coming to today's medicine, medical / somatic symptoms have gradually left their places to "biological indicators"; whereas the situation for mental symptoms is very different (Marková and Berrios 2009). Marková and Berrios (2012) emphasize the need to generate a psychiatric epistemology that makes it possible to look at both structural (synchronic) and temporal (diachronic) relations between mental phenomena in mental clinical syndromes. In terms of meeting such a need, theoretical and empirical explanations about self disorders are seen as good

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candidates. As a matter of fact, some of the empirical studies on this subject demonstrated that self disorders are more associated with schizophrenia than other psychotic disorders that are outside the schizophrenia spectrum and that this relationship is independent of the presence of overt psychotic symptoms (Handest and Parnas 2005, Haug et al.2012, Nordgaard and Parnas 2014, Parnas 2014). 2005), and many other studies reveal that self disorders are seen in all stages of the disease, including pre-illness and recovery periods in schizophrenia (Davidsen 2009, Møller and Husby 2000, Nelson et al.2012, Parnas 1999, Sass and Parnas 2003), so that self disorders as a *phenotypic marker* of the schizophrenia spectrum has sparked a great interest. As a result, the concept of the self has been included in the beta version of ICD-11 (WHO, 2018) as a defining feature of schizophrenia, although it has not been included in diagnostic guidelines for a long time.

Self is a very broad and ambiguous concept as a term. However, the "minimal self" expressed here refers to the pre-reflective and direct or immediate consciousness of action, experience, and thought as a concept widely discussed in neuroscience, philosophy of mind, and phenomenology (Nelson et al.2020). It is important to distinguish the word "reflective", derived from the word "reflection", which is frequently used in the article, from the concept of reflexive thinking / consciousness, which refers to the consciousness being conscious of itself, that is, the mind itself can be both its own subject and object (Cevizci 2005). It should also be noted that the concept of "minimal self" here is different from the concept of the self which is described as "narrative" or "social" self discussed in the psychology of self. Unlike the minimal self, which expresses the pre-reflective consciousness of action and experience, the narrative / social self contains reflective and metacognitive processes. As will be mentioned later, the narrative / social self expresses characteristics such as social identity, personality, habits and background, and psychological concepts such as "self-esteem" and "self-image" indicates the level (Nelson et al.2014).

In this article, firstly, theories about the self, the historical background of self disorders in schizophrenia and the current approach to this subject will be briefly discussed. In the last part of the article, along with the clinical symptoms indicating self disorders, the subjective experiences of two outpatients who we monitored in Hacettepe University Psychiatry Clinic, conducted in-depth interviews and recorded with a voice recorder will be examined. The first of the patients is an early-stage schizophrenia patient with delusions of grandeur, without hallucinations, disorganization, and negative symptoms, while the second is a schizophrenic patient with negative symptoms, who did not report any positive symptoms or signs of disorganization, since having been on clozapine treatment for the last two years. The reason for choosing these patients is to reveal that abnormal self-experiences can be found in different stages of the disease and to evaluate the quality of these experiences.

Theories About the Self

Many theories have been put forward about the self. However, it is possible to group all these theories under three main headings.

The first of these is the theory that suggests that the self does not exist. The Scottish philosopher David Hume (1888), one of the leading representatives of this approach, said: *"I think that if I go closest to what I call the self, I always think that warmth or coldness, light or shadow, love or hate, pain or pleasure or I hit the particular perception of this. I can never catch myself without a perception, and I can never observe anything other than perception."* In other words, according to Hume, beyond all those conscious states and processes, there is no self as a being with those conscious states. German philosopher Nietzsche (1904) claimed that the subject consists of a fiction, and that the "I" mentioned in denouncing selfishness does not even exist. A similar approach is found in 20th century philosophy in the announcement of the "death" of the subject by structuralist and postmodern philosophers. According to this subject or self; it is a "decentralized" passive location where historical, ideological and socio-economic forces and discourses intersect (Parnas and Henriksen 2019).

The second theory about the self is the "minimal (experiential) self" theory, which is mostly discussed in phenomenology-based approaches. At this point, we would like to briefly mention phenomenology-based psychopathology. First of all, it should be noted that what is mentioned in this article is not used in the sense of phenomenology, which is used synonymously with descriptive psychopathology in Anglo-Saxon psychiatry, which aims to define the symptoms and findings in psychiatric diseases, and this descriptive process is performed by an impartial and "objectifying" observer. In this article, the phenomenology, which is the continuation of the phenomenological psychiatry of Karl Jaspers (1959), tries to understand the subjective lives of the person with his statement, and represents a radical break from the sharp subject-object, mind-body and affect-cognition dualisms of the Cartesian tradition. (Bovet and Parnas 1993). According to this phenomenological approach, the self can only be detected simultaneously with experiences. That is, in this approach, the self cannot be understood in isolation from experiences and does not have certain experiential qualities on its own. Moreover, the self shows itself pre-reflectively in every experience as a certain "form" of experience (Parnas et al. 2005, Parnas and Henriksen 2019). This "form" of experience is the first-person perspective and sense of agency in every experience (Gallagher 2011). Accordingly, I perceive my actions, perceptions and thoughts as mine, live every experience in the I mode, and see myself as the source / subject of my actions and their consequences.

In addition, I do not need to think thoroughly to know that my thoughts, perceptions and actions are "mine", I know them pre-reflectively (Nelson et al.2020). This pre-reflective sense of self, which accompanies my experiences everywhere, is the foundation on which richer, more complex forms of the self, such as personality or narrative, have been built throughout my life (Henriksen and Parnas 2014). Moreover, this minimal sense of self can be described as the cause of the sense of integrity and continuity of identity at a particular time and at different times, the distinction between self and non-self, and a sense of uniqueness (Parnas and Henriksen 2019).

The third theory about the self is the "narrative self" theory. "Who am I?" "I am AB, in this age and in this body, I have these special preferences, values, tendencies, that temperament (including cognitive abilities, knowledge, temperament traits) and character." an answer like "narrative self" corresponds to. The narrative self is a product of numerous interactions with other people (especially childhood caregivers) and objects throughout life. The narrative self is highly language and culture dependent and is the most complex and sophisticated form of personality. There is no contradiction or tension between the above mentioned minimal self and the "narrative self"; moreover, the minimal self enters into this narrative structure as a precondition by structuring experiential life styles, and in this respect forms an aspect of the "narrative self" (Parnas and Henriksen 2019).

Self Disorders in Schizophrenia

Historical Background

In addition to the recent interest in the term self in the psychopathology of schizophrenia, many of the important figures of classical psychiatry in the 19th and early 20th centuries attached great importance to self disorders (Zahavi 2019). Chung (2007) states that in this period, the disorder of the self in schizophrenia was described with the concept *of "the affliction of the self".* Again in this period, it was customary to think of schizophrenia as the disruption of the perception of different dimensions of consciousness in unity (Stip 1997, Parnas 2011). Emil Kraepelin, who made the most prominent contributions to schizophrenia in the history of psychiatry, stated that although he looked for a descriptive feature of schizophrenia in the descriptive features of the disease, schizophrenia has "disunity of consciousness" and that schizophrenia resembles an "*orchestra without a conductor*" (Chung 2007). Parnas and Henriksen (2014) explain that Kraepelin's approach points to disorders of the self and that self disorders and disruption of the unity of consciousness are interrelated concepts with the following example: *"As I type this article, my current field of consciousness consists of various dimensions, including functions such as thinking, perception, movement, and visual, tactile, and proprioceptive stimuli. Their coherence or unity is determined by their being my experience; they all appear in a single field of awareness, in a single subject's field, that is, in my field ".* Eugen Bleuler also considered the basic disorder in personality as one of the main characteristics of schizophrenia and stated that the disease invariably caused an affliction of the self (Parnas and Handest 2003). Moreover, Bleuler mentioned the phenomena of transitivism, changes in the awareness of the body, thought insertion, and loss of boundaries in space and time, which are prominently included in the recent explanations of self disorders (Maatz and Hoff 2017). Minkowski, a student of Bleuler, said, *"madness... judgment is not caused by disorders of perception or will, but by disruption of the innermost structure of the self"* (Zahavi 2019). Again, as will be stated later in the article, he put forward ideas that are very close to the concepts of today's phenomenological psychopathology. Karl Jaspers, on the other hand, used the Ichstörungen (self disorders) concept for the description of schizophrenia and stated that it is not possible to understand the experiences of schizophrenic patients empathically because the sense of self is radically changed, impaired or lost in schizophrenic patients. Kurt Schneider accepted a radical qualitative change in the field of consciousness as a generative matrix of the first-rank symptoms. Schneider suggested that some self-experience disorders show high specificity to schizophrenia, and that in these self disorders, experience is determinant in the first personal givenness *(Ich-heit)* or *mineness (Meinhaftigkeit)* disorders. A similar approach to self disorders is also seen in diagnostic manuals. For example, in ICD-8 and ICD-9, which was valid until 1992, schizophrenia is described as a fundamental disturbance of the *personality*. These most basic functions that deteriorate in the personality are those that normally give the person a feeling of *individuality*, *uniqueness* and self-*direction*. What should not be disregarded here, however, is that the term "personality" in ICD-8/9 was borrowed from the writings of Karl Jaspers and Kurt Schneider, originated from the psychiatry and psychology of the first half of the 20th century, and the term used as personality in that period is temperament and usual characteristic that corresponds to the self or subjectivity we use today (Parnas and Henriksen 2014). Josef Parnas and Louis Sass (2003), today's representatives of phenomenological psychopathology, further developed these ideas by arguing that schizophrenia involves very basic transformations and changes in the sense of self and that such disorders of the self play the role of a pathogen that generates psychopathological symptoms.

Current Approach

Today, the phenomenology-based approach focuses more on the disruption of the pre-reflective and immediate consciousness of action, experience, and thought, in short, disorders of the minimal self. According to Sass and Parnas (2007), this approach is different from both traditional and current schizophrenia approaches. While classical

descriptive psychiatry, one of the traditional approaches, sees schizophrenia as a type of dementia in which cognitive capacity is generally decreased; The psychoanalytic approach sees schizophrenia as a regression to infantile or instinct-ridden forms of consciousness. Current approaches, on the other hand, base the symptoms of schizophrenia on mechanisms that are independent from each other or loosely related to each other. However, unlike the others, the minimal self disorder model is holistic and unifying, so it can be demonstrated at every stage of schizophrenia and in each of its positive, disorganized, and negative symptoms. In fact, in continental Europe, starting with Kraepelin and Bleuler, the basic features that can be seen in all areas of the consciousness of the schizophrenic patient, and in all stages of their illness are defined by the following concepts and terms: "disunity of consciousness (Emil Kraepelin)", "discordance (Henri Ey)", "intra-psychic ataxia (Erwin Stransky)"," autism (Eugen Bleuler) "," loss of vital contact with reality (Eugène Minkowski)"," cognitive dysmetria (Nancy Andreasen)". The common aspect of these definitions is that they point to a permanent change in the structure of subjectivity, not to a limited and temporary pathological mental content, unlike current approaches (Parnas 2012). We see another approach similar to these identification efforts in the recent definition of "basic symptoms". "Basic symptoms" refer to subjectively experienced disorders in mental processes such as thinking, speaking, attention, perception, impulse, stress tolerance and affect (Klosterkötter 1992).

In conclusion, rather than treating schizophrenia as a set of symptoms and signs independent from each other, the minimal self-disorder model aims to define it with the basic features that operate in all areas of consciousness and manifest themselves in the entire disease (Parnas 2011).

There are three intersecting aspects of minimal self disorders in schizophrenia.

Hyperreflexivity: Normally some of the person's sensations and thoughts are experienced in an implicit or automatic way. For example, when standing, I don't feel the ground my feet touch; I can only feel it if I direct my attention on my feet. When I think, I automatically know that a thought is generated by my mind. However, in schizophrenia these processes become unfamiliar and obvious to the person: Especially in the early stages of schizophrenia, they become processes that should be considered in a way that the patient cannot prevent (Grünbaum and Zahavi 2013, Sass and Parnas 2017). Because anything or a process foreign to the self draws the person's attention completely in that direction. The person begins to pay attention to these processes that are ordinarily considered normal and do not attract attention. This is a mental state that is not created by the person himself, which influences the person and strongly attracts their attention (Lewis et al.2019).

Diminished Self-affection or Diminished Self-presence: In this case, the person's "feeling of being a subject of an action" and "awareness of self" decrease. In the former (reduced sense of being subject of an action) thoughts, feelings and actions appear to operate anonymously or mechanically. In the second (decrease in self-awareness), there is a constant feeling of emptiness, a feeling of lack of identity, or the person feels fundamentally different from others (Parnas et al.2005, Sass 2014).

Disturbed grip or hold on the cognitive-perceptual world: It refers to the disturbances of the spatial and temporal structure of the experiential field. In this case, it is not known exactly whether any experience was actually experienced, and the person cannot distinguish between memories, real perceptions or imaginary experiences (Sass and Parnas 2017).

In schizophrenia, the first two of these three aspects of the minimal self disorders (hyperreflexivity and diminished self-presence) are perhaps necessarily accompanied by changes in relationships with objects or in the field of awareness (i.e. disturbed grip the cognitive-perceptual world). Because it is a pre-reflective self-presence and first-person perspective that provides the ground from which objects and meanings emerge (Sass and Parnas 2017). At this point, it will be useful to include Minkowski's thoughts. According to Minkowski, in schizophrenia, while there is a "loss of vital contact with reality" on the one hand, on the other hand, there is an exaggeration in the intellectual, spatial or schematic modes of consciousness and expression, in his own words, a "hypertrophied intellectualism". The transformation experienced in the loss of vital contact with reality affects the perception of reality and the vitality of the self. As can be seen, this situation is closely related to the " diminished self-affection" stated above. Another case, " *hypertrophied* intellectualism", has two aspects: an interrogative attitude and a tendency towards some kind of geometric or semi-mathematical abstraction. It is worth noting that this trend lacks vitality and flexibility. Although Minkowski does not particularly emphasize the increased awareness of the self, it should be clear that his concept of " *hypertrophied* intellectualism" captures at least certain aspects of the above-mentioned " hyperreflexivity" (Sass 2001).

Clinical Symptoms and Case Studies

There are some basic features of the clinical manifestations of minimal self disorders in schizophrenia.

First, there is a trait-like quality of abnormal self-experiences in schizophrenia. In other words, the trait-like character of abnormal subjective experiences emerges as a constant or recurring infrastructure of the patient's conscious life. This infrastructure determines the form (how) of the experience

rather than the content (what) of the experience (Parnas and Henriksen 2014).

Second, the onset of patients' experiences with self disorders often goes back to childhood or early adolescence. Likewise, many self disorders have vaguely entered the patients' style of experience during the first admission of the patients. At least in part for this reason, patients do not usually perceive initial self disorders as a "symptom" of a disease. Patients tend to perceive self disorders as an intrinsic feature of their existence, that is, as an aspect of how they experience themselves, others and the world (Parnas and Henriksen 2014). This may offer a new framework for understanding poor insight into the disease in schizophrenia (Henriksen and Parnas 2014).

Third, experiences of self disorders are generally not psychotic phenomena. Although the crystallization of psychosis in schizophrenia is associated with initial disorders of the self, symptoms of self disorders may not be experienced at the psychotic level. Experiences of self disorders are often expressed by patients as experiences of an "as if" nature (for example, "I feel as if I don't have a soul" or "I feel as though the thoughts are not from me"). In other words, it cannot be said that the reasoning of the person is impaired in such situations (Parnas and Henriksen 2014).

Fourth, patients often see their self disorders at the center of their illness, and self disorders cause more distress than psychotic symptoms (Møller and Husby 2000). Patients often report that no one talks to them about their subjective lives and experiences, and they are surprised when patients are asked about these experiences. In this context, it should be noted that interviews with patients to address their self disorders may have a healing value in alleviating their existential loneliness (Parnas and Henriksen 2014).

Finally, it is not possible to acquire patients' experiences of self disorders with a structured set of questions. Rather, it requires a phenomenologically adequate conversation aimed at establishing harmony and trust (Parnas and Henriksen 2014).

Case Studies

Patient One: "The experiment is over, you can all die."

Patients with schizophrenia often complain of nonspecific symptoms such as depression, fatigue or difficulty focusing in the early stages of their illness. However, when this symptom of a patient suffering from fatigue is evaluated in detail, it may be revealed that the patient's fatigue is related to a widespread inability to comprehend the everyday meanings of the world (Parnas and Handest 2003). Blankenburg calls this "nonspecific specificity". This implies the presence of "inability to grasp the meanings in the world", which is specific for schizophrenia, within a symptom such as fatigue that is not specific for schizophrenia (Mishara 2001). Similarly, the patient in question also complained of forgetfulness and not being able to learn new information during classes. When asked to elaborate a little, he said, **"I cannot penetrate anything around me, everything seems the same to me, whether it is time passing, I go somewhere else, it is a holiday, but everything is the same for me. Every detail of this interview is in my mind now, but then I will forget it".** Based on this statement of the patient, it can be said that the patient's nonspecific symptom such as forgetfulness is related to a condition specific for self disorders in schizophrenia, such as diminished self-presence. Because the most important characteristic of the diminished self-presence, especially in the early stages of the disease, is the feeling that it cannot fully penetrate the patient's experiences. In this situation, the patient feels as if there is a temporal or spatial distance between himself and his experiences. The patient can also describe this situation with neutral, ordinary expressions such as "I do not feel myself" or "I am not myself": It can also be described in terms such as "I am becoming inhumane", "I am transforming into a creature", "I feel like a living dead", "I feel like a strange ghost from another planet" or "everything feels the same or neutral to me" (Møller and Husby 2000). The patient was aware that the complaint of forgetfulness was not an ordinary thing, so he had done a lot of research on the subject on the internet. He finally found that the diagnosis best suited to his complaints was 'dyslexia' (the patient had never been diagnosed with dyslexia). The patient attributed many of his abnormal experiences to 'dyslexia'. The patient had changed many schools, when asked why he left his university department last time, he said, **"I could not do it either, after a certain place, I thought I had dyslexia and I also had learning difficulties. I mean, I am learning something, but I started to forget it in the same term. I mean, I was forgetting, something I knew it had been since I was little. I left him like that. "**. As mentioned before, patients with schizophrenia often state that their experiences with self disorders have started in childhood or early adolescence. Likewise, as mentioned above, schizophrenia patients may suffer more with issues related to self-disorders than psychotic symptoms. Although this patient also had delusions, the patient was only asking the treatment team to treat his "dyslexia" and said, **"I have schizophrenic symptoms but I can keep them under control, sometimes someone is watching me, sometimes I feel someone is listening to me, but maybe I mean, it seldomly occurs. So little. I can control. But my main problem is learning disability. "** In addition to the "dyslexia" explanation that the patient assigned for the complaint of forgetfulness, he explained the feeling that he was existentially different from all other people and brought an evidence of his difference in the experiential field as **he had the gene for cannibalism and did not eat human meat before, but he liked to eat human meat.**

Møller and Husby (2000) observed that early schizophrenia patients were overly preoccupied with philosophical, supernatural, and metaphysical themes. This situation may arise from the need for the individual to redefine and analyze everything due to the background of the experience that has changed as a result of the disorder of the minimal self. The search for a transcendental meaning (i.e. the search for metaphysics) is of course not limited to schizophrenia, it is a distinctive and pervasive feature of the human species. This search of man is fueled by a human paradox, which the contemporary German philosopher Dieter Henrich calls "basic relation". Accordingly, while we experience ourselves as spiritual, unique and autonomous beings; on the other hand, we also experience them as mortal and causally determined beings belonging to the world order (Parnas and Handest 2003). However, the instability of the self described hitherto disrupts the experiential balance normally characteristic of the "basic relationship" and intensifies the metaphysical search, leading to "existential reorientations" described by Møller and Husby (2000). The way patients re-experience existence can often change in the following ways: Reality seems somewhat dependent on the person's mind; physical causality in nature loses its regulating role; "other minds" become either mysterious beings or malevolent structures, the subject-object distinction becomes blurred, normally implicit the mental processes that will remain are subjected to an introspective gaze (Parnas and Handest 2003). At this point, the term "solipsism", which expresses a paradoxical mixture of the subjectivization of the world and others and the dispersion of the self, reflects such a position well. Solipism is a term derived from the Latin words "solus", which means one and only, and "ipse", which means self. This term refers to a position in the philosophical literature claiming that only my consciousness exists. In this case I can never be sure whether the world and other minds exist; at best they are creations of my own mind. This is a position motivated by a profoundly altered experience of the self and points to a new existential orientation. The solipsistic position often requires a unique sense of access to deeper and more fundamental layers of reality that other people cannot. Hence, it can be a quite different kind of grandiosity: the patient sees other people as pathetic, ontologically ignorant morons, pursuing only the superficial and material aspects of being (Parnas and Handest 2003). Our patient's metaphysical, supernatural, and philosophical pursuits were also intense. He described some of his experiences in philosophical terms (such as alter ego); he thought that he and the Prophet of Islam, Mohammed, shared the same mission, and both were the ultimate purpose or reason for existence of this world. He described these experiences as follows:

I am aware of everything at all times, so how should I explain, I am the ultimate human being, mentally or physically, so I am always aware of everything. I mean, I don't need to look at this (referring to the chair armrest), I also know this perception with my eyes closed, if I walk around here with my eyes, everything will look the same to me again, as if my eyes were open, and also because I saw it once. I am not like you, I see different things when I look at things than you do...Actually, there is an experiment going on on this planet, in this experiment all the people... They exist to create Mohammed and me, they suffer, they enjoy, they die, they are born, and if they perceive what they created, Muhammad and me constitute and formed and finished. This experiment no longer exists, it's over, making this experiment god. Why is God doing such an experiment because, Mohammed or I, either of us has to rule in the universe, so...But as I said the experiment is over, you can all die.

Patient Two: "I may be special, perhaps"

The first symptoms of the patient started ten years ago and at that time there were nonspecific symptoms such as social withdrawal, inability to focus, and difficulty in university classes. In the following periods, the patient was diagnosed with major depressive disorder, bipolar affective disorder and psychotic depression, and various treatments such as olanzapine, lithium, paroxetine and valproic acid were recommended. Parnas and Handest (2003) stated that the vast majority of schizophrenic patients were diagnosed with a major mood disorder at an early stage, because patients expressed their symptoms in an implicit / mysterious way, many of their symptoms were not specific to schizophrenia as stated above, and clinicians were not familiar with the abnormal non-psychotic experiences of schizophrenia patients. Throughout the outpatient clinic follow-ups, the patient spoke of his experiences of "having no soul, perceiving himself as an object", which can be regarded as diminished self-presence and impaired self- awareness, and he was afraid that people would think he was gay. Moreover, during the hospitalization period, the patient had experiences that could indicate hyperreflexivity, such as a decrease in spontaneity in human relations and excessive preoccupation with his mental processes, and experiences that could suggest the mood that Parnas et al. (2005) called "ontological anxiety". The patient described these experiences in Hacettepe University Psychiatry Inpatient Ward with a fearful expression and acting consistently:

Something will happen, sir. But I'm not homophobic (he was referring to homosexuality). It feels like they're doing something in the ward...bad thing. Could you please tell me if there is such a thing?

The patient was deeply suspicious of his sexuality and religious beliefs, did not trust other patients and healthcare professionals in the hospital, but did not express these issues with delusional certainty. As stated above, he did not have any positive symptoms or negative symptoms that seriously

impaired his functioning in 3 interviews, one of which was PANSS interview, two years after he was discharged. In the PANSS interview with the patient, the PANSS score was evaluated as 54, and in the other two interviews, the onset of the disease, the patient's subjective experiences and social life were evaluated in an unstructured manner. The patient described the pre-onset stage of the illness as follows:

This disease was there before it came out...For example, I was ill in when I looked good before I got that illness. It came out in 2010, but I was saying that I was sick on my own before. I knew but couldn't do anything. I did not consider going to a psychiatrist.

This statement of the patient is consistent with the above-mentioned view that abnormal experiences (ie self disorders) existed before the psychotic symptoms were crystallized. When the patient was asked what he meant by knowing that he was sick, he answered as follows:

So I knew I was not normal...I was feeling my difference so I was different. So it is, sir. Now I think I'm still a little different...Like, I can't improve. Like, I surrendered… As if I surrendered to the creator...So the thing is a bit like keeping a balance. Some people call it scrupulous, but it's like a desire to keep some balance...There's something wrong with my speech, so I'm afraid of making mistakes. I guess I'm a little hesitant or indecisive or scared.

The feeling that the patients are ontologically different indicates a decrease in the basic sense of self (Parnas et al. 2005, Sass 2014). It was stated above that some empirical studies have demonstrated that disorders in the minimal self persist in every stage of the disease. Although it is difficult to explain in this patient, it is seen that this feeling of being different starts in the early period of the disease and in the remission period. In addition, when the patient was thinking about the reasons for his difference from other people and the difficulties he experienced in his relationships, he attributed this to the presence of a speech disorder of himself. The patient had difficulty in choosing words while speaking, he often paused and thought or had indecisiveness about what he was going to say. This situation can be considered as one of the types of formal thought disorder that is a part of the disease, "expressive speech dysfunction" (Kircher et al.2014). However, the patient did not have a speech disorder at a level that could explain the kind of difference the patient felt for himself and the difficulties he experienced in his relationships. It should be kept in mind that the previous patient also attributed such difficulties to "dyslexia". **During the interview, where this patient's feelings of being different from other people were discussed, when the patient was asked to elaborate a little bit on his thoughts, the patient said that he thought he had divine powers after a while.** According to Parnas et al. (2005), the interviewer can bring these feelings of difference to the surface only with a detailed and in-depth interview, and these feelings can accompany the above-mentioned solipsistic features. Indeed, the patient began to express these solipsistic grandiose thoughts quite late in the interview. Moreover, the patient did not share this idea with anyone and did not take any action in line with this thought. This situation is compatible with the idea that self disorders can sometimes occur as "double bookkeeping" (Bleuler 1911), that is, living in the real world and psychotic at the same time, as stated by Parnas and Henriksen (2014).

The patient expressed his experiences when the interview proceeds as follows:

I was more troubled during my stay at the ward, but then I recovered a little. So I'm trying to keep up now...I'm struggling a bit...I had a trust problem back then, now I have some. It sounds like they're trying to use me. I guess I'm different so I don't know, maybe I can be a special person. Actually, I do not trust you either, you may be my enemy.

From this statement of the patient, the following can be said by considering the whole interview. First of all, it is important to realize that there is no delusional certainty here. It can also be said that the feeling of being different is accompanied by a solipsistic grandiosity and compelling harmony, and other minds become mysterious beings or malevolent structures. Despite these experiences, the patient continued to attend to this appointments regularly and was trying to explain his experiences despite all his doubts.

DISCUSSION AND CONCLUSION

In recent years, we have witnessed a rebirth of interest in the field of subjectivity and its disorders, particularly the severity and quality of non-psychotic abnormal subjective experience (Schultze-Lutter 2009, Sass and Parnas 2003). Contemporary research on abnormal subjective experiences in schizophrenia has used several different theoretical frameworks. The most common of these is the phenomenological approach (Lysaker & Lysaker, 2010). A prominent example of the the so called approach is the minimal self disorder model (Sass, 2014). In this article, the minimal self disorder model created by Louis Sass and Josef Parnas (2017) has been tried to be outlined and exemplified by the abnormal self experiences of two patients followed at the Department of Psychiatry, Hacettepe University, School of Medicine. If we summarize this model in general terms; The model has three dimensions that are tightly interconnected, interact with each other and can be understood more as the three aspects of a structure. These three dimensions are, in short, "hyperreflexivity", which means that sensations and thoughts that are normally experienced in an implicit or automatic way become unfamiliar and obvious to the person and the processes that the patient cannot prevent; "diminished self-affection", which refers to a decrease in the

sense of being the subject of an action and self-awareness; "disturbed grip or hold on the cognitive-perceptual world", which refers to the disruption of the spatial and temporal structure of the experiential field.

Several important features of the minimal self disorder model in schizophrenia can be mentioned briefly as follows:

First, this model aims to capture the object of psychiatry by addressing the domain of subjective experience and attempts to reveal the essence and *whatness* of schizophrenia (Parnas 2011). Because, as a pragmatic medical discipline, the object of psychiatry is the patient's abnormal mental experiences, that is, disorders of experience (Marková and Berrios 2012). It involves translating aspects into specific categories of signs and symptoms defined by a third-person perspective, thus providing "objective" and "shared information" for diagnosis, treatment, and research (Parnas and Zahavi 2002). As can be clearly seen, the mode of existence (ontology) of the "mental / subjective field" and how adequately it will be addressed and defined (epistemology) are fundamental issues for psychiatry (Marková and Berrios 2012). However, although consciousness or the mental field (i.e., ontology and epistemology of the object of psychiatry) has been the most controversial subject of scientific and philosophical debates until recent years, it has been little discussed in the psychiatric literature (Parnas et al.2013). Moreover, with the prevalence of DSMs in the world of psychiatry, some situations that Andreasen (2007) described as "unintended consequences" caused a departure from the object of psychiatry in psychiatric research, education and practice. Andreasen argued that language has been impoverished for the sake of language unity. Because, according to her, the diagnostic criteria in DSM have never aimed to provide a comprehensive explanation about the disorders. Instead, they were designed to be the minimum symptoms required to make a diagnosis. However, DSM criteria, which emphasize reliability rather than validity, were used as the main diagnostic source in many educational institutions, clinics and research, and as a result, other potentially important symptoms and findings of diseases that were not included in DSM were ignored. In addition, history taking, which is the basic assessment tool in psychiatry, has been reduced to questioning the criteria in DSM, and as a result, the abnormal experiential experiences of the patients are not questioned. As a result, Andreasen (2007) stated that DSM is an important attempt to create standardized diagnoses that will facilitate research and clinical diagnosis, on the other hand, it is argued that DSM diagnoses are not useful for research due to the lack of validity.

Second, the minimal self disorder model tries to define the basic characteristics (core clinical symptoms) that function in all areas of consciousness (such as affect, motivation, cognition, will, action) and manifest themselves in the whole of schizophrenia, as we have seen in history, as briefly mentioned above. In fact, the European psychiatric tradition is familiar with both the idea that there may be a disorder in the field of subjective experience in schizophrenia (Bleuler, Kraepelin, Berze, and Kronfeld) and attempts to define the core clinical symptoms of schizophrenia (Bleuler, Blankenburg, Minkowski) (Parnas 2011, Raballo and Parnas 2011, Parnas and Handest 2003). However, the DSM influence in psychiatry caused this tradition, which was effective throughout the 20th century, to be ignored, especially after 1980. It is beyond the scope of this article to discuss the benefit or harm of DSM diagnostic criteria to psychiatry. However, Andreasen (2007), in his influential article in which he declared the death of phenomenology in the USA (and perhaps all over the world through DSM), cites the following in order to indicate the need for the mentioned European tradition:

"...Some day, once the human genome and the human brain are mapped, Europeans can save American science by helping us understand who actually has schizophrenia or what schizophrenia really is, with a reversible Marshall Plan. "

Third, this model can detect individuals at high risk for early diagnosis and schizophrenia in many empirical studies (Koren et al.2020, Pionke et al.2020, Værnes et al.2019, Madeira et al.2019, Gaw Gada et al.2019, Gaw Gada 2018, Raballo et al.2018), self disorders are more associated with schizophrenia than other psychotic disorders (Handest and Parnas 2005, Haug et al.2012, Nordgaard and Parnas 2014, Parnas et al.2005), disease in schizophrenia occurrence in all stages of the disease, including premorbid and recovery periods (Davidsen 2009, Møller and Husby 2000, Nelson et al.2012, Parnas 1999, Sass and Parnas 2003) and positively associated with positive and negative symptoms of schizophrenia (Nordgaard and Parnas, 2014) has an important value in terms of.

Fourth, although it can be found in many psychiatric and neurological diseases, it is quite different from current approaches in terms of its approach to formal thought disorders (Kircher et al.2014), which are considered to be the core feature of schizophrenia. Accordingly, current approaches consider formal thought disorders as a one-dimensional phenomenon that do not have a distinguishing feature of any disease, and only accept that they are found in many diseases with different severity (Sass and Parnas 2017). However, Holzman et al. (1986) demonstrated that though with fuzzy borders, thought disorders in schizophrenia are different from other psychotic disorders. Here, the minimal self disorder model also emphasizes the specific nature of the thought disorder in schizophrenia, that is, it places emphasis on qualitatively different aspects from the thought disorders in other psychosis. On the other hand, it does not accept that thought disorders develop as a result of a deficit, as in current approaches, and takes into account its hyperreflexive, defensive and even semi-willed aspects (Sass and Parnas 2017).

Finally, the self-disorder model, which requires focusing on the patient's subjective experiences, can provide a better understanding of the patient and his problems. Trying to evaluate and understand subjective experiences — despite all their differences and their elusive qualities — makes an important contribution to the establishment of therapeutic allience. For the patient, it can be comforting to be aware that the difficulties experienced are understood by the psychiatrist. Self disorders can also serve as a target phenotype in etiology research; thus, the researcher can shift his attention from the positive or psychotic symptoms to the neural correlates of the basic disorders that occur in subjectivity in schizophrenia (Henriksen and Parnas 2017).

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