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# Anomalous self-experiences contribute independently to social dysfunction in the early phases of schizophrenia and psychotic bipolar disorder

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**Abstract**

**Background:** Psychotic disorders are associated with significant social dysfunction. Anomalous self-experiences (ASE) present in psychotic disorders could contribute to social dysfunction.
**Aim:** To investigate if ASE contribute to social dysfunction in the early phases of psychotic disorders after controlling for factors related to social functioning including diagnoses.
**Methods:** ASE were assessed by means of the EASE (Examination of Anomalous Self-Experience) in 76 patients referred to their first adequate treatment for schizophrenia or psychotic bipolar disorder. Diagnoses, symptom severity, and functioning were assessed using the Structured Clinical Interview for the Positive and Negative Syndrome Scale, Calgary Depression Scale for Schizophrenia, Premorbid Adjustment Scale, Global Assessment of Functioning—Split Version, and Social Functioning Scale. Neurocognitive assessments included measures of psychomotor speed, working memory, executive and memory functions. Duration of untreated psychosis was also assessed.
**Results:** High levels of ASE were significantly associated with poorer social functioning in the early phases of schizophrenia and psychotic bipolar disorder also after correcting for diagnosis.
**Conclusion:** This study demonstrates the significance of ASE for social dysfunction in patients with psychotic disorders, and contributes to the understanding of the complexity of illness-related factors that affect social functioning.


## 1. Introduction

The major psychotic disorders, i.e. psychotic bipolar disorder and schizophrenia, are associated with significant social dysfunction [1–3], to the extent that social dysfunction constitutes part of the diagnostic criteria in the DSM-IV [4].

Social function is a heterogeneous concept, comprising both social roles, i.e. the part people play as members of a social group, and actual social performance. Several factors are associated with social dysfunction in people with schizophrenia, most prominently neurocognitive impairments [5] and negative symptoms [6]; but not positive symptoms to the same extent [6]. This impairment is often already present at first treatment contact in people with these disorders, and is at this point associated with childhood maladjustment and duration of untreated psychosis (DUP) [7–10]. Social dysfunction is also present among people at risk of developing psychosis and might contribute to the prediction of psychosis onset [11]. In people with bipolar disorder, social dysfunction appears to be associated with neurocognitive impairments [12–14] and also with

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persisting depressive symptoms [15]. Recent studies also show that social dysfunction is present among people with bipolar disorder even in euthymic phases of the disorder [13,14,16] and at first treatment contact [15,17]. One study found that the social dysfunction was related to the course of untreated disorder, as persons with previous untreated episodes of mania had more dysfunction at treatment onset than those experiencing their first episode [17].

Recently there has been a renewed focus on phenomenology in psychotic disorders, including studies of anomalous self-experiences (ASE; disturbance of basic self-awareness or sense of self) [18–21]. Within the frame of continental phenomenology, the notion of sense of self (or identity feeling) can be described on three hierarchical but interconnected levels: the narrative, the reflective, and the prereflective self [22]. The narrative self refers to particular explicit characteristics, like personality and the narratives of the self; whereas the reflective self is the awareness of a stable "I" over time and situations. The prereflective self is the most basic level of self-awareness, implicit, preverbal, and inseparable from subjective experience per se. This prereflective self-awareness is a necessary basis for the other two levels. ASE are subtle disturbances of the basic self, affecting the person's deepest sense of being, the experience of him- or herself as a vital subject, naturally immersed in the world, and the sense of continuity and coherence in self-experience [22,23]. ASE include certain and subtle forms of depersonalization, anomalous experiences of cognition and stream of consciousness, self-alienation, pervasive difficulties in grasping familiar and taken-for-granted meanings, unusual bodily feelings and existential reorientation, resulting in communication and social disturbances [24]. The variants of self-disorders should however not be considered as separate symptoms, but as overlapping aspects of a whole or gestalt. ASE are believed to underpin several conventional symptom dimensions such as positive, negative and disorganized psychotic symptoms [23] and found to be linked to depression and suicidality [25,26].

Basic self-awareness is the primary ground for the intentionality of consciousness, that is, the directedness of consciousness towards others and the world [23], and is therefore clearly related to social relatedness and functioning [27]. ASE include unusual bodily feelings, which may disrupt the more unconscious bodily resonance with other people in face-to-face interaction since mirroring and intuitive awareness are important to grasp the meanings and attitudes of another person [27]. Another aspect of ASE is disturbed "common sense", implying that different aspects of the person's inner world and the manifold shared everyday realities are no longer self evident [28,29]. For example, a patient said that she did not understand why people said "hello" to each other every time they met. It seems self-evident that this disruption of intuitive consensual social understanding will have a negative impact on social functioning [19,22,27]. Despite the *prima facie* reason to believe that ASE would influence social functioning and, some indications of a relationship in help-seeking adolescents, we are not aware of any previous empirical study of the relationship between ASE and social dysfunction in patients with psychotic disorders.

Recent studies indicate an overlap in the genetic vulnerability between schizophrenia and bipolar disorder [30]. The conventional clinical symptoms in schizophrenia and bipolar disorder are also partly overlapping [4]. Even if ASE are present to a larger extent in schizophrenia spectrum disorders [19–21], they are also modestly present in psychotic bipolar disorder [18,20]. To study if ASE independently contribute to social dysfunction in psychotic disorders we here chose to include a wider range of disorders, including both schizophrenia spectrum- and psychotic bipolar disorders. Our hypothesis was that high levels of ASE are related to poorer social functioning even after controlling for other factors known to be related to social functioning; including premorbid adjustment, duration of untreated psychosis, neurocognitive function, negative symptoms, other aspects of current symptomatology and diagnosis.

## 2. Materials and methods

The current study is part of the Norwegian Thematically Organized Psychosis (TOP) Study and involved all psychiatric treatment facilities in two neighbouring Norwegian counties (Hedmark and Oppland, population 375,000 people). Inclusion criteria were: Age 18 to 65 years; consecutive in- or outpatients referred to their first adequate treatment for a DSM-IV diagnosis of schizophrenia spectrum psychosis (schizophrenia, schizophreniform disorder and schizoaffective disorder) (SZ) or psychotic bipolar disorder (bipolar disorder I and NOS) (BP). Receiving first adequate treatment was defined as not having previously received adequate antipsychotic medication for 12 weeks or until remission. Patients with bipolar disorder had to present psychotic symptoms, and first adequate treatment was defined as first treatment for a manic episode.

Being a naturalistic study, there was some variation in treatment status (including medication). Some patients had just started treatment and some had made contact with the treatment system but not yet initiated treatment at the time of inclusion. Exclusion criteria were: head injury with neurological complications, neurological disorder and mental retardation (IQ < 70, Wechsler Abbreviated Scale of Intelligence; WASI) [31]. Patients with concurrent substance use disorders were not excluded as long as they did not meet the criteria for DSM-IV substance induced psychotic disorder. To enhance statistical power, we also included 16 patients consecutively enrolled in a closely related ongoing study of young psychosis patients born in 1985/86. They met the same inclusion and exclusion criteria except for the strict definition of first treatment, but they were all in an early phase of their treatment course, with an even shorter mean