

## Self-centrality, psychosis and schizotaxia: a conceptual review

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**Abstract.** The phenomenon of self-centrality denotes a qualitative modification of the psychotic experience. Transitory experiences of self-reference have regularly been found in subjects in the prodromic phase and at the beginning of psychosis or in the post psychotic phase, and are specifically identified in the semeiotics of Basic Symptoms. However, self-centrality, in addition to being a morphological organizer in the psychotic crisis, also manifests itself in schizotypal personality disorders and in first-degree relatives of schizophrenics (where it is correlated to the degree of schizotypal traits). In these subjects, manifestations of self-centrality of a lesser intensity could be an indication of a latent vulnerability trait, which could modulate personal and psychopathological expressions of the schizotaxic diathesis. ([www.actabiomedica.it](http://www.actabiomedica.it))

**Key words:** Self-centrality, subjective experience, beginning psychosis, schizophrenia spectrum, schizotaxia, vulnerability

### Introduction

Autocentric-like experiences, which often include self-reference, have been described and contextualized in relation to the psychopathology of psychosis by Bleuler (*Beziehungswahn*) (1), and by Kretschmer (delusion of sensory relation, which brings about a “paranoid transformation of personal experience”) (2). Later, the same was done by Schneider who, along with Jaspers and Gruhle, pointed out that in the context of delusional perception the emergence of abnormal meaning occurs “generally in a sense of self-centrality” (3, 4). Next, Binswanger coined the prototypical notion of “being placed in the center” as a crucial turning point where the passage from a natural experience to a delusional one takes place (Ilse’s case) (5). Nevertheless, a description more specifically geared towards a characterization of the formal peculiarities of psychotic onset was originally put forth by Conrad, and later, in the French psychopathological literature, by Grivois.

“Incoherence, polymorphism, loss of sense”, is the way that Sirere, Naudin and Grivois (6) sum up the clinical phenomena of the inaugural psychotic experience, stressing subjective experiences as a unifying factor. Among such subjective experiences, “centrality” could be a useful starting point when attempting to outline certain types of organizers which are part of the acute onset of psychosis.

Accordingly, in *Die beginnende Schizophrenie* (7), Klaus Conrad outlines a detailed analysis of the phenomenological stages of the onset and development of psychotic consciousness, stressing the psychopathological importance of the gestaltic change in elemental ways of experiencing (8).

In fact, Conrad points out that in the experience of the abnormal, attribution of meaning (apophany), and the consistent impression of being at the center of the “world” (anastrophe) are the “two elements characteristic of the structural mutation of the schizophrenic experience” and are “immediately and reciprocally related”. Anastrophe, in particular, would attest to

“an extremely altered capacity to change systems of reference”, which results in a “loss of degrees of positional freedom”. The ability to “freely change reference systems” is, according to Conrad, the foundation of interpersonal attunement and hence represents the spontaneous ability of each person, albeit living in the center of his or her “world” to see themselves from “the outside”, “from above”, “from a bird’s eye view”, (and to) relate their own “world” to that general world of others” (7).

“In his state of psychosis”, Conrad continues, “the schizophrenic has lost this possibility of transcendence ...no matter what he looks at and no matter in what direction the arrow of his intent is aimed, that object “relates to him”.

The impossibility to change perspective already comes to the surface in the *Trema phase*, where “the impossibility of transcendence is experienced as a barrier” and the entire psychic field is permeated with an imminent and undefinable state of alarm. This experience evolves into apophany (characterized by the total unfolding of the anthropological device of revelation) and into anastrophe (characterized by the slipping into a diffuse and impending *erlebnis* of self-reference), which may, however, subside if it does not crystallize and permit a return of the ability to decentralize oneself.

According to Grivois (9), centrality (represented by an erroneous self-attribution of the intentions, judgments or behaviors of others) can be viewed as a clinical constant in beginning psychosis. The birth of psychosis resides in the crisis of interpersonal relationships which results in an abnormal conviction of being a focal point at the center of the world. “Centrality”, Grivois states, “is due to a collapse of subjectivity which derives from an insecurity in the relationship with others.” (10).

At first, the experience is purely perceptive and mimetical, without any threatening significance, only to become a “specific emotion which intensifies” so that the most insignificant and marginal interactions and exchanges become signs that allude to the subject in question.

Next, the process evolves into a general “alteration of interindividuality” (*centralité*) which modifies, “at times in a striking way”, the experience of being a man in a social context. “The individual feels as if he is at

the center of reality to the point that everything that happens on a mundane level is related to him” (11).

In a recent conceptual revision, Sirene, Grivois e Naudin (4, 6) have proposed an anthropophenomenological interpretation of centrality as a “fourth form of missing existence” subsidiary to the triptych of Binswanger (“fixed exhilaration”, “eccentricity”, “mannerism”). The concept of *centralité*, in fact, constitutes a breach in the relationship between the amplitude of experience and the capacity to elaborate, which constitutes the anthropological proportion and provokes a profound spatial distortion of inter-personal orientation.

It is the specific notion of *centralité* as a “*forme de la Présence manquée*” which accounts for its perseverance in the pre- (12-14) and post-psychotic phase (15-17), where the self-centered approach is the favored medium in “enduring earthly existence each time that the patient experiences a conflictual situation that he or she does not know how to manage” (18).

### Self-centrality and the Basic Symptoms Model<sup>1</sup>

The dynamic pathogenetic models of Huber (transitions between various Basic Symptoms) (19, 20) and Klosterkoetter (serial connection) (21), within the context of “understanding” according to Jaspers, allow for a stimulating psychopathological revision of beginning psychosis. Within this conceptual framework, it is possible to redefine the self-centered experience into phenomenologically unitarian sequences. The latter guide the elaboration of overt productive symptoms and, contemporaneously, allow for a refined clinical discrimination between delusional self-centrality (ie. apophanic Self-Centrality) and a more preliminary, subtle and elusive form, that is, subapophanic self-centrality, (16, 17) (in which the Copernican turning point can still be reached).

<sup>1</sup> The concept of “Basic Symptoms” is clinically based on: basic experiences, uncharacteristic and aspecific, lived as a disturbance, and confined to the subjective sphere (19,20). Technically, Basic Symptoms indicate a personal perception of a deficit in drive, emotions, perception, interaction, thought, language, and planning activities, and can be qualified using the *Bonn Scale for the Assessment of Basic Symptoms* (22) [BSABS].

This basal self-centrality, which is included in the Bonn Scale for the Assessment of Basic Symptoms<sup>2</sup> (22), denotes the fundamental precariousness of the ability to transcend on a primarily prereflective and protopathic level, and is probably due to the intervention of transphenomenic neurofunctional mechanisms (10, 11, 22, 23).

Indeed, the self-centered experience is a paradigm of disturbed intersubjectivity which subsumes the preservation of the “ability to transcend” (*Überstiegsfähigkeit*) as a precondition for the intuitive establishment of “vital attunement” with the environment (24). In particular, if the psychotic condition also includes a pathology of intersubjective competence, the disturbance of the ability of attunement involved in self-centrality (especially when subapophanic in nature as described by the Basic Symptoms model), could be a psychopathological indicator of psychotic vulnerability and could modulate the course of the disease.

Already in the “as if” form, self-centrality reveals a state of *surproximité* (25) to the world which impedes the “ability to reside serenely among things” (26) and alludes to an underlying autistic vulnerability (27, 28).

### Clinical evidence

On the empirical level the relationship between self-centrality, anomalous subjective experiences (and/or Basic Symptoms), and psychosis has been examined using different experimental paradigms.

#### Onset

A ten-year prospective study (Cologne Early Recognition Project) performed on a group of subjects

treated in the clinical setting for putative prodromic symptoms has shown that certain Basic Symptoms, included in the subsyndrome “thought, perception, language and motility disturbances,” have a high positive predictive value in identifying individuals at increased risk of transition into schizophrenia (79 individuals out of 160 evaluated). Among these “highly predictive prodromal symptoms” (HPPS) transitory ideas of reference experienced in the “as if” mode are also included (Item C1.17 of the BSABS: specificity, 0.89; false positives, 5.6%) (29).

More recently the same group performed a “short term follow-up” which confirms the positive predictive power of HPPS already after fifteen months (13, 14).

In addition, the same research team has found that when comparing the anomalies of subjective experiences preceding the first schizophrenic and depressive episode, self-centrality is among the discriminatory Basic Symptoms (in addition to: feeling overwhelmed by sensory stimuli, disturbances in auditory perception, and disturbances in the ability to control non-verbal expression and affect), indicating that this combination of Basic Symptoms precedes the onset of the overt clinical episode by two to seven weeks (30).

In accordance, the preliminary results of the EPOS (European Prediction of Psychosis Study) when analyzing the baseline symptomatology in a High Risk Sample in Amsterdam, have shown self-centrality to be present in over three fourths of the subjects studied (76%) (31).

#### Postpsychotic phase

Given a series of empirical indications derived from groups of subjects in the postpsychotic phase, it is possible to view self-centrality in a more relative way not only as an elective *erlebnis* at the onset (or in the immediate prodromic pre-psychosis), but also as an expansion of its psychopathological relevance to intercritical periods characterized by a relative stability of symptoms (15). In the postpsychotic phase patient, in fact, the discrimination between apophanic (i.e. delusional) and subapophanic Self-Centrality is appropriate in that it allows for the distinction between

<sup>2</sup> The item C1.17 “*Subject-Zentrismus*” of the BSABS, explicitly describes the “Centrality of the Subject” as an “experience of self-reference perceived and described by the patient who sees unimportant events, such as the behavior and comments of others, as being referred to him, even though he realizes at the same time (or immediately afterwards) that such an event is impossible or improbable. The patient has the feeling of being in the center of events without having a concrete or elaborated sense of such experience (22).

overt aspects of the psychotic experience, and more subtle qualitative changes in spatial perception which are not yet organized in a delusional sense (15, 16).

Transitory impressions of self-reference “with an immediate ability to reactivate the Copernican turnover” are recognizable in over two thirds of schizophrenic subjects in psychotic remission (15). The presence of self-centrality is associated with a particular psychopathological profile: greater intensity of xenopathic content compared to other delusional themes and higher levels of basal-distress (16). In addition, self-centrality is strongly correlated to subjective experiences, such as alexithymia, depersonalization, and basic obsessions (15).

A re-evaluation of the preliminary results in a wider sample has confirmed that of the three psychopathological constellations of greatest pertinence to sub-apophanic self-centrality (delusions of “control-persecution”, alexithymic “difficulty identifying feelings”, and “abnormal body feelings”), the cenesthetic Basic Symptoms are those most highly predictive of its cooccurrence (17).

The importance of self-centrality in the characterization of schizophrenic self-experience is further validated by a comparative evaluation of Basic Symptoms in different diagnostic classes: subapophanic self-centrality increases the discriminative power of subjective experiential anomalies (32) (designated according to phenomenological criteria (33) to characterize core aspects of the schizophrenia spectrum<sup>3</sup>). This is the case where affective disorders, as well as obsessive-compulsive disorders, are concerned indicating that a consideration of autocentric disturbances of intersubjectivity could be useful to understand the psychopathological experience of schizophrenia (17, 23, 32).

<sup>3</sup> Included in this reclassification of Basic Symptoms, we find seven subclassifications which are: *Diminished affectivity* (global deflection of affective potential), *Disturbed contact* (difficulties and subjective embarrassment in social and interpersonal relationships), *Perplexity* (altered articulation and intuitive interpretation of meanings), *Cognitive disorder* (a reduced flow in cognitive processes), *Self-disorder* (a disorder in the experiences of self), *Coenesthesias* (disorders in bodily experiences) and *Perceptual disorder* (perceptive distortions) (33).

### *Schizotaxic vulnerability*

The phenomenon of self-centrality also manifests itself in subjects with schizotypal personality disorder and in first-degree relatives of schizophrenics<sup>4</sup>. This population has a high schizotaxic risk (34-36) and presents (as has also been found on a neurocognitive and personality level) a profile of anomalies of subjective experience which can be collocated midway between the general population and the conditions typical of the clinical spectrum (36, 37), with a particular reference to cognitive and cenesthetic Basic Symptoms (34). The correlation between such symptoms and the intensity of schizotypal traits (38) seems to suggest that an altered experience of physicality and cognitive proficiency constitute the psychological correlate (35) of the dimensions of schizotypy (39). Further, it has been found that sub-apophanic self-centrality is correlated both to cognitive-perceptual as well as to interpersonal factors of schizotypy, thus representing a shared experiential background for both (23).

Additional research, above all in developmental psychopathology, is necessary to ascertain whether the predisposition to self-centrality is a prerequisite for the development of positive and negative traits of the schizotypy, or whether it is a consequence. However, it seems plausible (considering the Basic Symptoms Model (19,20) and the theory of Meehl (35)) that a common schizotaxic vulnerability provokes a transphenomenological liability in the intersubjective space. The latter reverberates on the level of personality in the interpersonal and cognitive-perceptive dimensions of the schizotypy, as well as in the experiential one of transitory experiences of self-reference (23, 37).

### *Clinical, therapeutic, and diagnostic implications*

A careful consideration of the phenomenon of “central polarization”, both in its more subtle form (“as

<sup>4</sup> The cross-sectional “as if” self-centrality in recently evaluated samples (34), analyzed in the out-patient clinic of the Psychiatric Section of the Neurosciences Department of the University of Parma has shown: control groups [ $<3\%$ ], siblings of schizophrenic subjects [ $12\%$ ], patients with schizotypal personality disorder [ $71\%$ ], schizophrenic patients in postpsychotic remission [ $69\%$ ].

if”) and in the overt form, has important clinical consequences in that it allows for a prediction of the susceptibility to schizophrenia and psychotic relapse, thus making possible the formulation of an adequate observational and therapeutic protocol.

Psychotherapeutic, educational, and psychopharmacological intervention on Basic Symptoms can arrest their transition to psychotic symptoms, thus facilitating the return to less persistent and disturbing symptoms (first level Basic Symptoms) and avoiding a stable and autonomous psychosis (20, 21). In this context, in order to maximize the patient’s coping skills, the analysis of the experience of self-centrality is a priority.

On this topic, Grivois and Grosso stress the importance of a “clinical-relational” approach when treating beginning psychosis. The doctor and the patient find themselves auspiciously “sharing a perspective of common intelligence regarding the event. The clinician attempts to reconstruct ...the development of the episode in progress starting from its recent interpersonal roots without introducing simplistic notions of causality”, and without undertaking a hurried and reductive “search for meaning in the past”, but rather “modestly attempts to address that which most defines the acute state of suffering of the patient” (11).

Aside from helping the patient to verbalize an experience which would otherwise be a source of tremendous anguish, this model has implications on a rehabilitative level, in that it permits the recognition of a specific dominion of interpersonal vulnerability which, if not alleviated in a timely fashion, represents a potential interference both in the therapeutic relationship and in the social integration of the patient.

## Conclusions

Self-centrality (SC) is an emblematic characteristic of the experience of beginning and post-psychosis. These experiences, which are specifically addressed in the semeiotics of Basic Symptoms, recall the original notion of Conrad of “loss of degrees of freedom” as a prelude to the “psychotic change in experience” and are associated with discenesthetic anomalies in the experience of the lived body (17).

In this context, a perturbation of the elementary mechanisms which regulate relationships of interpersonal coordination (11) could constitute the transphenomenological *primum movens* of *concernement*, which becomes transformed into a disturbance in interpersonal relationships and experiences expressed on a behavioral level as a predisposition to social withdrawal. The latter, which is also found in schizotaxic individuals in terms of a social aversiveness trait, could be influenced by a greater proneness to transitory disturbances of central polarity<sup>5</sup> (23).

Thus, the psychopathological analysis of experiences of self-centrality is promising both in terms of a clinical-therapeutic perspective and in terms of research. Elusive disturbances of interpersonal space are in fact, today, insufficiently characterized by notions of “altered interpersonal contact” which primarily focus on minus-asthenic aspects of the interpersonal deficit, neglecting the potential effect of experiences such as self-reference, that are more indicative of a relative “incapacity to keep the world at a distance” (18). In this perspective, self-centrality is a recognizable experiential phenotype, which is particularly suggestive when attempting to elaborate an empirical approach subsidiary to the renascent interest in the phenomenon of loss of social competence in the schizophrenic spectrum (40, 41), as well as autistic vulnerability in schizotaxic individuals (23, 27, 28).

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<sup>5</sup> As Grivois and Grosso specify, (11) “the influence of its minor forms is a normal experience, common to all men when it touches them” and ephemeral changes in its involvement can appear even in unexpected social situations, or can be particularly applicable to anxious or phobic individuals”. In any event, the amplification and the persistence of *concernement* that becomes “irresistibly invasive” and unavoidable seems to mark the global qualitative transformation of the experience that signs the beginning of psychosis and is traceable, albeit in a more elusive and subtle sense, to subtle derailments of the *Ubersiegsfähigkeit* even in relatives of schizophrenics.

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