Arşiv Kaynak Tarama Dergisi
Archives Medical Review Journal

Understanding "The Self": Concept, Phenomenology and Psychopathology

"Benliği" Anlamak: Kavram, Fenomenoloji ve Psikopatoloji

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ABSTRACT

Self is a complex phenomenological construct. Disorders of self are a less often discussed phenomenon even with the wide prevalence. This article attempts to revisit the psychopathology of disorders of experience of self primarily based on phenomenological description. Descriptive, biological, etiological and social perspectives are discussed.

Key words: Disorder of self, depersonalisation, schizophrenia, hypochondriasis.

ÖZET

Benlik kompleks bir fenomenolojik yapıdır. Benlik bozukluğu, prevelansı yüksek olmasına rağmen az tartışılan bir fenomendir. Bu makalede benlik bozukluğunun fizyopatolojisini yeniden incelemek için öncelikli olarak fenomenolojik tanımlamalara değinilmiştir. Tanımlayıcı, biyolojik, etyolojik ve sosyal açılardan tartışılmıştır.

Anahtar kelimeler: Kişilik Bozukluğu, depersonalizasyon, şizofreni, hipokondriasis.

Introduction

Concept of self

What exactly is meant by the "self"? The term self is arguably not describable phenomenologically. In an observation, an observer and an observed object are required. A

thing what observes that thing cannot be the same. The self takes an exception for being its basic nature to be experienced as either subject or object[1,2].

Self-awareness is contrasted with subject awareness. As we have to differentiate a number of modes of object awareness, so we have to do the same for self awareness, since the modes in which the self become aware of itself do not present any single or simple phenomenon. The formal characteristics of self awareness are activity/agency of self (that it is I who is thinking, doing, and feeling), the unity/coherence of the self (that at any moment of time I am one person), the continuity of identity of the self (that I am the same person now that I was in the past and that I will be in the future) and the boundaries of self (that I can distinguish between myself and the rest of the world as not self)[1]. Scarfetter argues that, one's awareness is a special feature of self-distinguishing from other observing objects and adds it as the fifth character, the vitality of self (that is knowing that I exist)[3]. One can feel how it pains when hurt (subjective) also one can explain how the other one experiences a pain (objective). Thus self serves the ability of a person to view himself in relation to others. Specifically it is how he believes other people see him. Ramachandran & Blakeslee, calls vitality as a self-reflection and calls the as the more elusive of all the characters. 'I' begin with our bodies, thus self has a character of embodiment where the ownership usually restricts/ tied with a body, which could be the sixth character of self[4].

Bahnson explains the changeable and amorphous self-image develops with age[5]. Starting from the "Soma" the self entangles the environment by means of differentiation. The family, role play, societal descriptions encapsules these during late childhood. The self, enlarges itself with reemerging importance of body-image of adolescence gradually incorporating the redefined social roles, to initiate investing in the environment.

One of the unique characteristic of the somatic self is that it is experienced both inside and outside, in both self and object. The extremes of anxiety, pain, and sexual excitement, are the state which enhances the awareness of physiological systems or organs as objects: 'my heart banging', disintegrating them from the integrated self. Though it's through the body that "self" contacts the outside world, many semantics describe the way person conceptualizes his self. *Self-concept, body image, body schema and body cathexis* are the varieties of constructs across spectrum of conscious awareness, physical materialistic, temporo-spatial dimensions[6].

It can be defined with its fivefold character similar to that of Jasper and Scarfetter[1,3,6]:

1. Continuity: lots are our experiences with a lot of time in life; but only one is 'I', who feel of past, present and future.
2. Unity or coherence of self: diverse are our sensory experiences, memories, beliefs and thoughts; but each of us experience ourselves as one single person, as a unity.
3. Sense of embodiment or ownership: we feel, 'we' begin with our bodies.
4. Sense of agency: 'we' are in-charge of our own actions and destinies. We have a 'free will' which formulates our 'to be done'.
5. Self reflection: most elusive of all, the self, almost by its very nature, is capable of reflection of being aware of itself.

Hence, self is a complex phenomenological construct. Disorders of self are a less often discussed phenomenon even with the wide prevalence. This article attempts to revisit the psychopathology of disorders of experience of self primarily based on phenomenological description. Descriptive, biological, etiological and social perspectives regarding self are also discussed.

Biological perspective: V S Ramachandran attempted at explaining the self's characters through their biological correlates. He with Hirstein enlisted characteristics[4]:

1. The embodied self: or the self anchored within a single body, which is similar to body image.
2. The Passionate self: the emotional aspect of self mediated by limbic system and amygdale, an essential aspect of self
3. The executive self: which is the 'free will' allowing to make a choice and give motor commands, attributed the anterior cingulated gyrus.
4. The mnemonic self: organizing yourselves on long strings of personal recollections and memories present in the memory circuits
5. The unified self: imposing coherence on consciousness, filling in and confabulation by the brain process associated with limbic and parts of cingulate gyrus.
6. The vigilant self: by intralaminar and thalamic nuclei driven by pedunculopontine nuclei processes the vigilance.
7. The conceptual and social self: is the same which conceptualizes other abstract concepts like "love", "happy" or "Mind".

Social perspective: The existence of 'self' portray itself in the background of 'non-self'. The theory of mind or mentalisation implies to the ability of an individual to recognize the state of mind of others. This awareness of others mental activity opens up a new world for understanding our own behaviors, beliefs and desires which leads to 'self'. Deficits in theory of mind (ToM) is reported in patients of autism, schizophrenia; though controversy regarding ToM as a trait marker, a state marker and a psychosis induced deficit remains to be resolved[7].

Disorders of Self

In descriptive psychopathology the term ego disorders or disorders of self means the abnormal inner experiences of I-ness and My-ness which occur in psychiatric illness. These may occur in the patient's state of inner awareness irrespective of any changes he may show in his attitude to or experience of the world outside himself[6]. Within the formal characteristics, self-awareness displays a range of developmental levels from a plain, bare existence to a full life with a conscious wealth of sensitive experience. In the course of such development, the self grows aware of itself as a personality. Abnormalities of self awareness show themselves typically as a lack of one or other of these formal characteristics[1].

Disorders of Awareness of Being/Vitality

"Do I exist?" is never a question a person generally asks. It is by virtue of assumption, we unquestionably are sure of our existence. The existence of reality is accepted because of presence of self[6]. In core experience of nihilistic, this core belief is questioned with 'I do not exist', 'there is nothing in-here' and so "*I is (am) dead*".

Self-awareness is present in every psychic event. In the form of "I think" it accompanies all perceptions, ideas and thoughts. Every psychic manifestations, whether perception, bodily sensation, memory, idea, thought or feeling carries this particular aspect of being mine of having an "I" quality, of personally belonging, of it being one's own doing which is termed as personalization. This may be disturbed in various psychological disorders. If this psychic manifestation occurs with the awareness of their not being mine, of being alien, automatic, independent, arriving from elsewhere, the phenomenon is called depersonalization[1]. This could be a lesser form of nihilistic ideas: an alteration of the way one experiences oneself which is accompanied by a feeling of an alteration, or loss of significance of self- 'I feel unreal, a bit woozy, as though I can't be quite certain of myself any more'[6].

In depersonalization, the patient feels that he is no longer his normal natural self, which is often associated with a feeling of unreality so that the environment is experienced as flat, dull and unreal. This aspect of the symptom is known as derealization[8]. Depersonalization and derealization go together because the self and the non self together forms the experience of a one continuous whole[6]. Normal sensory experience of one's body, ability to imagine and remember is ceased leading to an inhibited feeling and feeling of one's behavior becoming automatic[1]. Subjectively patients always experience a change in mood with depersonalization; the patient loses the feeling of familiarity he has for himself. He may describe himself as feeling like a puppet: hollow, detached and strange, on the outside, uninvolved with life; himself like a ghost- not solid, a stranger to himself. He experiences a loss of emotion. Similarly, with derealization he may describe his environment as flat, dim in colour, smaller, cloudy, dreamlike, still, 'nothing to do with me', and also lacking in emotional significance[6]. The localisation of this symptom to an individual organ is called desomatization. Different possible parameters are affected here like size or quality, appearing larger or tinier or empty or detached, or 'filled with water of foam' or feeling of being weightless, or his leg as floating or affected is simply the familiarity of the organ[2].

Ackner defines this phenomenon as a disorder of subjective unpleasant experience of an internal or external change, characterized by a feeling of strangeness[9], or unreality with affective involvement and fair insight. He excludes the experiences with delusional elaboration, ego boundary disorders of schizophrenia and loss or attenuated of personal identity. Sedman observed that it is best to reserve the use of this word to the *as if feeling* rather than the experience of unreality that occurs in psychosis; the 'as if' affixation used by the patient to denote the uncertainty and that it is not used literally[10]. This is a subjective state of unreality with a feeling of estrangement from the sense of self or from the external environment[11,12].

Depersonalization is a common experience occurring in 30-70% of young adults under moderate stressful situations[8]. Ackner reported the experiences to be *intensely unpleasant* by patients than healthy subjects[2]. An emotional crisis or a threat to life may lead to complete dissociation of affect which can be regarded as an adaptive mechanism which allows the subject to function reasonably without being overwhelmed by emotion. Milder degree of dissociative depersonalization occurs in moderately stressful situations, so that depersonalization is quite a common experience. Since dissociative depersonalization is a

common experience, many patients will complain about it when they realize that it is a symptom in which doctors are interested. Nearly one half of series of college students reported depersonalization experiences when a questionnaire designed to pick out depersonalization experiences were administered[8].

The phenomenon depersonalization can occur in normal healthy subjects. Some people may have feelings of 'not being quite themselves…. looking in on themselves from the outside', and so on, without provocation. Others may have such experiences at times of powerful emotional stimuli or life crisis of any valence: extreme happiness, falling in love, the loss of bereavement, or intense fear or anger. Depersonalization experiences occurring in normal healthy people are not experienced as unpleasant but the patients describe them as intensely unpleasant experiences[6].

Eliciting this phenomenon is not always an easy task. The *'as if'* content may not be overtly expressed in exaggerated reporting of some persons like appreciation needing personalities or with learning disabilities. The basic experience of existence is altered in this state and patients may feel "going crazy". Thus they will remain reluctant to report their experiences or will report the associated features like anxiety, depressive symptoms or somatic concerns. It will be difficult for the doctor to portray and extraordinarily difficult for the patient to describe. Depersonalization can be found in anxiety states with phobias (the phobic-anxiety depersonalization syndrome) occasionally, it is the outstanding symptom in depressive states. This may give rise to a mistaken diagnosis of schizophrenia, because the unsophisticated and dull patient may have great difficulty in describing depersonalization and the examiner is misled by the bizarre description of the symptom[8].

Depersonalization Syndrome is distinct from depersonalization as a symptom, a symptom in manic-depressive illness, schizophrenia, agoraphobia, panic disorder, post traumatic stress disorder & other non psychotic disorders; few personality traits in particular had been implicated to anankastic traits. The syndrome as enlisted by Sierra and Berrios prevails with: emotional numbing, changes in visual perception, changes in experience of body and loss of feelings of agency; which features in addition to the symptom itself[13]. F 48.1 Depersonalization-Derealization disorder in ICD-10, views both phenomenons simultaneously[14]. But 300.6 Depersonalization disorder in DSM-IV distinguishes itself from Derealization unaccompanied by depersonalization in 300.15 Dissociative disorder NOS.

Depersonalization, as rightly mentioned in Sims is more often associated with depression and anxiety but DSM IV classifies depersonalization disorder under dissociative disorder, which is psychopathologically misleading[2]. DSM 5 again reunifies these into a single disorder under dissociative disorders. It also uses them as a sub-specifier of dissociative symptoms in anxiety disorders[15].

Temporal and limbic lobe were considered to be associated with these symptoms in temporal lobe epilepsies after Wilder Penfeilds' stimulation experiments over superior temporal and medial temporal gyri, produced depersonalization and derealization experiences[16]. Latter evidence from neuromaging studies have also pointed towards the association between anterior cingulate gyrus, medial frontal gyrus and these symptoms[11]. Seirra and Berrios then proposed "cortico limbic disconnection" model of depersonalization in 1998[13]. Over activation of prefrontal cortex is responsible for emotional dampening by overly inhibiting the limbic system but disconnection between reciprocal parts causes' hyper cognitive state wherein people know what they should feel but because of hypo emotionality they could not really feel it[11].

Disorder of Activity of the Self

Conation (movement), Volition (will), Cognition (thinking), Affection (emotional feeling) and Perception (sensing) are the basic activities of the self. Every psychic event is an amalgamation of these activities which gives a unified experience of performance. When this general awareness of one's own performance gets altered in different directions it will be quite incomprehensible, difficult to imagine and not open to empathy[1].

Moving may show abnormality. In passivity experience or delusion of control in patients with schizophrenia will have problems in awareness of one's own performance, feels inhibited and retarded from outside, feel as if they were pulled from behind, immobilized, and made of stone[1]. They suddenly find they cannot go on, as if they were paralyzed and then suddenly it has all gone again. Their speech is suddenly arrested. They may have to make involuntary movements. This is all are felt as some alien, incomprehensible power at work[1]. *Memorizing and imaging* when altered in a depressive mood state, one feels unable to initiate the act of memory. Alternatively during a psychotic episode a patient feels that, this when it occurs is not initiated by him but from outside himself. *Willing* for an activity is also an activity of the self. A lassitude develops, usually during abnormal mood states causing changes in an ability

to initiate activity, a feel of power often with life's vagaries. Sometimes however, it is not the affect associated with the change of activity, but the belief about the initiation of the activity which is changed[6]. These are the passivity experiences.

Disorder of Immediate Awareness of Self-Unity

The experience of the basic unity of the self can undergo some notable changes. Sometimes, for instance, while talking one may feel that he is talking rather like an automaton, quite correctly may be, but we can observe ourselves and listen to ourselves. When this dissociation lasts longer, disturbing the flow of thought, that 'doubling' of personality is experienced[1].

Double Phenomenon Doppelganger

The double or doppelganger phenomena are an awareness of oneself as being both outside alongside, and inside oneself: the subjective phenomenon of doubling[6]. It would be cognitive, ideational and experiential but not of perceptual quality. As a clear hallucination, seeing one's double is rare (autoscopy), but the vague feeling of being beside oneself, alongside oneself or having another self (the soul-double) is quite common. There could be different possible psychopathological explanations for the phenomenon of non-organic, non-psychotic doubling:

1. Fantasy
2. Depersonalization: 'while talking we may notice that we are talking rather like an automaton, quite correctly maybe, but we can observe ourselves and listen to ourselves'[1].
3. Conflict: 'Two beings live within my breast where reason struggles with passion'[1].
4. Compulsive ideas: repetitive, resisted, self-produced and self-ascribed.
5. Double personality: referring to alternating states of consciousness.
6. Being in two, being doubled: 'When both chains of psychic events so develop together that we can talk of separate personalities, each with their own peculiar experiences and specific feeling – associations, and each perfectly alien and apart from the other'[1].

These experiences are not wholly distinct from each other and they do overlap; however, there are phenomenological differences between them which are important.

Autoscopy *(Heautoscopy, phantom mirror image)*

It is a clear complex multimodal (visual, somatic, kinesthetic and even auditory at times)

hallucination of seeing himself is phenomenologically a separate entity from doppelganger. It is not just a visual hallucination, though visual phenomenon is an essential feature, because kinesthetic and somatic sensation must also be present to give the subject the impression that the hallucination is he. The feeling of familiarity for one self is lost and self is viewed quite dispassionately and objectively; and often associated with parietal lobe lesion[6].

Multiple Personality (Dissociative Identity Disorder)

In multiple personality disorder the patient assumes in series a number of different personalities17. More than one personality embodies the same person in different time frame. Knowledge of the other personality and like and dislikes about other personas varies across personalities17. Clinically commonly seen types are Simultaneous partial personalities, Successive well-defined partial personalities and Clustered multiple partial personalities6.

This again needs to be differentiated from naive or appreciation needing personalities, who may leave out the 'as if' and they say that they are two people. Fish explains that "in psychogenic and depressive depersonalization the patient may feel that he is talking and acting in an automatic way, which may lead him to say that he feels as if he is two persons"8. In possession a person may feel that he is two people, two personalities acknowledged to be existing in the same body at the same time frame. Here a self is subdued by a non-self, and the non-self would embody the physical material of the self. The self then usually recedes to the non-self, which takes over all the characters of the self. Some patients with schizophrenia also feel that they are two or more people, although this is not common8.

Disorder of Continuity of Identity of Self

"I was there, I am here and I will be here" is a fundamental assumption of life without which competent behavior cannot take place. The time perception is lost and the continuity of self may be questioned. A patient with schizophrenia may feel that he was not the person that he was before the illness. This may be expressed as a sense of change8. In fantastic paraphrenia some may claim that "I who was there is not the one. Mr Sh**m who was there is dead and I am R**I" . This complete alteration in the sense of identity is exclusively psychotic, there is a break in the sense of identity of self, and there is a subjective experience of someone completely different6.

Lesser intensity of loss of continuity occurs in non-psychotic individuals, where even after

knowing that he is truly himself both before and after, but feels altered from what he was. "Many things seems to have changed, I feel I have changed". It is never to the extent that he actually believes himself to be a different person, it is more that thoughts and feelings do not seem to be in keeping with himself as he has come to accept himself6. The present would be observed as a past recalled event. Some may a sense that one has previously seen or experienced what is transpiring for the first time, termed as Déjà vu. It is a false impression that the current stream of consciousness has previously been recorded in memory. Déjà entendu and Déjà pensé forms similar feeling with a sound and thought respectively, as an earlier felt experience.

Possession State

There is a temporary loss of both the sense of personal identity and full awareness of the surroundings. The person acts as if he has, and believes himself to have been, taken over by another person. The difference between those conditions that constitute disorder and those that may be considered as being within a cultural or religious context alone is that the former are unwanted, cause disorders to the individual and those around, and may be prolonged beyond the immediate event or ceremony at which it was induced[6]. Jaspers differentiated between states of possession presenting with an altered consciousness, and states of possession in which consciousness remains clear, the former were usually dissociative (hysterical) in origin whilst the latter were more often associated with schizophrenia[1].

Disorder of the Boundaries of Self

The physiological schema of the body and the continuity and integrity of memory and psychological function is the basis for awareness of the self[8].

Boundaries of Self in Schizophrenia

In the alienation of personal action which is commonly seen in Schizophrenia, a person will not just lose the control over his thought, actions or feelings, but also experience them as being foreign or manufactured against his will by some foreign influence.

The fundamental nature of schizophrenia appears to be the experience of invasion of ego boundary; the first rank symptoms portray *merging of self with non-self* : *Passivity experiences* are those events in the realm of sensation, feeling, drive and volition which are experienced as made or influenced by others and all *passivity experiences* falsely attribute functions which are

actually coming from inside the self to non self influences from outside. Passivity experiences of thinking occur as *thought withdrawal, thought insertion or thought broadcasting*. Experiences of *auditory hallucination*s are also ascribed to the sensory stimuli outside the self, whereas in fact, they arise inside the self. These auditory hallucinations comment upon the patient in the third person. Usually we think of our self in the first person singular. Occasionally we address ourselves as "you", in the second person, but we do not think about our self nor comment on our actions in the third person as "he": this reveals a considerable disturbance of the boundaries of self. Similarly *hearing one's own thoughts* out loud implies locating one's innermost core experiences in distant space exposes a massive disturbance of the boundaries of self.

Similarly in *delusional percept*, a normal perception is correctly perceived and correctly regarded as being outside self. However, delusional percept is delusional interpretation of the object of perception, which is actually neutral and irrelevant to self, as highly relevant with intense personal meaning. This implicates that the meaning of the perception, although in reality is outside the self, has become incorporated within the self[8]. Thus the ipseity/selfhood is lost. Comparing the phenomenon of self disturbances, automatic or deficiency-like factors involving self/world or self/other confusion and erosion of first-person perspective were found more in schizophrenia than with depersonalization[18].

However, we need to note that it is the interviewer identifying an ego disturbance or disorder of the patient's experience of self; the patient himself complains of the upsetting content not of the disordered form of self-experience. Voices arguing or discussing or commenting with each other is interpreted by the sufferer as coming from outside himself, whereas it is actually inside, an interpretation by observer, as a disturbance of ego boundaries[2]. So while studying phenomenology it will be incorrect to explain these phenomenons under disorders of boundaries of self. But some of the experiences may of patients with schizophrenia still seem to be disintegrated boundary through phenomenology. As Jasper describes, some may identify themselves with the objects of the outer world; they suffer from what others do[1]. If someone is spinning, they say 'why are you spinning me?' or, when a carpet is beaten, say 'why are you beating me?' It is also clear that many of the first rank symptoms like Passivity experiences and thought alienations have an experiential nature which surpasses the rubric of thought and perception.

Disorder of the Embodiment/ Awareness of the Body

The body represents the physical manifestation of the individual being. The disorders

associated with embodiment may be with basic questioning of the tenet of self inside the body or with the disturbances in the awareness of physical manifestations of the body. The first type has described with various types of Depersonalization and desomatization phenomenon. The later type is explained by Cutting by classifying them five subheadings[19]:

1. Disorders of belief about the body: with undue concern towards the well-being of the body. This includes hypochondriacal as well as narcissistic images of body.
2. Disorders of bodily function: where the sensory, motoric functioning and other general body systems are deemed to be non-functional or functioning abnormally. This includes dissociative and somatoform disorders.
3. Disorders of the physical characteristics and (d) emotional value of the body: with overt dislike towards the appearance of the body. Manifestations spans across Body dysmorphic disorder, gender identity disorder and eating disorders with body image changes.
4. Disorders of the sensory awareness of the body: where body size are found accentuated (Hyperschemazia), diminished (Hyposchemazia/aschemazia) or distorted (paraschemazia).

Current psychiatric nosology is based on the form of psychopathology than the content. But due to variations in the cultural observations, the disorders of self get an independent diagnostic status. One of the examples to this statement will be hypochondriasis, whose content is the excessive concern with health, either physical or mental. Possible forms of the condition include primary delusion, a delusion secondary to hallucination or another delusion or mood state, an overvalued idea, an obsessive rumination, a depressive rumination or a part of worries[6]. Most hypochondriacal symptoms occur in relation to anxiety and depression[6].

There is a distinction between fearing illness when there are no bodily symptoms and fears and distress associated with bodily symptoms. This shows the overlap between illness phobias (unreasonable fear of developing illness) and hypochondriasis (preoccupation with symptoms).There will also be difficulty in diagnosis when a person with demonstrable physical pathology complains excessively about his symptoms; his complaints appear to be out of proportion to the anticipated suffering and disability of the illness.

Commonest organs implicated are musculoskeletal, gastrointestinal, and central nervous system. Several mechanisms play their role[6]:

1. Misinterpretation of normal bodily sensations
2. Conversion of unpleasant affects especially depression into physical symptoms
3. The experience of autonomic symptoms: caused by disorder of mood
4. A learned behaviour in patients with long standing physical illness

Is hypochondriasis a separate condition a symptom or a syndrome, a noun or an adjective? In the older psychiatric classifications, and also surprisingly in both ICD 10 and DSM IV, hypochondriasis or hypochondriacal disorder is given a separate designation[20]. However in ICD 10 and in the more detailed rubric of DSM IV, hypochondriacal disorder forms one category of somatoform disorders. In ICD 10 somatoform disorders are part of 'Neurotic, stress related and somatoform disorders' (F40-F48); it is used adjectivally to describe one type of neurotic disorder. Hypochondriacal symptoms are present in depression as somatisation; schizophrenia, in different forms; somatisation disorder with recurrent but frequently changing complaints; and in children with long term medical treatment as Masquerade syndrome. DSM5 partially rectifies by terming the disorder as Illness anxiety disorder and includes it in the obsessive compulsive spectrum disorder, with giving precedence to form again than the content[15]. Under psychosocial stress certain predisposed individuals, like those with Histrionic (hysterical) traits, develop dramatic onset disorders with content of symptoms complying with local culture[8]. Course of these are usually restricted for 1-3 weeks but may recur further. Manifestations include grossly unusual behaviour, volatile mood, transient occurrences of alterations of speech, depersonalization with altered body awareness, and symptoms somewhat similar to delusions and hallucinations. Koro, Dhat syndrome, Frigophobia, latah, Evil eye, voodoo, Windigo and Amok are certain of these culture bound syndromes with phenomenological symptoms of disorders of self[6,14,19].

Conclusion

Self by hosting all the psychic activities will be the Theatre complex of psychopathology. Though most of the psychopathology have its root in the disturbance of the self, some of the phenomenon plays exclusively in the domain of awareness of self. Phenomenological study will be incomplete by neglecting the disorders of Self. Understanding this phenomenon is extremely necessary, given the wide manifestations across the healthy and diseased mind. Also to enrich the empathetic abilities and diagnostic skills, discerning the subtle disturbances are of paramount importance.

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Geliş tarihi/ Received: 29.03.2016
Kabul tarihi/Accepted: 04.05.2016