Schizophrenia Bulletin vol. 45 no. 1 pp. 106–113, 2019
doi:10.1093/schbul/sbx183
Advance Access publication January 24, 2018

Identity Disturbance, Feelings of Emptiness, and the Boundaries of the Schizophrenia Spectrum

Maja Zandersen*,[1] and Josef Parnas[1,2]

[1]Mental Health Centre Glostrup, University Hospital of Copenhagen, Broendby, Denmark; [2]Center for Subjectivity Research, University of Copenhagen, Copenhagen, Denmark

*To whom correspondence should be addressed; Mental Health Centre Glostrup, Broendbyoestervej 160, 2605 Broendby, Denmark; tel: +45-30256818, fax: +45-38645550, e-mail: maja.zandersen@regionh.dk

Historical and current research on borderline personality disorder reveal certain affinities with schizophrenia spectrum psychopathology. This is also the case for the borderline criteria of "identity disturbance" and "feelings of emptiness," which reflect symptomatology frequently found in schizophrenia and schizotypal personality disorder. Unfortunately, the diagnostic manuals offer limited insight into the nature of these criteria, including possible deviations and similarities with schizophrenia spectrum symptomatology. In this article, we attempt to clarify the concepts of identity disturbance and feelings of emptiness with an emphasis on the criteria's differential diagnostic significance. Drawing on contemporary philosophy, we distinguish between a "narrative" self and a "core" self, suggesting that this distinction may assist differential diagnostic efforts and contribute to mark the psychopathological boundaries of these disorders.

Key words: borderline/schizotypal/self-disorders/core self/narrative self

Introduction

Borderline personality disorder (BPD) became an official diagnosis in 1980[1] and its prevalence among psychiatric inpatients is now reported to be about 20%.[2] Concomitantly, there has been a decline in the use of the hebephrenia (disorganized schizophrenia) diagnosis.[3] It is not clear whether such changes in incidence reflect new patterns of psychopathology or are simply consequences of different diagnostic "popularities."[4] In a review of historical and current psychopathological evidence of BPD, we have claimed that it is nearly impossible to distinguish BPD from the schizophrenia spectrum disorders, especially schizotypal personality disorder (SPD).[5] Two BPD criteria, ie, identity disturbance and chronic feelings of emptiness, distinguish (together with self-mutilating behavior) BPD from all other personality disorders. Unfortunately, these criteria remain insufficiently defined. What is it like to have an "unstable self-image or sense of self" or to experience "chronic feelings of emptiness"? Importantly, these symptoms are consistently found in the classical and recent literature on schizophrenia spectrum disorders.

The aim of this article is to examine the phenomenological nature of the concept of identity disturbance and feelings of emptiness and to clarify their diagnostic significance with respect to the differential diagnosis between BPD and the schizophrenia spectrum. After a historical outline of the criteria, we present a phenomenological explication of the concepts of identity and self and introduce a distinction between "core" and "narrative" selfhood that may be differential diagnostically useful. Finally, we present and discuss a clinical case with diverging diagnostic perspectives.

The Vicissitudes of Diagnostic Terms

The DSM and ICD diagnostic criteria of identity disturbance and feelings of emptiness appear in table 1. While there are no descriptions of the experiential quality of feelings of emptiness, identity disturbance is described in terms of uncertainty concerning career choices, values, goals, and friendship patterns. In the DSM-IV,[6] the concept of "a sense of self" appears for the first time but is undefined. Instead, we find this term as part of the definition of identity in DSM-III (table 1). Noteworthy, this definition links disturbance of identity also to schizophrenia. DSM-IV and DSM-IV-TR[7] have no definitions of "identity" and none of the DSM editions offer a definition of the term "self." The formulation of diagnostic criteria is remarkably poor in ICD-10.[8] In the alternative model for personality disorders, included in Section III in DSM-5, "identity" and "self-direction" form a "self

© The Author(s) 2018. Published by Oxford University Press on behalf of the Maryland Psychiatric Research Center.
This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com

Table 1. DSM and ICD Descriptions of BPD Identity Disturbance and Feelings of Emptiness

	DSM-III	DSM-III-R[9]	DSM-IV, DSM-IV-TR, DSM-5	AMPD in DSM-5 Section III	ICD-10
Identity criterion	ID manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, longterm goals or career choice, friendship patterns, values, and loyalties, eg, "Who am I?", "I feel like I am my sister when I am good."	Marked and persistent ID manifested by uncertainty about at least 2 of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values.	ID: markedly and persistently unstable self-image or sense of self.	*Identity:* Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism; chronic feelings of emptiness; dissociative states under stress. *Self-direction:* Instability in goals, aspirations, values, or career plans.	Disturbances in and uncertainty about self-image, aims, and internal preferences (including sexual).
Emptiness criterion	Chronic feelings of emptiness or boredom	[*As in DSM-III*]	Chronic feelings of emptiness	[*See above*]	Chronic feelings of emptiness
Descriptive Section	A profound ID may be manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, or long-term goals or values. There may be problems tolerating being alone, and chronic feelings of emptiness or boredom.	A marked and persistent ID is almost invariably present. This is often pervasive, and is manifested by uncertainty about several life issues, such as self-image, sexual orientation, long-term goals or career choice, types of friends or lovers to have, or which values to adopt. The person often experiences this instability of self-image as chronic feelings of emptiness or boredom.	There may be an ID characterized by [… *see criterion above*]. There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations. […] Individuals with Borderline Personality Disorder may be troubled by chronic feelings of emptiness […]. Easily bored, they may constantly seek something to do.		The patient's own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness.

Table 1. Continued

	DSM-III	DSM-III-R[9]	DSM-IV, DSM-IV-TR, DSM-5	AMPD in DSM-5 Section III	ICD-10
Glossary of Technical Terms	**Identity**: The sense of self, providing a unity of personality over time. Prominent disturbances in identity or the sense of self are seen in Schizophrenia, Borderline Personality Disorder, and Identity Disorder	**Identity**: [*As in DSM-III*]	**Identity**: *No definition in DSM-IV and DSM-IV-TR* [*DSM-5 see next column*] **Self**: *No definition*	**Identity**: Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.	
	Self: *No definition*	**Self**: *No definition*		**Self**: *No definition*	

Note: ID, Identity disturbance.

functioning severity dimension," providing a more elaborate description of identity disturbance, yet still without any additional clarification of the term "self."

Psychoanalytic Roots of Disturbed Identity and Feelings of Emptiness

In the pre-DSM-III literature, the concept of "borderline" was typically considered a variant of schizophrenia.[5] Many contributions came from psychoanalysts, describing identity disturbance and feelings of emptiness as reflecting disturbances at a *structural* level of the psyche. In their terminology, "structure" may refer both to the overall psychic structures in Freud's model of the id, ego, and superego but also to single mental structures or processes such as defensive or cognitive functions.

In the most influential article on the subject, Deutsch[10] described a group of patients with what she termed "as if" personalities, referring to the patient's readiness to mold oneself according to the surroundings and anticipating the widely used characteristic of borderline patients as having a *chameleon*-like adaptability to others.[11,12] Deutsch found that her patients were not aware of their "as if" personality. Rather they felt an inner emptiness, which they tried to overcome by an exaggerated identification with others. Notably, Deutsch considered these patients to belong to the schizophrenia spectrum.

The DSM criterion on identity disturbance has its root in the psychoanalytic concept of "identity diffusion." Erikson[13] defines the term "identity" as expressing "a mutual relation in that it connotes both a persistent sameness within oneself (self-sameness) and a persistent sharing of some kind of essential character with others" (p. 57). "Identity diffusion," on the other hand, manifest in various features such as a disintegration of the sense of inner continuity and sameness, difficulties in committing to occupational choices, and difficulties with intimacy. The main figure formulating identity diffusion as a key pathology in borderline patients was Kernberg,[14,15] who synthesized (and modified) the constructs of several of his predecessors.[13,16–20] Kernberg[12] refers to identity diffusion as "the lack of an integrated self concept and an integrated and stable concept of total objects in relationship with the self" (p. 39). Contradictory self and object images are permanently split rather than being synthesized into a more coherent image. This formulation (apparently kept on a *sub-personal* [unconscious] level) draws on Klein's description of the mechanism of "splitting" and the association between excessive splitting and a disturbance in "the feeling of the ego," which she believed to be the roots of some forms of schizophrenia.[16] With respect to the more *experiential* level, ie, the level of phenomenal symptoms, Kernberg[21] finds identity diffusion to be reflected in the patients' incapacity to give an integrated description of self and significant others. They are uncertain about their major interests, their behavior

patterns are chaotic, and their commitments to work and other people are unstable.

Kernberg's concept of borderline personality organization includes patients with schizoid, paranoid, narcissistic, hypomanic, and antisocial personalities, impulse-ridden character disorders,[22] "as if" personalities,[10] psychotic characters,[23] inadequate personalities, and patients with multiple sexual deviations—in other words, a number of "categories" many of which were considered to be affiliated with schizophrenia. The capacity for reality testing and the relative intact ego boundaries in patients with borderline personality organization are what delimit these patients from the psychoses.

Feelings of emptiness have been described within a variety of conditions, including psychoses,[24] depression,[25] schizoid,[26,27] narcissistic,[28] and borderline personality.[12] In this literature, one may encounter descriptions of a sense of deadness or absence of inner feelings; of unresponsiveness; of boredom and superficiality; of depersonalization. Such experiences may be fluctuating, episodic, or chronic.[29] Typically, feelings of emptiness in borderline patients have been considered the experiential consequence of a disturbance in some sort of feeling or sense of *self*,[30,31] eg, described as a continuum of experiences from "a sense of incompleteness, vagueness, a search for 'one's being'" to a psychotic conviction of "actual personal extinction or nonexistence."[32] (p. 471)

Kernberg[12] described how namely patients with identity diffusion experience various forms of emptiness depending on the pathological structure of personality. Patients with a schizoid personality may experience emptiness as an "innate quality that makes them different from other people" (p. 215) and here the experience of emptiness is related to phenomena such as apathy and anhedonia. In patients with a narcissistic personality, the feeling of emptiness is moreover characterized by "strong feelings of boredom and restlessness" (p. 217), resulting from the potential lack of gratification from others.

Although rich in theoretical and clinical perspectives on borderline patients, the psychoanalytic approach has been difficult to translate into descriptive diagnostic criteria (table 1) and is characterized by diverging theoretical perspectives. Most importantly, descriptions of the *experiential* (phenomenal) level of psychopathology are often conflated with complex meta-psychological constructs, which concern a *sub-personal* (unconscious) level of pathology. This is evident in Erikson's[13] view on identity as referring to (1) "a conscious sense of individual identity," (2) "an unconscious striving for a continuity of personal character," (3) "a criterion for the silent doings of ego synthesis," and (4) "an inner solidarity with a group's ideals and identity" (p. 57). Similarly, Kernberg introduces a *self concept*, referring to "the integration of representations of the self."[21] Does this refer to the person's beliefs about him-/herself, which can be linguistically expressed and thematized? Or is it a sub-personal, unconscious, dispositional structure that only occasionally becomes materialized as a belief about oneself, eg, through psychotherapy?

Identity, Self, and the Schizophrenia Spectrum

Descriptions of a disturbance of identity or sense of self in schizophrenia spectrum conditions are as old as the concept of schizophrenia itself. Bleuler[33] reports a patient who "is not really herself, she is merely a reflection of herself" (p. 145) while other patients report that they "can't catch up with themselves" or that they "have lost their individual self" (p. 143). Bleuler considered these disorders as part of the fundamental symptoms of schizophrenia (including also formal thought disorder, disorder of affectivity, anhedonia, ambivalence, and autism). When Bleuler claimed that the essential feature of schizophrenia was a peculiar "alteration of thinking, feeling and relation to the external world which appears nowhere else in this particular fashion" (p. 9), or when Jaspers[34] talked about "process phenomena" inaccessible to psychological understanding, they seem to indicate a confrontation with the illness features that are located at a *structural* level of experience.[35] Briefly, this level concerns the "how" of the experience rather than the "what" (the content) of experience. During the last 15 years, these disturbances have been conceptualized as *structural changes of the patient's self*, operating at a non-thematic level of consciousness (the "ipseity disturbance model"[36,37]). A series of phenomenologically inspired empirical studies have demonstrated a selective hyper-aggregation of structural-experiential self-disorders in schizophrenia and schizotypal disorders,[38–40] which occur in the pre-onset conditions[41,42] and tend to persist over the course of illness.[43,44] Such disturbances were in fact part of the schizophrenia definition in the ICD-8 and ICD-9, stating that schizophrenia entails "a fundamental disturbance of personality […that] involves its most basic functions, those that give the normal person his feeling of individuality, uniqueness, and self-direction"[45] (p. 27).

In the pre-DSM-III era, the experiential self-disorders were emphasized in articles on "pseudoneurotic schizophrenia,"[11,46] referring to patients with temporally unstable clinical pictures and fluctuation of seemingly neurotic symptoms in the presence of fundamental schizophrenia symptomatology. Examples of the latter were experiences of anhedonia, apathy, and of feeling "dead and empty."

In his existential-phenomenological study of schizoid and schizophrenic persons (including also "borderline cases"), Laing[47] described their experiences of a lack of autonomous identity, personal consistency, and temporal continuity. They usually experience their "self" as disembodied, and they feel empty, unreal, dead, and differentiated from the world. They are unable to sustain a sense of self as persons, which is why they are equally unable to experience neither separateness from nor relatedness to

others in a usual way. They may fear losing their identity in a relationship as well as feel dependent on the other for their very being.

Identity and Self: Conceptual Considerations

Personal identity and selfhood are a perennial topic of philosophy. In a common sense psychological understanding, *personal* identity refers to a set of persisting features that identify and individuate a person. If asked on the street "who are you?" a by-passer may answer "I am John Smith" and he may proceed with a list of biographical, characterological and cognitive characteristics. In this type of understanding, we pay no attention to the *structure* or *form* (the "how") of the underlying experience.

The French philosopher Paul Ricoeur[48] characterized personal identity as emerging in the triangle of idem-identity (sameness), ipse-identity (selfhood) and interpersonal relations. Idem-identity, or sameness, refers to persisting yet malleable personal features such as personality traits, character, temperamental dispositions, and values, which change over the span of life in our social interactions. All these features may be expressed in linguistic (propositional) terms and may be contemplated upon in self-reflection.

The sameness of the changing idem-identity is assured by the selfhood or ipse-identity (ipse = self or itself). The *who* or the elusive subjectivity of experience remains persistent over the lifespan and is exemplified by Ricoeur with the notion of keeping a promise: If I keep a promise made when I was 20 years old until I am 80, the keeper of the promise is the *who* of personal identity. The *who* or the first-person perspective is usually never a theme or object of conscious awareness and attention but simply a tacit structure of experience. Contemporary phenomenology and cognitive science make an analogous distinction between the "narrative" self and the "minimal"[49–51] or "core/basic" self.[52,53] The notion of core self refers to the first-personal manifestation of all experience, ie, an experience is never anonymous but manifests always itself as *my* experience. In other words, our *experiencing* articulates itself in the first-person perspective, involving a persisting sense of self-presence as an abiding implicit feeling of "I-me-myself"[54] (perhaps also addressed by Erikson in his description of self-sameness). The core self implies a sense of self-coincidence, privacy of our inner world and the "me/not me" demarcation, psychosomatic unity (embodiment), and an experience of one's being as "having begun in or around birth and liable to extinction with death."[47] (p. 42)

It is upon this core self that the narrative self is developed in social and linguistic interactions. The core self is a prerequisite of the narrative self.[50,55] It implies the *who* (in Ricoeur's term) for a person to be introverted, ambitious, friendly. In normal experience, the structure and the content of experience are interwoven and the structure of experience usually does not become the object of our reflection (ie, the object of experience). The by-passer John Smith mentioned above would probably not include in his answer to us that he is experiencing the world in the first-person perspective. Patients with schizophrenia, however, can describe such structural disturbances of self-experience, eg, various distortions of first-person perspective, incomplete sense of substantiality-embodiment, and an ephemeral sense of self-presence.[55] In psychopathology, there may be disturbances at either one or both levels of selfhood, though also in a clinical setting these levels may not be easy to differentiate. Usually, disturbance of the structural level of selfhood, entailing an instability of the basic subject-world relation, will also manifest as disturbance of narrative features, including interpersonal functioning, emotional regulation, and direction in life. However, disturbance of the narrative level of selfhood will not in itself cause structural disorders of the core self. Being confused about career choice or being impulsive typically does not entail problems with demarcation or self-presence (see also the clinical vignette below).

The criterion of chronic feelings of emptiness may be informed by the distinction between core self and narrative self. Currently, the criterion is left without any guidance regarding the experiential level; possibly, the term "chronic" is an attempt to capture the existential (trait) quality of this symptom. At the narrative level of selfhood, feelings of emptiness may emanate from a lack of interests, values, and directions in life. At the level of core self, however, the emptiness may be related to a feeling of being ontologically different from others, described in the schizophrenia literature as "Anderssein."[56] This concept does not refer to the feeling of being different at a personal or narrative level (eg, being brighter, taller or more interested in football than others), but to the feeling that one's very *being* is different (similar to Kernberg's description of an "innate quality" of being different from others). When emanating from structural disturbances of core self, feelings of emptiness may also be related to, eg, a distorted first-person perspective with a pervasive loss of "mineness" or to different forms of depersonalization. What apparently is a metaphoric expression of the patient ("feeling empty inside") may in fact be an expression of a very concrete experience of being hollow.

As mentioned above, the features of narrative selfhood can be consciously represented but also the features of the core self are phenomenally accessible when we reflect upon the way in which we experience something. Thus, neither the concept of narrative or core self appeals to certain unconscious or sub-personal structures or mechanisms, and this possibility of phenomenological descriptions makes these concepts useful in psychopathology. Below, we will demonstrate their utility in a clinical vignette.

A Clinical Vignette

Amanda, 23, single, high school degree with good marks. Since then, she has been ambivalent about her future education and dropped out of 2 university programs. She lives in a dormitory and is on a sick leave. She was admitted to a psychiatric facility 1 year ago after her second suicide attempt. At this admission, she reported a tendency to act impulsively and mentioned occasional episodes of cutting herself. She described herself as sometimes agitated and restless and with difficulties sustaining relations. She felt "depressed," without energy, cried a lot without knowing any reason, and did not attend school.

During the research interview, she reported feeling different from her peers during childhood as if she was somehow "not on the same side" as them. In adolescence, this feeling has intensified and changed into a vague sense of uniqueness or superiority, perhaps being "brighter" than other people. However, she does not think that she is more intelligent than others are but that she perhaps has a better insight into the conditions of human existence. This sense of difference may change into a feeling as if in a bubble and not truly part of the world.

She has no idea who she is. When trying to describe herself, the only adjectives that come to her mind are "lazy" and "energetic." She cannot point to any specific personal values, preferences, or interests. Her "personality" solely depends on the role she chooses to take. When looking in a mirror, she sometimes has a feeling as if looking at an unfamiliar person. At times, her thoughts and feelings become somehow anonymous and "free flowing" as if not truly related to her. She also describes how her memories feel detached from her, as if her childhood was not her own but someone else's childhood. She wonders whether she is transsexual, or if the reason why she is so confused about her identity is because she should have been a boy instead of a girl. She also wonders if she is perhaps homosexual without having recognized this (she feels sexually attracted only by men). She plans to consult a clairvoyant in order to get a better grip about herself.

Her lack of identity feels as a sort of emptiness, "there is *nothing* inside of me, nothing like a *soul* or anything." She describes this emptiness as "a black hole" and as "a gap" in the middle of her chest. She senses this gap in a concrete way, specifying its size. Previously, she felt that the hole became smaller when having a boyfriend, but it was always there. Then she tried having 2 boyfriends at the same time, but this did not help either. Now she wonders if she needs to have several simultaneous boyfriends in order to make it disappear.

The feeling of emptiness is linked to a feeling of not being at one with her body. She experiences her body only as "a tool," which is there in order for her "to walk from A to B." Her thoughts and feelings are in her head; her body is empty. At the peak of such experiences, she feels a sort of painful restlessness and anxiety without autonomic symptoms. She describes her "self" in a concrete sense as being outside of her body. She feels as a "fluent existence," as a "fluent blob" in the air instead of a whole person. She reports her "I" as being so blurry that she sometimes thinks she cannot even die because there is no "core" that can be "taken out of the game." When walking on the street, she may experience that strangers stare at her and she wonders whether it is because that they can see that she is empty.

The patient was diagnosed with BPD on the basis of identity disturbance with unclear goals, feelings of emptiness, indications of unstable affectivity and mood, self-mutilating acts, and disturbance of interpersonal relations. Her episodes of depression were seen as consistent with the BPD diagnosis. She undoubtedly fulfills the DSM-5 BPD criteria on their face value. However, she also fulfills the criteria for SPD.

It is quite clear that the identity problem is the central feature of this clinical picture, affecting the patient's interpersonal life and educational career. This is evident on the level of what we have called narrative selfhood, eg, she reports that she has no personal values, preferences or interests. However, her identity problems seem not only to be located at the level of narrative selfhood but also to entail disturbances of a very basic and structural level of experience. For example, she experiences a pervasive sense of diminished or insecure self-presence: she has no abiding and substantial feelings of an "I/me/myself." She expresses a fundamental (ontological) difference from others ("Anderssein"). Her first-person perspective becomes distorted with the ensuing anonymization of thought processes and memories, which sometimes loose the character of "mineness." Her ambivalence and lack of direction in life, which are manifest on the narrative level of selfhood, are in our view linked to her pervasively diminished sense of self-presence or even existence. In fact, she describes a fundamental loss of centrality of being (eg, she feels as a fluent blob in the air). From this perspective, it is the disturbance of the core self that infuses her narrative identity with instability and a feeling of always playing a role. She describes further disturbances of the core self, comprising spatialization of experience (eg, she senses her emptiness in a very concrete spatialized manner) and a loss of the ordinarily unproblematic sense of psychophysical unity or embodiment (in fact, her episodes of cutting were motivated by feelings of anhedonia and deadness in the body). Her thought processes reveal a tolerance for contradictions ("lazy" and "energetic") and psychosis-near reasoning (eg, increasing number of boyfriends would diminish her sense of emptiness). In sum, the patient presents a range of disorders of the core self characteristic of the schizophrenia spectrum

disorders with clear consequences on the level of narrative identity.

Discussion

In our opinion, identity disturbance and feelings of emptiness play a significant role in the differential diagnosis of schizophrenia spectrum and BPD. However, the definitions of these criteria are disconnected from any overarching psychopathological context and thus open to multiple interpretations. Moreover, although disturbances of core self have been consistently described as a constitutive feature of the schizophrenia spectrum,[57] a reference to such disturbances in schizophrenia appears only in the DSM-III (Glossary of Technical Terms) and is entirely absent in the subsequent editions of the DSM. This leaves clinicians with BPD as the most obvious diagnosis for patients describing disturbance in their "sense of self." Interestingly, the proposal for a definition of schizophrenia in ICD-11 includes the notion of a disturbance of self-experience.[58]

The distinction between form (structure) and content of psychopathological phenomena, which Jaspers emphasized already 100 years ago, is in our view crucial with respect to differentiating disorders of personality from the schizophrenia spectrum, and BPD from SPD in particular. In this context, we find a distinction between the "narrative" and the "core" self useful. Importantly, the structural changes of the core self—located on prereflective levels of consciousness and therefore usually not an object of folk psychological reflection—are, as mentioned, experientially accessible and lend themselves to description and classification.[59] Today's frequency of the BPD diagnosis may also be linked to restrictive criteria for schizophrenia, emphasizing psychotic symptoms of high severity levels.[3,5] The BPD and SPD diagnoses (the latter only infrequently used) probably diagnose the subthreshold patients which would typically meet the ICD-8 and ICD-9 criteria for schizophrenia, including the pseudoneurotic pictures.[60,61]

In conclusion, we believe that the current task of psychiatry is to regain its interest in psychopathology and refine its concepts and descriptions.[62] Such orientation may counteract an increasing skepticism about phenotypic classification.[63]

Acknowledgment

The authors have declared that there are no conflicts of interest in relation to the subject of this study. This research was supported by the VELUX FOUNDATION.

References

1. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC: APA; 1980.
2. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: APA; 2013.
3. Parnas J. DSM-IV and the founding prototype of schizophrenia: are we regressing to a pre-Kraepelinian nosology? In: Kendler KS, Parnas J, eds. *Philosophical Issues in Psychiatry II: Nosology*. Oxford, UK: Oxford University Press; 2012:237–259.
4. First MB. Factors in the development of psychiatric epidemics. In: Kendler KS, Parnas J, eds. *Philosophical Issues in Psychiatry IV: Classification of Psychiatric Illness*. Oxford, UK: Oxford University Press; 2017:130–142.
5. Zandersen M, Henriksen MG, Parnas J. A recurrent question: what is borderline? *J Personal Disord*. In press.
6. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: APA; 1994.
7. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed., text rev. Washington, DC: APA; 2000.
8. World Health Organization (WHO). *The ICD-10 Classification of Mental and Behavioural Disorders. Diagnostic Criteria for Research*. Geneva, Switzerland: WHO; 1993.
9. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed., rev. Washington, DC: APA; 1987.
10. Deutsch H. Some forms of emotional disturbance and their relationship to schizophrenia. *Psychoanal Q.* 1942;11:301–321.
11. Hoch PH, Cattell JP. The diagnosis of pseudoneurotic schizophrenia. *Psychiatr Q*. 1959;33:17–43.
12. Kernberg OF. *Borderline Conditions and Pathological Narcissism*. Northvale, NJ: Jason Aronson; 1985.
13. Erikson EH. The problem of ego identity. *J Am Psychoanal Assoc*. 1956;4:56–121.
14. Kernberg O. Borderline personality organization. *J Am Psychoanal Assoc*. 1967;15:641–685.
15. Kernberg OF. A psychoanalytic classification of character pathology. *J Am Psychoanal Assoc*. 1970;18:800–822.
16. Klein M. Notes on some schizoid mechanisms. *Int J Psychoanal*. 1946;27:99–110.
17. Hartmann H. Comments on the psychoanalytic theory of the ego. *Psychoanal Study Child.* 1950;5:74–96.
18. Jacobson E. Contribution to the meta-psychology of psychotic identifications. *J Am Psychoanal Assoc*. 1954;2:239–262.
19. Jacobson E. *The Self and the Object World*. New York, NY: International Universities Press; 1964.
20. Mahler MS. A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. *Psychoanal Study Child*. 1971;26:403–424.
21. Kernberg OF. What is personality? *J Pers Disord*. 2016;30:145–156.
22. Reich W. *Der triebhafte Charakter: Eine psychoanalytische Studie zur Pathologie des Ich*. Leipzig, Germany: Internationaler Psychoanalytischer Verlag; 1925.
23. Frosch J. The psychotic character: clinical psychiatric considerations. *Psychiatr Q*. 1964;38:81–96.
24. Federn PC. *Ego Psychology and the Psychoses*. New York, NY: Basic Books; 1952.
25. Fenichel O. On the psychology of boredom (1934). In: Fenichel H, Rapaport D, eds. *Collected Papers of Otto Fenichel*, vol. 1. New York, NY: W. W. Norton & Company; 1953:292–302.

26. Fairbairn WRD. *Psychoanalytic Studies of the Personality*. New York, NY: Brunner-Routledge; 1952.
27. Guntrip H. *Schizoid Phenomena, Object Relations and the Self*. London, UK: Karnac Books; 1968.
28. Kohut H. *The Restoration of the Self*. Chicago, IL: The University of Chicago Press; 1977.
29. Adler G, Buie DH Jr. Aloneness and borderline psychopathology: the possible relevance of child development issues. *Int J Psychoanal*. 1979;60:83–96.
30. Singer M. The experience of emptiness in narcissistic and borderline states: I. Deficiency and ego defect versus dynamic-defensive models. *Int Rev Psychoanal.* 1977;4: 459–469.
31. Levy ST. Psychoanalytic perspectives on emptiness. *J Am Psychoanal Assoc*. 1984;32:387–404.
32. Singer M. The experience of emptiness in narcissistic and borderline states: II. The struggle for a sense of self and the potential for suicide. *Int Rev Psychoanal*. 1977;4:471–479.
33. Bleuler E. *Dementia Praecox or the Group of Schizophrenias (trans. J. Zinkin)*. New York, NY: International Universities Press; 1950.
34. Jaspers K. *General Psychopathology (trans. J. Hoenig & M. W. Hamilton)*. London, UK: John Hopkins; 1997.
35. Parnas J. A disappearing heritage: the clinical core of schizophrenia. *Schizophr Bull*. 2011;37:1121–1130.
36. Sass LA, Parnas J. Schizophrenia, consciousness, and the self. *Schizophr Bull*. 2003;29:427–444.
37. Nelson B, Parnas J, Sass LA. Disturbance of minimal self (ipseity) in schizophrenia: clarification and current status. *Schizophr Bull*. 2014;40:479–482.
38. Parnas J, Henriksen MG. Disordered self in the schizophrenia spectrum: a clinical and research perspective. *Harv Rev Psychiatry*. 2014;22:251–265.
39. Raballo A, Sæbye D, Parnas J. Looking at the schizophrenia spectrum through the prism of self-disorders: an empirical study. *Schizophr Bull*. 2011;37:344–351.
40. Haug E, Lien L, Raballo A, et al. Selective aggregation of self-disorders in first-treatment DSM-IV schizophrenia spectrum disorders. *J Nerv Ment Dis*. 2012;200:632–636.
41. Nelson B, Thompson A, Yung AR. Basic self-disturbance predicts psychosis onset in the ultra high risk for psychosis "prodromal" population. *Schizophr Bull*. 2012;38:1277–1287.
42. Nordgaard J, Parnas J. Self-disorders and the schizophrenia spectrum: a study of 100 first hospital admissions. *Schizophr Bull*. 2014;40:1300–1307.
43. Nordgaard J, Handest P, Vollmer-Larsen A, Sæbye D, Pedersen JT, Parnas J. Temporal persistence of anomalous self-experience: a 5years follow-up. *Schizophr Res*. 2017;179:36–40.
44. Nordgaard J, Nilsson LS, Sæbye D, Parnas J. Self-disorders in schizophrenia-spectrum disorders: a 5-year follow-up study. *Eur Arch Psychiatry Clin Neurosci*. 2017. doi:10.1007/s00406-017-0837-3.
45. World Health Organization (WHO). *Glossary of Mental Disorders and Guide to Their Classification: For use in Conjunction with the International Classification of Diseases, 8th Revision*. Geneva, Switzerland: WHO; 1974.
46. Hoch P, Polatin P. Pseudoneurotic forms of schizophrenia. *Psychiatr Q*. 1949;23:248–276.
47. Laing RD. *The Divided Self: An Existential Study in Sanity and Madness*. London, UK: Penguin Books; 1960.
48. Ricoeur P. *Oneself as Another*. Chicago, IL: The University of Chicago Press; 1992.
49. Gallagher S. Philosophical conceptions of the self: implications for cognitive science. *Trends Cogn Sci*. 2000;4:14–21.
50. Zahavi D. *Subjectivity and Selfhood: Investigating the First-Person Perspective*. Cambridge, MA: MIT Press; 2005.
51. Gallagher S, Zahavi D. *The Phenomenological Mind*. 2nd ed. Abingdon, UK: Routledge; 2012.
52. Damasio AR. *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*. New York, NY: Harcourt Brace; 1999.
53. Parnas J. The core gestalt of schizophrenia. *World Psychiatry*. 2012;11:67–69.
54. Parnas J, Henriksen MG. Mysticism and schizophrenia: a phenomenological exploration of the structure of consciousness in the schizophrenia spectrum disorders. *Conscious Cogn*. 2016;43:75–88.
55. Parnas J, Henriksen MG. Selfhood and its disorders. In: Stanghellini G, Broome M, Fusar-Poli P, Fernandez A, Rosfort R, Raballo A, eds. *The Oxford Handbook of Phenomenological Psychopathology*. Oxford, UK: Oxford University Press; in press.
56. Motobayashi Y, Parnas J, Motobayashi Y, Kimura B, Toda DL. 'The "schizophrenic" in the self-consciousness of schizophrenic patients', by Mari Nagai (1990). *Hist Psychiatry*. 2016;27:493–503.
57. Parnas J, Licht D, Bovet P. The Cluster A personality disorders: a review. In: Maj M, Akiskal HS, Mezzich JE, Okasha A, eds. *Personality Disorders. WPA series: Evidence and experience in psychiatry*, vol. 8. Chichester, UK: John Wiley and Sons; 2005:1–74.
58. ICD-11 Beta draft for schizophrenia. https://icd.who.int/dev11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1683919430
59. Parnas J, Møller P, Kircher T, et al. EASE: examination of anomalous self-experience. *Psychopathology*. 2005;38:236–258.
60. Jansson L, Handest P, Nielsen J, Sæbye D, Parnas J. Exploring boundaries of schizophrenia: a comparison of ICD-10 with other diagnostic systems in first-admitted patients. *World Psychiatry*. 2002;1:109–114.
61. Handest P, Parnas J. Clinical characteristics of first-admitted patients with ICD–10 schizotypal disorder. *Br J Psychiatry*. 2005;187:49–54.
62. Parnas J, Sass LA, Zahavi D. Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object. *Schizophr Bull*. 2013;39:270–277.
63. Parnas J, Henriksen MG. Epistemological error and the illusion of phenomenological continuity. *World Psychiatry*. 2016;15:126–127.