

Passive and Active Schizophrenia: Toward a New Descriptive Micropsychopathology

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The “experiences” reported by individuals affected by schizophrenia are fundamental components of the descriptive approach adopted by current diagnostic systems for mental disorders and by clinical diagnostic interviews and rating scales for the assessment of the symptoms of schizophrenia. However, the technical literature does not rely on a specific definition of experiences in schizophrenia. This article introduces a specific, restrictive, operationalized definition of the “experiential substrate” of schizophrenia, defined by the “self-giving” “passive experiences” of the disorder that break into the consciousness of the affected individual, and are distinguished from the “active” acts of judgment formulation and conviction/belief attainment. The experiential substrate of schizophrenia may be considered similar to the experiential substrate of pain. The operationalization of the definition of passive experiences can enable the experiential substrate of schizophrenia to be acknowledged as an independent domain with a specific role in the assessment of the disorder, a role that is substantially omitted or ignored by current research and practice. The term “descriptive micropsychopathology” is proposed for this new method aimed to describe passive experiences and active judgments as independent domains to enhance the reformulation of criteria for symptom assessment and, consequently, reformulation of the criteria for the assessment of the efficacy and effectiveness of interventions aimed at prevention, care, and rehabilitation in schizophrenia. A new measure focusing on the evaluation of the passive experiences of schizophrenia and on the disturbance they cause to patients is also described.

Key words: psychopathology/symptom/experience/judgment/subjective

Introduction

This article introduces and defines the domain of the “experiential substrate” and the “passive experiences” of schizophrenia. Passive experiences are subjective experiences characterized by passive reception of the experience. The term “passive,” used in reference to the experiences of a disorder, shares the same basic etymology of the term “patient,” and the passive experiences are similar to the simple and immediate experiences of pain described in medicine: an individual may feel, suffer, and undergo the experiential substrate of schizophrenia in the same way that other individuals feel, suffer, and undergo the experiential substrate of physical pain. Therefore, other meanings of the term experience (ie, the action of putting to the test, trial, experiment, to make experiment of, to test, to try) are excluded from the experiential substrate, passive experiences, and “passive domain” of schizophrenia because they do not imply the passive nature of this psychopathology domain.

The passive experiences of schizophrenia are here considered a fundamental, independent domain with a precise role in descriptive psychopathology. Passive experiences and active judgments, in particular those judgments formulated in terms of “conviction” or “doubt” about the passive experiences themselves, are distinct domains that need to be analyzed independently. The term “descriptive micropsychopathology” is proposed to describe these independent domains and the architecture of their possible interactions. This article is particularly focused on the definition of passive experiences due to their being currently neglected, omitted, or ignored as an independent domain and their being intermingled and confused with acts of judgment in current descriptive psychopathology.

The introduction and definition of the domain of the experiential substrate and the passive experiences of schizophrenia are divided into 3 main sections. The first section starts with key definitions of experiences, symptoms, and the descriptive approach in psychopathology. This general framework is followed by the new operational definition of passive experiences. This new definition is then applied in an analysis of “thought insertion” and Jaspers’ “delusion proper” and discussed in relation to the relevant historical and current approaches in descriptive psychopathology. The second section of the

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article analyzes a number of semistructured and structured clinical interviews to clarify how this new descriptive approach applies in practice and how these measures conflate what has been defined here as passive experiences with other phenomena. Finally, the third section discusses some practical issues related to the passive experiences of schizophrenia for the assessment of efficacy, effectiveness and subjective usefulness of treatments, and the implications for adherence to treatment in research and practice.

Experiences and Descriptive Approach in Psychopathology

Readers of this article are likely to be familiar with current diagnostic tools and outcome measures. However, they might be less familiar with historical nosology, definitions of psychopathology concepts (Phillips),¹ or phenomenology (Andreasen²).

The descriptive approach in psychopathology was conceptualized by Jaspers³ at the beginning of the 20th century. Jaspers³ emphasized the importance of the descriptions of the patients' experiences, a domain of psychopathology which he named "phenomenology":

Phenomenology is the study which describes patients' subjective experiences and everything else that exists or comes to be within the field of their awareness. These subjective data of experience are in contrast with other objective phenomena, obtained by methods of performance-testing, observation of somatic state or assessment of what the patients' expressions, actions and various productions may mean (p53). ...An experience is better described by the person who has undergone it ... The patients themselves are the observers and we can only test their credibility and judgment Psychotic self-descriptions are not only unique but yield reliable results and through them we have discovered many of our basic concepts. If we compare what patients say we find much that is similar (p55).

Jaspers' concepts focusing on the "description" of the patients' experiences influenced mainstream psychopathology in the areas of clinical interviews, symptom assessment, and diagnostic formulation during subsequent decades. In particular, Schneider⁴ wrote:

Our psychopathology uses the methods of descriptive analysis (pXV). ... the methods of clinical interview from the standpoint of psychopathology were established decades ago by Karl Jaspers... (p94). We have emphasized abnormal experiences and abnormal expression as diagnostically significant symptoms ... (p132).

Similarly, in the 1970s, Wing et al⁵ noted:

... In psychiatric practice there is often nothing else to go on but the patient's own description of his experiences (p4).

and these views were subsequently reflected in *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*

(*DSM-III*), and *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*.⁶

Work began on *DSM-III* in 1974 with publication in 1980. *DSM-III* introduced a number of important methodological innovations, including ... a descriptive approach that attempted to be neutral with respect to theories of etiology (pXXVI).

The word "phenomenon" (Andreasen⁷)

... is now roughly equivalent to reported or observed experiences of patients (or signs and symptoms in psychopathology) This type of study focuses on human experience at a fine graded and detailed level and does not make inferences about specific disease states

Experiences and Symptoms in Psychiatry and Medicine

In spite of the universal use and abuse of the term "experiences," a specific, technical, operationalized definition of experiences has not been yet formulated and the term experiences is systematically omitted from psychiatric glossaries. As a result, psychiatry lacks a clear definition of the domain of the experiential substrate of psychiatric disorders and consequently of the relationships between experiential substrate, symptom, and sign in psychiatry and medicine. Jaspers³ emphasized that the key feature of "symptom" and "sign" (the 2 terms share the same basic meaning of "indicator") is to recognize an underlying event, in its causal aspect, which we cannot perceive directly:

The extra-conscious element which we cannot perceive directly is recognized by a sign or symptom. All the phenomena of psychic and somatic life are conceivable as signs or symptoms, when we consider the underlying event in its causal aspect. If the extra-conscious element is a known physical process, the psychic phenomena are then signs or symptoms of this process ... (pp459-460).

This concept is further elaborated by Schneider⁴:

What does a symptom mean? In medicine we take it to mean the sign of an illness, an understandable indication of an illness. Experience teaches that this or that sign occurs with this or that illness, and through experience we learn that if we heed certain signs, we can conclude the presence of a certain illness. ... What meaning can "symptom" have with these "endogenous psychoses", ie those that have no demonstrable somatic base. Still thinking in medical terms we may say that the onset of delusion, for example, is a symptom of an illness, undemonstrable, it is true but it can at least be postulated. It would be wiser, however, in this case to understand by "symptom" some generally characteristic, constant feature of a purely psychopathological nature that can be structured into an existing state with a subsequent course. In this case the medical connotation of symptom is abandoned. A psychopathological structure consisting of a "state" and "course" is not an illness which can produce symptoms. Thought withdrawal, for instance, is at bottom,

not a symptom of the purely psychopathologically conceived state of schizophrenia, but it is a factor frequently found and therefore a prominent feature of it If we find thought-withdrawal in a psychosis of not known somatic base, there is only an agreed convention that I then call this psychosis a schizophrenia. It seems well worthwhile preserving this particular meaning of "symptom". We are in a sphere of endogenous, not demonstrably somatic, psychoses, which at present are only psychopathologically established. The "token sign" or characteristic feature is, therefore, still a clinical concept, referring to a psychopathologically constructed "state" and "course" (pp130-132).

The objective/subjective distinction is reported by Jaspers⁸ to refer simply to the modality in which the symptoms are evaluated

"Objective symptoms" include all concrete events that can be perceived by the senses, e.g. reflexes, registrable movements, and individual physiognomy, his motor activity, verbal expression, written productions, actions and general conduct, etc.; ... It is also usual to include under objective symptoms such features as delusional ideas, falsification of memory, in other words the rational contents of what the patient tells us Subjective symptoms ... are all those psychic experiences and phenomena which patients describe to us and which only become accessible to us at second hand through the patient's own judgment and presentation"

and "objective symptoms" are not assigned a special value as indicators of the underlying event which we cannot perceive directly.

The current definition of symptom in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*⁶:

a subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner (p828).

and the definition of sign⁶:

an objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual (p827).

underlines the differentiation between symptom, defined as a subjective manifestation of the "pathological condition" *because* it is reported by the affected individual, and sign, defined an objective manifestation *because* it is observed by the examiner.

The relevance given to the source of clinical information (subjective or objective collection) in the symptom/sign categorization in comparison with the key feature of their possible value as indicators has been criticized in medicine⁹ and is particularly fragile in psychiatry and schizophrenia.

This article introduces and defines the experiential substrate and the passive experiences of schizophrenia, a domain that is to be considered "subjective" and a possible

indicator of what, according to Schneider,⁴ "only an agreed convention names schizophrenia." Passive experiences can be considered conceptually similar to the characteristic subjective experience of pain radiation in myocardial infarction. If the somatic base of myocardial infarction was unknown, the characteristic subjective (passive) experience of pain radiation would be considered an indicator of what only an agreed convention would name myocardial infarction.

In this context, among possible indicators, the descriptive psychopathology of schizophrenia should in particular differentiate

- (i) passive experiences directly described by the subject (only the subject is able to "observe" them), whose evaluation by the clinician relies simply on the mere *transcription* of the description of the experiential substrate of the disorder given by the subject (ie, passive experiences in the various domains, of thought, perception, emotion, etc.);
- (ii) subject's judgment (incidentally, the term "judgment" is currently neglected by psychiatric glossaries) observed by the clinician, whose evaluation relies on the clinical evaluation of the subject's active and intentional process of judgment formulation, either on his/her own passive experiences or not, either in terms of doubt or belief/conviction, either delusional or not (ie, delusional judgments); and
- (iii) behavioral symptoms observed by the clinician, whose evaluation does neither rely on any subject's mere self-observation and description of the experiential substrate nor on the subject's judgment (ie, pressure of speech, affective blunting, movement disorder).

The passive experiences, that only the patient is able to observe, can be transcribed and collected independently and may be valuable symptoms and indicator of schizophrenia in themselves. Similarly to the assessment of pain, where the subjective experience of pain and pain behavior are independently assessed, the passive experience (ie, of hallucination) needs to be assessed separately from the related judgment or behavior (ie, "hallucinatory behavior") and not collapsed with them.

This article focuses on the first type of possible indicators: the experiential substrate and passive experiences of schizophrenia as a specific, independent domain. Judgment and behaviors are examined only to clarify the boundaries of the passive experiences and to highlight their different nature. In particular, the distinction between the passive experiences of the disorder and the judgment formulated by the patient toward the passive experiences themselves, aimed to understand or explain the passive experiences, will be carefully examined.

Definition of the Passive Experiences

The following explicit, restrictive use of the term passive experiences in schizophrenia is formulated. Passive experiences (hypothesized to represent the experiential substrate of the disorder) are defined as follows:

- (i) Passively and involuntarily received, simple, immediate, self-giving.
- (ii) Nonoptional, unavoidable, self-evident.
- (iii) Easily recognized and acknowledged by patients, who are able to describe and recognize/acknowledge the individual passive experiences if adequately questioned.
- (iv) Experienced in various areas (eg, thought, perception, emotion).
- (v) Potential indicators of schizophrenia.
- (vi) Frequently experienced as enigmatic and puzzling.
- (vii) Frequently experienced as disturbing.

This restrictive definition of the passive experiences excludes the subject's

- (i) Active and intentional "position taking" toward each passive experience;
- (ii) Actively and intentionally formulated judgments, ideas, notions, convictions, and beliefs;
- (iii) Acts of judgment formulation aimed to understand/explain each passive experience in terms of doubt/belief, no conviction/conviction, uncertainty/certainty; and
- (iv) Acts of judgment formulation aimed at understanding or explaining the passive experience in terms of its relationship to a codified and/or operationalized symptom or diagnosis of schizophrenia ("awareness of illness" or "insight").

The terms passive experiences, passive domain, and experiential substrate should not be confused with terms like "passivity phenomena" or with the "positive" and "negative" domains. The passive experiences, passive domain, and experiential substrate are intended to refer to the general schizophrenic condition.

Thought Insertion, Jaspers' Delusion Proper, and Passive Experiences

To clarify how this new definition applies, 2 core concepts in the psychopathology of schizophrenia will be analyzed due to their controversial categorization: thought insertion (Mullins and Speance¹⁰) and Jaspers' delusion proper (Spitzer et al,¹¹ Jones et al,¹² and Owen et al¹³). They provide a useful opportunity to examine how this new approach may contribute to their reformulation.

Thought Insertion

Jaspers³ included thought insertion in the domain of "awareness of self." He described how thought phenomena differ from the "normal," "familiar" process of thinking.

We take it for granted that when we think, it is we who think, a thought is our thought and the notions that strike us—and perhaps make us say not 'I think' but 'It occurs to me'—are still at the same time our thoughts, executed by us The thought phenomena of schizophrenics is something quite different in that they talk about 'thoughts made by others' (passivity thinking) and 'thought withdrawal', using words coined by themselves, which psychopathology has had to take over ... The patient does not know why he has this thought nor did he intend to have it ... (p122)

This approach did not change substantially in Schneider⁴:

Among the many abnormal modes of experience that occur in schizophrenics, there are some which we put in the first rank of importance (p133) ... the group of symptoms which constitute "loss of identity"(ego disturbance): Thought-withdrawal, passivity thinking, diffusion of thought, and all passivity experiences whether feeling, drive or volition, may be involved ... (p134).

nor in the Present State Examination (PSE)⁵ which considered this phenomenon an "experience" and not a delusion itself:

The essence of this symptom is that the subject experiences thoughts which are not his own intruding into his mind (p160).

The PSE⁵ instructions for rating thought insertion are

Include only thoughts recognized as alien. Do not include delusional elaboration, only basic experience (p207).

DSM-IV phenomenon of thought insertion was included as a specific example of the symptom "delusions" and considered a "bizarre delusion"⁶:

Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences ... delusions that express a loss of control over mind and body are generally to be considered bizarre, these include a person's belief that his or her thoughts have been taken away by some outside force ("thought withdrawal"), that alien thoughts have been put into his or her mind "thought insertion" ... If the delusions are considered to be bizarre only this single symptom is needed to satisfy Criterion A for schizophrenia (p299).

The *DSM-IV* thought insertion and thought withdrawal may be considered only homonymous of the "original" Schneider's first rank symptoms: Schneider considered them abnormal modes of experience, while *DSM-IV* intermingled and conflated them with delusions.

Jaspers' Delusion Proper

Delusion proper (defined also as “primary, final, irreducible delusion,” and “delusional experience”) was a concept developed by Jaspers³ to distinguish 2 large groups of delusions according to their origin:

We can then distinguish two large groups of delusion according to their origin: one group emerges understandably from preceding affects, from shattering, mortifying, guilt provoking or other such experiences, from false perception or from the experience of derealization in states of altered consciousness, etc. The other group is for us psychologically irreducible; phenomenologically it is something final. We give the term delusion-like ideas to the first group; the latter we term “delusion proper”(p96).

Delusion proper, defined by Jaspers³ phenomenologically as a final experience that is psychologically irreducible, has 2 other main characteristics: It is “beyond our understanding” and it is characterized by the “intrusive knowledge of the meaning.”

If we try to get some new understanding of these primary experiences of delusion we soon find we cannot really appreciate these quite alien modes of experience. They remain largely incomprehensible, unreal and beyond our understanding (Jaspers, p98) Everything gets a new meaning ... the environment offers a world of new meanings. All thinking is thinking about meanings ... There is an immediate intrusive knowledge of the meaning and it is this which is itself the delusional experience (wahn-erleben). If we distinguish the different sense-data in which meaning of this sort can be experienced, we can speak of delusional perception, delusional ideas, delusional memories, delusional awareness, etc.) (p99). [In Schneider,⁴ the criterion of something primary, psychologically irreducible is not adopted (p114) in his definition of delusional perception (p104) and delusional notion (p107). Note of the Author]

DSM-IV invoked Jaspers to characterize bizarre delusions¹⁴:

... bizarre delusions ... would be implausible. The definition represented an effort to invoke Jaspersian concepts of “non-understandability”(*DSM-IV Sourcebook*, Vol 1, p345).

Three alternative definitions formulated to improve (unsuccessfully) the reliability of bizarre delusions (Spitzer et al¹¹) included the ununderstandability of Jaspers' delusion proper:

... “delusions proper” which are by their nature “psychologically irreducible,” that is un-understandable. ... While “delusion-like ideas” occur in many psychopathological states, according to Jaspers, “delusions proper” are relatively specific of schizophrenia ...

An example of a delusion that was rated as “bizarre” according to each of the 3 formulations (the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*, definition “involving a phenomenon that the person's culture would regard as totally implausible,”

a definition that involves “beliefs that violate virtually all subcultures' understanding of the natural and physical world,” and finally a definition “that involves thought processes that are so divorced from normal human experience that the delusions are ununderstandable”) is reported below¹¹:

A 41-year-old woman had the delusion that a famous author had obtained a machine that she was using in an attempt to cure the patient of her emotional problems. This machine was able to read her thoughts and to insert thoughts and feelings into her mind. The writer has failed in her attempt to cure the patient, who now intended to sue her for harassment.

However, the Jaspers' delusion proper quoted in *DSM* might be considered only homonymous of the “original” Jaspers' delusion proper: Jaspers related the ununderstandability to the “immediate intrusive knowledge of the meaning” rather than simply to “... thought processes that are so divorced from normal human experience ...” The exclusion criteria of “primary” delusion adopted, eg, by the PSE⁵ may be considered incompatible with the *DSM* example reported above: “... Do not, of course, include delusions which are explanations of other phenomena, such as thought insertion, hallucinations, subcultural beliefs, etc., as most are ...” (p173).

The patient's description above can be compared with the following patient's words reported by Jaspers³ in which the enigmatic experience is not completely intermingled and “obscured” by the judgment about it.

... However precisely my thoughts are understood and however much entire sentences are shouted at me by the apparatus, it is a fact that I know quite definitely that to a large extent these are not my own thoughts and that is the great puzzle ... (p580).

Enigmatic, puzzling characteristics of experiences of the disorder have been frequently described in the scientific literature: Kraepelin¹⁵ reports the “bewildered and confused patients to whom everything appears changed, incomprehensible and mysterious” (p48). The subjects use words and sentences like *infamous game* (p56), *enchanted house* (p112), *mystery* (p112), *secret gossiping* (p117), *something false in things* (p118), *puzzles* (p169), *masked* (p169), and *secret* (p169) and formulate questions (ie, inwardly directed to the voices): ... *Why are you speaking in me? ... Why do you torment me? ... What is your real object? ... Are you human beings or spirits? ...* (p193-p194).

Similar words and sentences are described in Bleuler¹⁶: *strange, different*, (p68); Mc Ghie and Chapman¹⁷: *frightening, unexpected*; Cutting¹⁸: *frightening* (pp259, 279), *unreal* (p267), *unexpected* (p279); and Jaspers³ himself: *amazing* (p73), *alien* (pp86, 118), *bewitched* (pp100, 102), *unnatural* (pp100, 102), *ambiguous* (p100), *uncanny*

(p102), *unusual* (p102), *odd* (pp100, 152), *inexplicable* (p118), *extraordinary* (p124), *surprised* (pp72, 77, 152), *riddle* (p579), and *puzzle* (pp153, 580).

The terms reported above are hypothesized to represent the enigmatic connotations of the experiential substrate of the disorder that may be suffered in any affected function (thought, perception, mood, etc.) in schizophrenia. These enigmatic characteristics indicate that the experiences of the disorder are unexpected, are received suddenly, are “self-giving,” and have frequently abnormal, strange, alien connotations for the patients themselves.

The Jaspers’ concept of “delusional experience/delusion proper/primary delusion,” characterized by “intrusive knowledge of meaning” and by being “ununderstandable,” has been loosely adopted to support different and incompatible views of delusions. This concept is not considered worthy of adoption in the approach presented here. This concept and, in particular, the construct of the “phenomenologically final, psychologically irreducible, beyond our understanding, delusional experience (wahn-erleben) of meaning,” might collapse and intermingle a number of different phenomena: (1) the patient’s enigmatic passive experience, (2) the patient’s acts of judgment directed to understand/explain the enigmatic passive experience, (3) the psychopathologist’s enigmatic experience of the patient’s delusion, and (4) the psychopathologist (not) understanding/explaining the patient’s delusion. Therefore, the alien, enigmatic, not understandable patient’s delusional experience/delusion proper/primary delusion that is observed by the clinician (and is beyond the clinician’s understanding) may simply mirror the alien, enigmatic passive experience that irrupts in the awareness of the patient (and that is beyond the patient’s understanding).

For Jaspers,³ the “enigmatic” was confined to the researcher’s active, intentional, and voluntary reaching the margin of a mode of knowing:

... Everything enigmatic therefore is a reminder to us to accept the failure of a particular mode of comprehension and at the same time to search for some other mode whereby the facts are no longer enigmatic to us but become a ground for insight. Everything enigmatic always lies at the margins of a particular mode of knowing ... (p752).

and it is here hypothesized that the patients could passively, unintentionally, and involuntarily reach a similar margin of their personal mode of knowing toward the enigmatic passive experiences of the disorder. These passive experiences might be received persistently and might continue to remain a puzzle for the patient over time, in spite of his or her attempts aimed at “understanding” or “explaining” them.

In the descriptive approach presented here, any passive experience of a disorder may be considered “beyond the understanding of affected subjects,” similarly to any passive experience of any physical condition (eg, physical

pain). Acts of judgment formulation aimed at intentionally understanding or causally explaining passive experiences are consequently not included in this definition of passive experiences. They are here considered (active) acts of the subject toward his/her own self-giving, possibly alien and enigmatic passive experiences of the disorder. In this approach, the definition of “delusion” formulated toward the passive experiences should imply that

- (i) The act of judgment formulation is always at the basis of the “delusional judgment” (the Jaspers’ term “delusional experience” is considered misleading in this approach and excluded).
- (ii) The judgment may be expressed in terms of belief or doubt, conviction or no conviction, certainty, or uncertainty.
- (iii) The delusion stems from an “active,” intentional process of judgment formulated by the subject toward his own specific self-giving experiential substrate (obviously, it does not exclude that the delusional judgment formulation could be actively developed in the absence of any specific passive experience).
- (iv) The conviction/belief that characterizes the subject’s delusion will be always the end-point “evidence” of his or her active, intentional, process of judgment formulation about passive experiences and it is not to be confused with the “self-evidence” of the immediate, self-giving, passive experiences of the disorder.

A New Measure to Assess the Experiential Substrate of Schizophrenia

The *Scale for the Assessment of Passively Received Experiences* (PRE) is a measure currently under development by the author of this article. The PRE items focus on passive experiences of schizophrenia as an independent psychopathological domain and as distinct from judgments made to understand and explain the passive experiences. This measure is radically different from other clinical measures. The PRE includes several questions referring to different passive experiences of thought insertion, including

Do you ever have the feeling that thoughts that are not your own are suddenly put in your head against your will?

This question explores the passive domain by identifying and describing the specific passive experience and disentangling it from the active acts of the process of judgment formulation. These acts may be further examined by a proper articulation of subsequent questions aimed at analyzing the acts of the judgment formulation and at exploring and describing the architecture and the interactions of the process from passive experience to judgment (and delusion) and from judgment (and delusion) back to passive experience. An individual

- may report that he or she has the specific passive experience

and this is hypothesized to be the specific, irreducible, final, original passive experience, and subsequently may or may not take this passive experience as the substrate of a possible pathway of acts: he/she

- may or may not “take a position” about this original passive experience;
- may or may not develop acts of judgment formulation for understanding/explaining the passive experience in terms of doubt or conviction, uncertainty, or certainty;
- may or may not develop delusional notions/ideas for understanding/explaining this passive experience;
- may be doubtful or convinced, uncertain, or certain about his/her delusional understanding/explaining of this passive experience.

The individual may proceed in a possible pathway of acts in the opposite direction, from the conviction about his/her possible delusional understanding/explaining of the passive experience to the original passive experience itself and

- may or may not intentionally and actively return back to the original passive experience;
- may or may not retake position toward the original passive experience

and to use the original passive experience as a firm point and “lever” to reformulate previous judgments aimed at understanding/explaining the passive experience itself: he/she

- may or may not reformulate alternative explanations of the passive experience;
- may or may not compare his previous understanding/explaining the passive experience (either delusional or not) with a number of alternative possible options aimed at understanding/explaining this passive experience;
- may or may not recognize that other options for understanding/explaining the original passive experience (either delusional or not) may not be worse than his or her previous act of understanding/explaining.

This process disentangles the original passive experience from acts of intentional judgment formulation about the experience and also accounts for the relevant opportunity to reconsider and critically evaluate both the original experience and competing explanations of it, criticism that may only be possible for the patient through a return to the original passive experience.

The disorder may be characterized only by the passive experience that the subject receives because he/she has

not yet proceeded along a chain of judgment formulation about a specific passive experience, because he/she is unable to formulate such a judgment, simply because he/she has not sufficient motive to formulate a judgment either delusional or not toward the passive experience.

Interview questions focusing only on the passive experience might be considered similar to the simplest medical exploration of the patient’s passive experience of physical pain. The physician never asks: “*Do you think, suspect, doubt, postulate, notice, know, have the idea, are convinced or believe you have pain here?*” because the nature of the simple, immediate, self-giving, passive experience of pain is obvious. The patient might take an active position toward his or her experience of pain, might search for a meaning for it and/or formulate causal explanations, but those phenomena are distinct from the immediate, specific, independent, self-giving experience of pain, which is well recognized as an independent domain that needs to be consistently assessed.

Thought insertion is here defined as an immediate, self-giving, self-evident passive experience in the domain of the experiential substrate of schizophrenia which irrupts in the awareness of the subject similarly to the experience of pain. This phenomenon is distinguished from the intentional, active process of judgment formulation that the subject may or may not develop toward this passive experience, either aimed at understanding the meanings of the experience or at explaining its causes. This judgment may be formulated in terms of doubt or conviction/belief and may or may not be delusional.

The passive domain is not considered in the criteria (Andreasen¹⁹) proposed for assigning a cutoff score for symptomatic remission in schizophrenia, which suggests that a symptom severity score of mild or less (Positive and Negative Syndrome Scale [PANSS] item scores of ≤ 3 ; Brief Psychiatric Rating Scale item scores of ≤ 3 , and Scale for the Assessment of Positive Symptoms [SAPS]-Scale for the Assessment of Negative Symptoms [SANS] scores ≤ 3) on all items as representative of an impairment level consistent with symptomatic remission of the illness.

These symptomatic remission criteria have been considered to have clinical validity (Van Os et al²⁰) and to be both sensitive and specific indicators of clinical status (Opler et al²¹).

However, if these operational criteria for defining symptomatic remission in schizophrenia are applied, ie, to delusions, as they are defined in the SAPS and the PANSS, following the approach presented here, the key cutoff of remission is simply limited to the transition through the border “being convinced/questioning” about the delusion (SAPS) and “tenaciously holding/not tenaciously holding” (PANSS) the delusion (the SAPS and the PANSS scales will be examined in detail in the following section).

These criteria neglect a fundamental border that might be particularly useful in the definition of transition to remission: the border between (1) the possible passive

experience, as here defined (ie, thought insertion), about which the judgment (or delusional judgment) is formulated and (2) the possible judgment (or delusional judgment) in terms of “questioning/not tenaciously holding” and being convinced/tenaciously holding toward the passive experience itself (ie, thought insertion).

Obviously, the fundamental assessment of the remission of the passive experience itself (ie, of thought insertion) is also clearly neglected, an important omission because these experiences may be independent symptoms (indicators) of schizophrenia, may be persistent over time, may be severely disturbing for the patient, and if not specifically assessed, continue to be largely ignored by research and care.

Experience, Judgment, and Delusion in Semistructured and Structured Clinical Interviews

The semistructured and structured clinical interviews currently in use may be considered to share a basic, common conceptual problem: the term experience is not technically, operationally defined; it is interchangeably used with other terms; its passive nature is not considered and it is confused with acts of judgment about the experiences, actively formulated ideas, notions, and beliefs, either delusional or not, held with either doubt or firm conviction.

To further clarify the operationalized definition of passive experiences presented above and illustrate how this approach differs in practice from other approaches, a number of well-known clinical measures are examined in detail: Composite International Diagnostic Interview (CIDI), Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID), SAPS, and PANSS.

Diagnostic Clinical Interviews

Composite International Diagnostic Interview. The CIDI is a fully structured psychiatric diagnostic interview in which interviewer judgment plays no part in the responses. This respondent-based interview, frequently administered by lay interviewers, uses totally structured questions that the respondent answers, often in a yes-no format.

The CIDI-1²² question about thought insertion

Have you ever been convinced that strange thoughts, or thoughts that were not your own, were being put directly into your mind? ...

collapses the passive experience with judgments in terms of conviction about the experience.

The CIDI has been recently reformulated by the World Mental Health (WMH) Survey Initiative Version of the World Health Organization—CIDI (Kessler and Ustun²³). The authors report that the previous CIDI approach was based on the assumption that “psychotics

would be more willing to admit their symptoms if these phenomena were normalized”:

... The standard version of the CIDI introduces the psychosis questions with the statement: “Now I want to ask you about some ideas you might have about other people ... The first question is “Have you ever believed people were spying on you?” A great many people answer these responses positively, the vast majority of whom give plausible answers. This is not surprising as the experiences asked about are all quite common

The authors²³ noted that this approach generates an enormous number of false positives that would complicate the process of screening for psychosis and also introduce the strong possibility of errors in classifying false positives as cases based on open-ended responses. They have reformulated radically the CIDI interview to avoid these problems:

The philosophy behind the WMH-CIDI approach is the opposite: to make it clear to respondents that we are asking about odd experiences; to motivate reporting with an introduction that validates the experiences and points to the importance of learning more about them; and beginning the questioning with hallucinations rather than delusions in order to reinforce the introductory remarks about the questions being about odd behaviours.

The CIDI-3.0 reformulation of the question referring to thought insertion:

... The third thing is really two. One is believing that some mysterious force was inserting many different strange thoughts—that were definitely not your own thoughts—directly into your head by means of x-rays or laser beams or other methods. [The other is believing that your own thoughts were being stolen out of your mind by some strange force.] Did you ever have either of these mind control experiences?

The authors’ aim of formulating a question indicating sufficiently “odd experiences” to avoid false positives through a single yes/no “totally structured question” is reinforced by including in the question the indication/suggestion of a causal explanation of thought insertion (“by means of x-rays or laser beams or other methods”). The term experiences is not technically defined by the authors and it is interchangeably used with terms like “ideas” and “behaviors.” The authors do not specify if they consider irreducible or reducible what is described in this totally structured question that can be administered by lay interviewers.

If what CIDI-3.0 describes is not irreducible, as is hypothesized here, this formulation could confuse and collapse (1) the passive experience with (2) the act of judgment formulation in terms of belief about the passive experience and with (3) the act of judgment formulation in terms of belief about the causal explanation of

the phenomenon (intentionality of external force and instruments to put in practice the intention of control).

Future CIDI revisions may benefit from reformulating questions that link experiences to delusional causal explanations. The interviewer should (1) first assess independently the experiential substrate of the disorder and (2) only subsequently attempt to identify the complex “architecture” of the possible process of delusional judgment formulation about the experiences themselves, using a number of appropriately designed, *step-by-step* questions to prevent a collapsed question from inducing a collapsed answer. Lay interviewers might not be ideal for these step-by-step types of questions.

Structured Clinical Interview for DSM-IV Axis I Disorders. The SCID-I²⁴ is a semistructured interview for making the major *DSM-IV* Axis I diagnoses. It is administered by a clinician or trained mental health professional who is familiar with the *DSM-IV* classification and diagnostic criteria. The SCID-I does not have a specific section aimed at defining, evaluating, and scaling thought insertion as a specific symptom. The user’s guide refers to thought insertion only in the context of “delusions of being controlled” in which

Feelings, impulses, thoughts or actions are experienced as being under the control of some external force.

The clinical interview employs the following question:

Did you ever feel that someone or something outside yourself was controlling your thoughts or actions against your will?

This is followed by the question specifically focusing on thought insertion

Did you ever feel that certain thoughts that were not your own were put into your head? (What about taken out of your head?)

Even though the specific questions focus on the respondent’s “feeling,” the experiential substrate of the disorder is not independently defined, described, evaluated, or scaled by the SCID. The SCID focuses the rating only on the differentiation between “overvalued idea” and delusion, while the assessment of the experiential substrate is omitted: in rating each type of delusion the interviewer must differentiate a delusion (which warrant a rating of 3=threshold or true) from a strongly held overvalued idea (which warrant a rating of 2=subthreshold). *DSM-IV-TR* definition of overvalued idea⁶

An unreasonable and sustained belief that is maintained with less than delusional intensity (i.e. the person is able to acknowledge the possibility that the belief may not be true (p826).

ignores the description of the independent domain of the experiential substrate of the disorder.

Thought insertion is not considered by SCID-I to be an independent symptom (indicator) with an independent score: it is to be simply checked by the rater as a feature of the symptom (indicator) delusion of being controlled. The rationale for this decision is not provided. If thought insertion is not simply a feature of the delusion of being controlled, but an independent passive experience and a possible independent symptom (indicator), as hypothesized here, the procedure of *first* interviewing the subject about the delusion of being controlled and *then* checking about thought insertion might insubstantially suggest to the patient that the external control is acknowledged by the interviewer as “cause” of what is received by the subject as a passive experience of thought insertion. If, as here hypothesized, the passive experience of thought insertion is an independent symptom of schizophrenia, this interview procedure could be source of confusion for the patient.

Future SCID-I revisions may benefit from reformulating questions and administration procedures that assess thought insertion and the delusion of being controlled. The interviewer should first focus on the assessment of the passive experience of thought insertion as an independent symptom and separately assess the delusion of being controlled as a different symptom, using carefully designed step-by-step questions.

Scales for Symptoms Assessment

Scale for the Assessment of Positive Symptoms. The *SAPS* (Andreasen²⁵) is designed to assess positive symptoms, principally those that occur in schizophrenia. It is intended to serve as a complementary instrument to the *SANS*.

In the *SAPS* thought insertion is defined:

The subject believes that thoughts that are not his own have been inserted into his mind. For example, the subject may believe that a neighbor is practicing voodoo and planting alien sexual thoughts in his mind. This symptom should not be confused with experiencing unpleasant thoughts that the subject recognizes as his own, such as delusions of persecution or guilt.

The related questions are

Have you ever felt that thoughts were being put into your head by some outside force? Have you ever experienced thoughts that didn’t seem to be your own?

The *SAPS* scales thought insertion as follows:

- 0—None.
- 1—*Questionable*.
- 2—*Mild: Subject has experienced thought insertion, but doubts it occasionally.*
- 3—*Moderate: Clear experience of thought insertion, which occurred on two or three occasions in a week.*

- 4—*Marked: Clear experience of thought insertion, which occurs frequently; behavior may be affected.*
- 5—*Severe: Clear experience of thought insertion which occurs frequently, pervades the subject's life, and affect behavior.*

The SAPS describes and scales judgments in terms of doubt/no doubt and does not describe what is considered here the independent domain of the passive experience of thought insertion. Thought insertion is reported by the SAPS as “experienced”; however no technical definition of the experience is provided, and the relationship between experience and delusion is not operationalized.

The SAPS Global Rating of Severity of Delusions, defined “... false beliefs that cannot be explained on the basis of the subject's cultural background ...” is based on “... duration and persistence of delusions, the extent of the subject's preoccupation with the delusions, his degree of conviction, and their effect on his actions ... the extent to which the delusions might be considered bizarre or unusual”

- 0—*None.*
- 1—*Questionable.*
- 2—*Mild: Delusion definitely present but, at times, the subject questions the belief.*
- 3—*Moderate: The subject is convinced of the belief, but it may occur infrequently and have little effect on his behavior.*
- 4—*Marked: The delusion is firmly held; it occurs frequently and affects the subject's behavior.*
- 5—*Severe: Delusions are complex, well formed, and pervasive; they are firmly held and have a major effect on the subject's behavior; they may be somewhat bizarre or unusual.*

Thus, the SAPS does not define or assess the experiential substrate of schizophrenia separately from acts of judgment. Instead, it intermingles thought insertion with “false” belief.

Positive and Negative Syndrome Scale. The PANSS²⁶ is a semistructured clinical interview “conceived as an operationalized, drug-sensitive instrument that provides balanced representation of positive and negative symptoms and gauges their relationships to one another and to global psychopathology.” It is frequently used for the evaluation of treatment response in schizophrenia. Thought insertion is not specifically assessed in the PANSS' delusions. In the PANSS, delusions are defined as “beliefs that are unfounded, unrealistic, and idiosyncratic.”

The PANSS uses the following scale to rate delusions.

- 1—*Absent: Definition does not apply.*
- 2—*Minimal: Questionable pathology; the patient may be at the upper extreme of normal limits.*

3—*Mild: Presence of 1 or 2 delusions that are vague, uncrystallized, and not tenaciously held. The delusions do not interfere with the patient's thinking, social relation, or behavior.*

4—*Moderate: Presence of either a kaleidoscopic array of poorly formed, unstable delusions, or a few well-formed delusions that occasionally interfere with the patient's thinking, social relations, or behavior.*

5—*Moderate-severe: Presence of numerous well-formed delusions that are tenaciously held and occasionally interfere with the patient's thinking, social relations, or behavior.*

6—*Severe: Presence of a stable set of delusions that are crystallized, possibly systematized, tenaciously held, and clearly interfere with the patient's thinking, social relations, and behavior.*

7—*Extreme: Presence of a stable set of delusions that are either highly systematized or very numerous and dominate major facets of the patient's life. This behavior frequently results in inappropriate and irresponsible action that may even jeopardize the safety of the patient or others.*

The experiential substrate of the disorder is not defined, described, or evaluated in the PANSS scaling of delusions. Similarly to the other measures discussed above, the PANSS describes and scales acts of judgment formulation in the key modalities of tenaciously held/not tenaciously held, “stability/unstability,” “systematization/not systematization,” and “crystalization/not crystalization.” The PANSS ignores/omits the assessment of the treatment response of what is considered here the independent domain of the experiential substrate of the disorder and the possible subjective disturbance that the passive experiences (ie, thought insertion) may directly cause to the patient over time.

Effectiveness, Subjective Usefulness, and Adherence to Treatment

The experiential substrate and the passive experiences of schizophrenia may have a significant role in the assessment of the efficacy and effectiveness of treatments for schizophrenia. Many passive experiences of schizophrenia are reported by subjects as severely and immediately disturbing in themselves, and the assessment of this domain may provide a potentially valuable extension of current methods for evaluating clinical outcomes and treatment impact and for informing research and development of new treatments and new drugs for schizophrenia.

The main strategy for drug development has been to target positive psychotic symptoms (hallucinations, delusions, and disorganization) and hope that antipsychotic efficacy will extend to other aspects of schizophrenia, including negative symptoms. The relative lack of success in developing pharmacological treatments for negative symptoms points to the insufficiency of this strategy

and raises questions about the assumption of a common neuropsychopharmacology (Kirkpatrick et al²⁷).

Recent conclusions about the efficacy and effectiveness of antipsychotic medications from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) (Lieberman et al²⁸) relied on time to discontinuation of medication for any reason—a side effect, poor efficacy, or the patient’s decision about adherence—as the principal outcome variable. A single clinical rating of symptoms, The *PANSS* was evaluated as a secondary outcome. In all, 75% of 1493 patients with schizophrenia, recruited at 57 US sites and randomly assigned to receive conventional and atypical antipsychotics, stopped taking their first medication before the end of the 18-month study. The opportunity to switch to another antipsychotic only marginally reduced the 75% global discontinuation before the end of 18 months. The CATIE results were considered discouraging because they demonstrated that treating schizophrenia, even with newer, second generation drugs, is only partially effective and is associated with problematic side effects (Freedman²⁹).

The focus on positive psychotic symptoms of schizophrenia is likely due to the relevance they have in the current diagnostic practice on the basis of their supposed roots in the history of psychiatry:

... Those patients who qualify by virtue of having delusions and hallucinations manifests the most typically Kraepelinian form of the disorder ... (*DSM-IV-TR Guidebook*^{30(p163)}).

... Only one Criterion A symptom is required if delusions are bizarre ... (*DSM-IV-TR*^{6(p312)}).

However, Kraepelin¹⁵ did not consider “delusions and hallucinations” as the most typical form of “dementia praecox”:

... unfortunately there is in the domain of psychic disorders no single morbid symptom which is thoroughly characteristic of a definite malady (p257) ... In the controversy about the significance of isolated morbid symptoms... the frequently employed conception of “catatonic” phenomena embraces a number of characteristics which are only in the smallest part specially peculiar to catatonia... A more or less convincing proof is given by their accumulation and their connection with yet other disorders in themselves likewise not characteristic, as hallucinations, delusions of influence on will ... As already mentioned genuine negativism, instinctive, purely passive resistance, seems to me to possess the relatively greatest significance as an isolated symptom ... (p261).

and the “bizarre ununderstandable Schneiderian delusion” previously examined might be better described, as it is here proposed, by the interaction of passive experience and the acts of judgment toward the passive experience, suggesting that even the narrowest definition of “psychotic” reported in *DSM-IV-TR*⁶:

... The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations

occurring in the absence of insight into their pathological nature ... (p827).

might not be sufficiently narrow because it might collapse, eg, the passive experience of thought insertion and the active judgment toward this experience (either delusional or not, either formulated in terms of doubt or conviction/belief), domains that might be different and heterogeneous.

The centrality of delusions and hallucinations (mainly defined and scaled on the basis of the conviction about false beliefs of delusions and of the conviction about the reality of hallucinations) may have resulted in a vicious circle in which the effects of “antipsychotics” may influence the “narrowest” definition of psychosis and the narrowest definition of psychosis may influence new drug discovery and development. This possible “vicious circle” may have precluded the extension of the assessment of medications’ impact to the experiential substrate of the disorder and to the subjective disturbance resulting from individual passive experiences of the disorder. The failure to assess passive experiences and the disturbance they cause has implications for future drug discovery and drug development and also for other aspects of schizophrenia. The National Institute of Mental Health (NIMH) consensus statement on treatments in the area of negative symptoms of schizophrenia acknowledged the omission of the assessment of the experience of emotion reported by the subject, as opposed to the “objective signs” of blunted affect:

... Some factor analyses suggest that the domains proposed by the NIMH group are incomplete, and that the inclusion of other relevant domains may be beneficial when characterizing negative symptoms. Emotional experience is one area that has not been completely addressed ... (Alphs³¹). ... A decrease in emotionality—the subjective experience of emotion, as opposed to the objective “signs” of blunted affect—may be an important omission from the domains addressed by the Consensus Statement. However, as should be clear from the Consensus Statement, the conference participants did not intend to present their list of subdomains of negative symptoms as the final word (Kirkpatrick³²).

In assessment of the impact of pharmaceutical interventions, the experiential substrate and the passive experiences in schizophrenia might be considered comparable to the nonspecific subjective symptom of pain associated with a variety of medical conditions. Most drugs, including all psychiatric drugs, are approved based on their recognized impact on specific diseases or syndromes. For example, multiple “antipsychotic” drugs are approved for the treatment of schizophrenia. However, other drugs are approved based on their impact on nonspecific symptoms such as pain (Laughren and Levin³³):

... A third type of claim that the FDA will consider is for a non-specific symptom, that is one that is not limited to

a single disease entity. The non-specific symptoms pain and fever are examples of this third type of claim

If we examine the consensus on the recommended measures to assess core outcome measures for pain clinical trials (Dworkin et al³⁴),

... There are various aspects of pain that can change as a result of treatment, and the results of reviews of the literature on pain assessment in adults support the recommendation that measures of pain intensity, the use of rescue treatments, pain quality and the temporal components of pain should be considered when assessing pain outcomes. Self-report measures provide the “gold standard” in assessing pain outcomes because they reflect the inherently subjective nature of pain, but they should be supplemented by careful assessment of the use of rescue treatments. Depending on the specific objectives of the clinical trial, other approaches to assessing pain can be considered, for example, overt expressions of pain and distress (“pain behaviors”)

the emphasis given to outcome measures of the inherently subjective nature of pain might be seen as a clear recognition (*gold standard*) of the experiential substrate of pain as a fundamental target for drug research and development.

The consensus on recommended measures for clinical trials related to pain cited above is in marked contrast to the neglect of the assessment of the experiential substrate and the passive experiences of schizophrenia. The potential benefit of treatment’s impact on passive experiences (ie, the specific impact on the passive experience of thought insertion itself and its possible subjective disturbance) will be missed if the assessment of treatment efficacy and effectiveness in schizophrenia does not include these experiences as a treatment target.

Treatments that minimize the immediate and specific passive experiences of the disorder and their often disturbing effects may be subjectively acknowledged by the patients as more personally useful than treatments that minimize “objectively” assessed symptoms, avoid future relapses, or control socially problematic behaviors. This personal value to patients would contrast with indications that have accumulated over time which suggest that treatment is principally aimed at solving the problems of persons other than the patient.

Treatment has been seen as solving the problem of society³⁵

... Public asylums for manics have been regarded as places of confinement for such of its members as are become dangerous to the peace of society ... (Pinel^{35(p3)}).

and the problems of the family:¹⁶

... It is not often that the fundamental symptoms are so markedly exhibited as to cause the patient to be hospitalized in a mental institution. It is primarily the accessory phenomena [i.e delusions, hallucinations. Note of the Author] which make his retention at home impossible, or it is they which

make the psychosis manifest and give occasion to require psychiatric help ... (Bleuler^{16(p94)}).

Ignoring the assessment and the development of treatments focused on symptoms that might be considered directly and personally disturbing for the patients may contribute to treatment nonadherence in schizophrenia and may contribute to the burden of the disorder on patients, families, and society.

Conclusion

The experiential substrate of schizophrenia has long been neglected, although it belongs to the fundamentals of psychopathology and clinical practice. Modern diagnostic tools and assessment approaches adopted the descriptive approach in psychopathology in ways that may significantly limit the power of current diagnostic tools and outcome measures in research and care. Clinical interviews that intermingle and confuse, according to the approach presented here, the passive experiences and the judgment formulated by the patient toward the passive experiences themselves may offer interviewed patients a potentially misleading model of some relevant symptoms of schizophrenia, model that might not have neutral effects on the patients affected by the disorder, and that research may need to test.

The definition of passive experiences provides the basis for the development of appropriate measures focused on the passive domain of schizophrenia as an independent domain of the disorder. Such measures have the potential to be an important outcome component of clinical trials evaluating the efficacy and effectiveness of treatments for schizophrenia. They could provide valuable information to pharmaceutical and nonpharmaceutical research and development in schizophrenia on the experiential substrate of the disorder, on the subjective disturbance it directly causes to the patient, on the treatment effects on the passive experiences, and on the personal usefulness of treatment and its impact on adherence to care.

Assessment of the passive experiences of schizophrenia also has the potential to improve the quality of care at the level of the individual patient and clinician. It can enable the reformulation of clinical interview procedures, and the ongoing patient/clinician discussion of the course and outcome of a patient’s passive experiences, including their subjective disturbance, may usefully facilitate informed collaborative decision making about medication regimens and other nonpharmacological interventions.

Psychopathology clearly needs new measures focusing on the experiential substrate of schizophrenia for the assessment of interventions aimed at prevention, care, and rehabilitation in schizophrenia. A new measure focusing on the high definition description of the passive experiences in schizophrenia (PRE—<http://www.preinstitute.org>) and on the disturbance they cause to patients has

been developed by the author and will be evaluated in the United States and internationally in several environments. Researchers and clinicians interested in this research field and willing to participate as collaborating sites to the evaluation process of the PRE and to the assessment of the experiential substrate of schizophrenia are invited to contact the author.

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