Exploring a lay Gestalt of schizophrenia? A Danish background population’s explanations on why and how first-episode schizophrenia patients’ narratives were intuitively sensed as contextually inappropriate

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Abstract

**Background:** Recent continental-phenomenological psychiatry emphasizes pragmatics or social and contextual inappropriateness as a core disorder of schizophrenia, which is potentially relevant to early identification and treatment. **Objective:** However, there are hardly any studies that examine the background population’s sensitivity to inappropriateness in schizophrenia, even if “common” people, from a pragmatic perspective, are likely to be highly sensitive to cultural-conventional norms, including (in)appropriateness. **Method:** One empirical evaluation of contextual (in)appropriateness in 10 narratives from first-episode schizophrenia patients and healthy controls, respectively, found that when a phenomenologically informed Danish population (n=157 high-school students; mean age, 18.5) was “blinded” to the control–patient status – that is, “anonymous” narratives of the wordless picture story *Frog, Where Are You?* – they consequently evaluated patient narratives as more inappropriate than appropriate and control narratives as more appropriate than inappropriate (significant with 0.007). Aiming to explore a potential pattern recognition, distinguishing patient from control narratives, the present study systematizes and discusses salient explanations from lay “experts” who almost consequentially (80% to 100%) evaluated patient narratives as inappropriate and control narratives as appropriate (n=63 of 157). **Results:** Explanations of inappropriateness concerned affective aspects (about how the patient felt or how the evaluators felt reading the narrative), formal aspects (about pauses, fluency, and brevity), and aspects about sense making (from lack of understanding to nonsense and strangeness). The background population may be sensitive to affective and formal inappropriateness, but only lay experts emphasize the lack of sense in the patients’ narratives. **Conclusion:** Further studies might benefit from investigating whether early referrals from family, friends, or schoolteachers of their own accord thematize such inappropriateness aspects, and whether questionnaires targeting inappropriateness could be developed and used in the early identification of young people at risk.

**Keywords:** first-episode schizophrenia; inappropriateness; narratives; phenomenology; pragmatics

Introduction

The question “what is schizophrenia?” remains largely unanswered. This “whatness”, the diagnostically defining and symptom-producing vulnerability trait or “core” of schizophrenia, is in recent continental-phenomenological psychiatry regarded as based not on cognitive deficits but on cognition used at the expense of pragmatics (1-4). “Pragmatics” is primarily understood in the sense of what is contextually or socially appropriate. An example to illustrate this basic lack of balance between cognition and pragmatics is the schizoid father who buys a coffin as a Christmas present for his dying daughter – a logically correct cognition, as she will eventually need it, but somehow manifesting a “friction” within our socio-cultural context (4). Social and contextual inappropriateness manifests most salient in the “interpersonal and communicative-symbolic space” (3, p. 68).
However, there are very few studies that examine the background population’s sensitivity to inappropriateness in first-episode schizophrenia, even if “common” people, from a pragmatic perspective, are likely to qualify as good “guessers” of appropriate cultural-conventional norms of social conduct (5), and even if distinctive and typical vulnerability traits often antedate the manifest illness (6), and consequently may be of crucial importance to early identification and treatment, well before the more flamboyant symptoms of hallucinations and delusions manifest and fulfill the diagnostic criteria stipulated at a very high severity level (4).

From a practical and pragmatic perspective, significant, loyal, and cultural-conventional “others” such as family, friends, and schoolteachers may sense discrete social or contextual inappropriateness several years before first admission.

One example is a colleague of mine who received an email from an acquaintance, who was in love with her, with a portentous p.s. saying “take care of your children”. She found this “warning” inappropriate probably because any utterance carries a claim of its own relevance and consequently allows various inferred meanings on the part of the hearer (7-8). In this case, for example “do I not take care of my children?” or “what happens if I am not especially careful?” The sender was later hospitalized and diagnosed with paranoid schizophrenia. Disambiguated in this diagnostic context, the p.s. may constitute a literal warning, albeit very direct and transgressive (basically, taking charge of her private life). The sharing of information may even reflect a sincere concern for my colleague, whom he was, after all, in love with. He was rejected as a romantic partner, and in the cleverness of hindsight, we may wonder what omniscient level of knowledge he possessed, which in the first place allowed him to warn her. A solemn and solipsistic grandiosity?

Obviously, the background population does not associate subtle, discrete inappropriateness with schizophrenia, but they might nevertheless communicate in lay language, core characteristics in early referral situations, or schoolteachers may recognize discrete inappropriateness in phenomenologically informed questionnaires as a potential long-term perspective of this study. The aim here is first and foremost to explore the lay language that may unintentionally point to core aspects of social or contextual inappropriateness verbalized in familiar, “common” language, which may nevertheless designate a vulnerability trait.

Background and method
The empirical background of the present study is a study that examined a “blinded” Danish background population’s sensitivity to contextual (in)appropriateness in first-episode schizophrenia patients’ narratives (9). Six narratives from first-episode patients and six narratives from healthy controls had been collected at Psychiatric Center Glostrup in Copenhagen between 2004 and 2007. These groups had been matched for age (range, 18 to 32) and education; however, only one male person responded when encouraged to participate in the control group. The patient group had received a diagnosis of schizophrenia following the ICD-10 (1994) and the duration of “first” episode was maximum two years. The control group had no reported history of psychotic illness. Patient and control narratives had been elicited from the wordless picture story Frog, Where Are You? (10); henceforth, F-WAY? This story is used in research projects around the world as language-elicitation material (11-12), including projects on first-episode schizophrenia patients in Norway (13) and Denmark (14).

Out of these 12 narratives, five patient narratives and five control narratives were selected for evaluation by the background population in order to reduce the amount of reading for the evaluators and not to exceed the time limit of 1.5 hours, which corresponded to one lesson in high school.

The background population or “lay” evaluation group (n=198; mean age, 18.5) was recruited among students from 10 high school classes from Næstved Gymnasium, Midtsjællands Gymnasium (Haslev), and Roskilde Katedralskole in Denmark. Participation was volitional. The choice of high school students as lay evaluators was based on the basic assumption that a fair evaluation of (in)appropriateness ought to derive from evaluators at approximately the same age and at the same educational level as the first-episode schizophrenia patients and controls who told the narratives [a more advanced evaluation of these narratives, based on pragmatically oriented functional linguistics, can be found elsewhere (15)].

The experimental evaluation procedure in the high schools had four stages (the third stage was central).

First, the evaluators/the students were introduced to the picture story F-WAY? via a slideshow.

Second, the evaluators were asked to tell a story from the pictures in the slideshow (silently in their “own head”). These two initializing steps in the evaluation procedure were undertaken to mime, as far as possible, the conditions under which patient and control narratives had once been collected. In general, and once again, the aim was to stimulate only fair evaluations. In particular, the evaluators were asked to tell a story themselves, because negative evaluations might have come too easy, if they had no firsthand experience with the narrative task (it might be easy to criticize what you have not tried yourself).
Third, the evaluators were given 10 narratives (approximately 7000 words) selected from the 12 narratives collected at Psychiatric Center Glostrup between 2004 and 2007 (see above). Thus, these narratives were told by first-episode schizophrenia patients (five narratives) and healthy controls (five narratives), and the evaluators were asked to intuitively evaluate which narratives they found “mostly appropriate and natural” and which they considered “sometimes inappropriate and in friction with” the narrative context and as a response to the storytelling task. This last pleonasm (“as a response” and “in the narrative context”) was used intentionally to emphasize the contextual focus of the study; what is contextually appropriate and inappropriate? Subsequently, the polysynonymous nature of language was disambiguated; the adjectival meaning of “appropriateness” (Danish “passende”) should not be associated with the meaning of combined verb and fixed proposition (Danish “passe til”) in the sense that the words should match the pictures, nor was “inappropriateness” a question of morality (the Danish “passende” has a strong moral meaning which might be provoked in an elicitation material-specific manner as a baby frog is taken away from its parents in F-WAY?). Finally, “intuitive” evaluation was explained as which narratives the student “felt for” and which narratives were “different from” their own narratives. The evaluation instruction was informed a priori by conceptual insights from phenomenologically oriented psychiatry; a method which is generally akin to a “front-loaded” research design, which molds the experiment in advance by e.g. phenomenological concepts or clarifications (16). More precisely, phenomenologically “informed” alludes to the emphasis in the evaluation instruction on (1) contextual inappropriateness, (2) a certain reliance on intuition as diagnostically informative, and (3) feelings of “Anderssein” or a certain difference, potentially perceptible to others as a reduced ability to empathize with, in the present evaluation, the character and events in the patients’ narratives. This method is not in itself “phenomenological”; phenomenological method use patients’ first-person perspective often with directly cited patients’ utterances concerning symptoms and illness experiences, but the present study is based upon “third”-person evaluation of narratives. Ideally, the present study analyzes lay language, which may be communicated from the patient’s first-person perspective and understood by others form the third person perspective. Thus, the discussion primarily focuses on central descriptions of the core Gestalt of schizophrenia as well as those evaluations of inappropriateness that may actually coincide with these – for example, when empirical-phenomenological studies report the patients’ subjectively felt “insecurity”, a “growing uncertainty”, or “strangeness” and the evaluators in the present study explain inappropriateness as based upon the patients “insecurity”, “strangeness”, or “the nonsense” in their narratives. The evaluators were “blinded” to the control and patient status – that is, which narrative was from patients and which was from controls. A small cell diagram followed each narrative, and the evaluators were asked to make a binary choice or, more precisely, to “put only one cross” (“natural” or “in friction?”). The patients’ narratives were A, C, F, I, and J, and the controls’ narratives were B, D, E, G, and H (the narratives were represented to the evaluators alphabetically):

Patient; ICD-10 diagnosis
A Male; F20.6 Simple Schizophrenia
C Female; F20.0 Paranoid Schizophrenia
F Male; F20.0 Paranoid Schizophrenia
I Male; F20.0 Paranoid Schizophrenia
J Male; F20.3 Mixed Schizophrenia

Control
B Female
D Female
E Female
G Male
H Female

Fourth, the evaluation group was given an “explanation” sheet and was asked to explain why or how each narrative was “mostly appropriate” or “sometimes in friction” with the context, or to illustrate this with directly cited examples from the narratives.

One hundred and fifty-seven students completed all parts of this procedure. The general result was that the patient narratives were consequently evaluated as more inappropriate than appropriate, whereas the controls’ narratives were consequently evaluated as more appropriate than inappropriate (9). Generally, 67% intuitively evaluated patient narratives as inappropriate and control narratives as appropriate (significant with 0.007). A problem, however, was that a broad range indicated that the sensitivity toward which narratives were from patients or controls were relatively individual.

The present study systematizes the salient lay experts’ explanations on why or how the patient narratives were inappropriate; that is, “experts” are defined as students who, guided by the phenomenologically informed evaluation instruction, in 80% to 100% of all evaluations evaluated patient narratives as inappropriate and control narratives as appropriate (n=63). The rationale for this design is that if almost all patient narratives are considered
inappropriate and almost all control narratives are considered appropriate, some pattern recognition potentially guided this evaluation. “Salient” explanations are explanations repeated by, usually, several lay experts; that is, when the evaluators seem to agree upon why the patients’ narratives are inappropriate as far as they literally use the same explanatory term.

Results
Explanations and explanatory trends
Table 1 shows the lay experts’ explanations cited directly of why or how the patients narratives were contextually inappropriate. The numbers in parentheses show how many evaluators used a particular explanation – for example, 31 evaluators concurrently evaluated the patient narratives as inappropriate, because they were “short”.

The explanations can be grouped into three subgroups: affective explanations concerning how the patient felt or how the evaluators felt reading the narrative; formal explanations concerning pauses, fluency, and brevity; and explanations concerning understanding, interpretation, and meaning as well as aesthetics, provisionally placed side by side, because meaning may be regarded as, basically, aesthetic.

### TABLE 1. Lay experts’ explanatory trends; formal, affective and meaning aspects

<table>
<thead>
<tr>
<th>FORMAL ASPECTS</th>
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<tbody>
<tr>
<td><strong>Length</strong></td>
<td><strong>Fluency</strong></td>
<td><strong>Unfilled pauses</strong></td>
<td><strong>Filled pauses</strong></td>
</tr>
<tr>
<td>“short” (n=31)</td>
<td>“not fluent” (n=15)</td>
<td>“many/“long pauses” (n=22)</td>
<td>“uhm” (n=18)</td>
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<tr>
<td>“not detailed” (n=13)</td>
<td>“not going as a story ought to” (n=1)</td>
<td>“notches” (n=4)</td>
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<tr>
<td>“enumeration” (n=5)</td>
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<td>“stops” (n=4)</td>
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<td>“only one sentence at a time” (n=1)</td>
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<td>“dots” (n=1)</td>
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<td>“keyword form” (n=1)</td>
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<td>“minimalistic” (n=1)</td>
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<tr>
<th>AFFECTIVE ASPECTS</th>
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<tbody>
<tr>
<td><strong>The patient is</strong></td>
<td><strong>The reading experience is for the evaluators</strong></td>
<td></td>
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<tr>
<td>“uncertain” (n=22)</td>
<td>“confusing” (n=10)</td>
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<tr>
<td>“confused” (n=9)</td>
<td>“annoying” (n=9)</td>
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<tr>
<td>“in doubt” (n=3)</td>
<td>“disturbing” (n=6)</td>
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<tr>
<td>“nervous” (n=3)</td>
<td>“boring” (n=5)</td>
<td></td>
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<tr>
<td>“unserious” (n=2)</td>
<td>“tiresome” (n=2) “distracting” (n=1)</td>
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<tr>
<td>“hesitating” (n=1)</td>
<td>“uncertain narrator, so I was uncertain of the events” (n=1)</td>
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<td>“afraid of what to say” (n=1)</td>
<td>“indifference affects the reader” (n=1)</td>
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<td>“feels uncomfortable in the situation” (n=1)</td>
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<tr>
<td>“in difficulties” (n=1)</td>
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<tr>
<td>“indifferent” (n=1)</td>
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<tr>
<td>“unfocused” (n=1)</td>
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<td>“unconcentrated” (n=1)</td>
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<tr>
<th>ASPECTS RELATED TO AESTETICS AND MEANING</th>
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<tbody>
<tr>
<td><strong>Aesthetics</strong></td>
<td><strong>Meaning/Understanding/Interpretation</strong></td>
<td></td>
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<tr>
<td>“only descriptions of pictures” (n=11)</td>
<td>“strange” (n=5)</td>
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<tr>
<td>“not so much story” (n=6)</td>
<td>“mystic” (n=1)</td>
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<td>“no fantasy” (n=4)</td>
<td>“gives no meaning” (n=3)</td>
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<td>“superficial” (n=3)</td>
<td>“does not understand” (“the experiment”) (n=2)</td>
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<td>“not making things up” (n=1)</td>
<td>“far from how I would tell” (n=1)</td>
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<tr>
<td>“too simple?” (n=1)</td>
<td>“disturbing and imprecise in relation to my own interpretation” (n=1)</td>
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<td>“no depth” (n=1)</td>
<td>“not clear, what he wants to say” (n=1)</td>
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<td>“does not catch me” (n=1)</td>
<td>“I do not interpret in the same way” (n=1)</td>
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<tr>
<td>“mechanical” (n=1)</td>
<td>“incorrect language, made me not understand the story” (n=1)</td>
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<td>“not empathic enough” (n=1)</td>
<td>“uncertain of what happens” (n=1)</td>
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<td></td>
<td>“difficult to follow the story” (n=1)</td>
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<td></td>
<td>“difficulty to find an understanding and a meaning” (n=1)</td>
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<td></td>
<td>“lack of understanding in relation to my own interpretation” (n=1)</td>
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<td></td>
<td>“difficulty in finding main story line” (n=1)</td>
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<td></td>
<td>“does not know how the story should be interpreted” (n=1)</td>
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<td></td>
<td>“wrong events” (n=1)</td>
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<td></td>
<td>“nonsense” (n=1)</td>
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Under formal explanations, lack of fluency and pauses are probably two sides of the same coin; “pauses” as the positive or neutral explanation and “lack of fluency” as the negative explanation for the same phenomenon of silence. Both are common in spoken language, but violate written language norms (all narratives were transcribed verbatim and printed as such to the evaluators). Consequently, spoken-ness characteristics may “naturally” have elicited contextual inappropriateness evaluations. On the other hand, spoken-ness characteristics are particularly interpretation rich as MacClay and Osgood (1959) suggest in one of the first influential works on pauses and hesitation signals (such as “uhm”): “naturally-appearing pauses and other hesitation phenomena influence the listener’s connotative judgments of the speaker, e.g. of the speaker’s “sincerity”” (17, p. 43). I will leave this issue, as the decisive factor is unclear (on “brevity” in 4.1).

Under affective explanations, the evaluators seem to mark a distance from the patients interpreted as “uncertain” and themselves experience the reading as “annoying”, “confusing” and “disturbing”, but this may be due to the evaluators' knowledge of their role as evaluators. The importance of affect in schizophrenia is discussed below (4.2).

Sensitivity to formal and affective explanations have previously been found in a qualitative study of one class (9); in the present study the lay experts add to this inappropriateness evaluation sense or meaning. But what is meant by meaning and related explanations?

Explanations of explanations; additional information from the evaluators

Occasionally, the explanations are supported by more than one explanation per narrative, presumably related enumerations or even sentence formed explanations with additional information elaborating further on this explanation, hereby, in various ways, constituting “explanations of explanations”.

If we take a closer look at the explanation sheets and ask what the lay experts meant by referring to no “meaning”, lack of “understanding”, different “interpretation” and “strange” or “mystic” patient narratives, each time these explanations occurred, this additional information appears rather ambiguous. The following analysis, reports all additional information about, what the evaluators meant by referring to these explanations of explanations. This method is transparent in the sense that all added explanations of explanations are presented below.

Lack of “meaning” is related to “brevity” as Narrative I is “too short, gives no meaning if you have not seen the pictures” and Narrative J is “short, gives no meaning” (evaluator 51). In addition, meaning is related to fictive elements as it “gives no meaning to me, that the animals talk” in Narrative A (evaluator 57). This explanation refers to the fictive or imaginary use of direct speech, which strictly speaking is not used in the wordless elicitation material. Finally, lack of orientation is found disturbing in Narrative I; “no proper meaning, because the boy suddenly gets a baby frog home with him, while the narrator had not introduced it beforehand” (evaluator 146).

Lack of “understanding” is primarily related to “pauses”. Evaluator 70 had “difficulty in finding an understanding maybe because of the pauses and “ehh”” in narrative A, and in the same manner narrative J was “difficult to read and understand because of “ehh, okay”. Similarly, evaluator 133 comments on Narrative F by “many notches…does not understand the story”. Additionally, evaluator 123 explains that “incorrect language made me not understand the story”, in Narrative A evaluator 149 distinguishes his own understanding from the patient’s understanding in narrative J “lack of understanding in relation to my own story”, and evaluator 83 explains that the narrator F “does not understand the experiment” (an explanation probably provoked by many initial questions about how to narrate, see below).

Narrative I, J and F (and occasionally Narrative A) are continually mentioned as lacking in meaning or understanding, which are related to formal aspects of “brevity” and “pauses”, respectively.

“Interpretation” is often related to the lay expert’s own interpretation. Evaluator 68 states that the patient “does not know how the story should be interpreted” (Narrative F), implying that evaluator 68 does know this, evaluator 103 states that “I don’t interpret the same way” (Narrative C), and evaluator 149 states that Narrative F is “very disturbing and imprecise in relation to my own interpretation” just as Narrative J is “lacking and incomprehensible in relation to my own interpretation”.

Finally, six evaluators find narrative I, J, C and F “strange” or “mystic”. Three evaluators explain that Narrative F “starts strangely” (evaluator 30), has a

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1 The explanations “notches”, “stops”, and “dots” seem to comment upon some perceived strangeness of such phenomena in the narratives, whereas the lay evaluators use of the term “pauses” probably recognize the conventional notation in the narratives (verbatim “… ” and “uhm”).

2 Thus, this study says nothing about self-other biases, e.g. evaluation of the oneself more positively than evaluations of a generalized other.

3 Evaluator 70 do not give additional explanation (“difficult to find an understanding and meaning” in Narrative F).
“mystic start” (evaluator 99), or that the narrator initially “destroys everything, is uncertain, disruptive and much like ‘then this happened and then this happened’” (evaluator 19). In addition, some evaluators explain that narrative I is “strange to read after the long stories” (evaluator 15), that Narrative J is “short, imprecise, strange” (evaluator 19), that Narrative C has “many strange pauses and details and a strange ending” (evaluator 26) and that Narrative F has “short paragraphs, which do not give meaning in relation to the events, strange details, which do not fit the story telling style” (evaluator 26). Finally, Narrative C “ends strangely, as if the frog does not come home” (evaluator 150, similar to evaluator 26 mentioned above).

To summarize, Narratives F, I, J and C were in particular found “strange” and “mystic”, and these four narratives were most frequently evaluated as inappropriate by the larger group of 157 high school students (respectively; 92%, 72%, 72% and 59%, 9).

Finally, if we take a closer look at when these narratives are inappropriate, it is especially at the beginning - that is, the story elicited from the first picture (Picture 1) and at the end. That is, the story elicited from the final picture (Picture 24), as indicated in italics in the previous paragraph.

Table 2 presents the full narration elicited from Picture 1 in Narratives I and J as well as the full narration elicited from Picture 24 in Narrative C, however, due to the lack of space only the initial narration elicited from Picture 1 in Narrative F is presented below (the patient’s questions continued). Comments in parentheses are the researchers answers to the patients questions (in Narratives I and J).

<table>
<thead>
<tr>
<th>Narrative F (Picture 1)</th>
<th>Narrative I (Picture 1)</th>
<th>Narrative J (Picture 1)</th>
<th>Narrative C (Picture 24)</th>
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<tr>
<td>I just have to figure out how to get started (you just take your time, and you can use these arrows when you need to). Yes. Does one (Danish: man) have to give the story a title? (You don’t need to... you don’t need to, you can if you want, but just (Danish altsk)... just try to make a story based on the pictures) Are you (Danish: man) allowed to give the boy a name?............. (...THE QUESTIONS CONTINUE...)</td>
<td>I will give it a try...okay...once upon a time, there was a boy. He had caught a frog...but when he went to bed, then, then the frog saw his chance to run away. Should I describe the pictures or tell a story? (It is your choice). Okay. Uhm...they, it is a boy and a dog, who has found a frog...uhm...that they are looking at... and then...and then they take the frog home again...even if it had a family...and a lot of siblings and a mother and farther. And I think, that was where it preferred to be. So it did not end quite happily. That was it, I think</td>
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These beginnings and this end share a particular characteristic. They are meta commentaries at an experimental level (italics in Table 2) as opposed to just “doing it” – that is, telling the story a level “inside” the narrative world. Narratives F and J apparently question the rules of the narrative game and in Narrative C, the story as depicted on the pictures takes its course independently of the narrator, who disagrees about this unhappy ending. Only if the pictures are somehow distant from the narrator, does the narrator have reasons to excuse her narrative potentially with “so it did not end quite happily”. In a similar vein, a patient’s indignant reactions toward the lack of ownership of her or his thoughts seem only relevant if a phenomenological distance is actually present – for example, “my thoughts have no respect for me” (18, p. 1301). This distance is described as coexisting and only occasionally to collide.

But what about Narrative C? The conjunction “selvom” (even if) in Danish introduces a reason that is left out or cancelled (19, p. 1548), as if the narrator cancels her own narrative. The narrator apparently reports events according to what is presented on the pictures (the boy leaves with a frog), “even” if it has a family, and the depressive magnitude of this is illustrated with the addition “and a lot of siblings and a mother and a father”. Finally, the patient explicitly uses the first person pronoun to announce her negative reaction to the story “and I think, it was there (with the family) it would preferably be. So it didn’t end very happily”; now, also, contrary to the traditional happy ending. Negations notoriously presuppose a counter-view, thus, saying “I’m not
coming tomorrow” presuppose that somebody thinks or might think the opposite or that something else was expected (20). In Narrative C, the narrator’s story collides with the narrative expectations of the standard happy ending. In sum, the pictures seem to take their independent course regardless of both the narrator and the narrative tradition.

These beginnings and this end may be considered “strange” by the lay experts, because the default position of the authorial authority is radically destroyed by questions in Narratives F and J, and because the narrator’s authorial lead in Narrative C collides with both the narrative tradition and the pictured events. Or generally because the patients have a certain distance toward their own narratives or merely describe events by “enumeration” – e.g., “then this happened and then this happened”.

A final remark: formal thought disorders, as measured by, for example, the Thought Disorder Index, are traditionally mediated by and measured as language deviations. The evaluators in the present study may obviously have taken into account, e.g., what they consider as inappropriate distance toward the (narrative) task, needless excessive qualification etc.

Discussion of empirical evaluations in phenomenological studies

Given the content, the explanations of inappropriateness in Table 1 are likely to be intimately related; one evaluator’s explanation that “uhm” is inappropriate, may by another evaluator be explained as inappropriate with at slightly different explanatory focus, because the narrative is “disturbing” for him to read (thus, formal and affective aspects collide). Likewise, one evaluator’s explanation that a narrative is “only description of pictures”, may by another evaluator be explained as inappropriate, because it is “boring” to read (thus, aesthetic and affective aspects collide), or “short” narratives as explained by one evaluator, may be “superficial” or even “strange” to another evaluator (formal and aesthetic aspects collide potentially with aspects of meaning). The imaginative ease with which the explanations may be related and occasionally are related by the lay experts suggests that this discussion is primarily relevant at a more abstract-conceptual level in the light of phenomenological conceptualizations and empirical findings.

Because everything is not inappropriate, given that many explanations may be categorized, e.g. as “affects”, the elusive nature of the evaluators’ explanations do not necessarily relate to the polysemy of language or the elusive nature of pragmatic taste trials. This elusiveness may simply reflect the elusive nature, as it is described, of the Gestalt of schizophrenia (21). For example, the Gestalt is defined as a pervasive “global” experience transcending “all domains of mental life” and consequently also inner and outer aspects (4, p. 1128). The psychiatrist “may not only register the external signs, but also sense an inner change (symptoms)” (21, p. 262). In the present study, the lay experts’ formal explanations register concrete “signs” of “brevity”, “fluency” and “pauses”, but also sense or interpret the patients’ inner feelings as being “uncertain”, “nervous”, “confused”, or “indifferent”.

The intriguing question “do the lay experts perceive the same core Gestalt of schizophrenia as the skilled psychiatrist” is, however, circular, since the lay experts were phenomenologically informed. Henceforth, the subsequent discussion primarily focuses on the central descriptions of the core Gestalt of schizophrenia as well as those evaluations that may actually correspond to these; in particular, “strangeness” as an extreme description and, for example, “uncertainty” as a more subtle, but persistent description.

Incomprehensibility, strangeness, lack of meaning, nonsense

In classic texts, something “Unverständliches” may be experienced by both patient and psychiatrist (22, p. 30) or be “incompréhensible” for the psychiatrist, but swiftly transformed into guiding life principles for the patient – that is, indicating some “meaning” dictating nothing less than life (23, p. 149) or “beyond our comprehension”, but nevertheless potentially indicative of the patient’s “failed attempts toward communication” (24, p. 339).

Despite differences, some agreement prevails. Even if the “incompréhensible” by definition is not understandable, it may still be shared with the listener as a “shared alienation, a feeling evoked by accurate intuitions of what the patient is actually going through” (25, p. 241). Patients may not communicate any precise meaning – given the “unexpected swerves and cryptic references” and “puzzlements that can erode the very framework of human understanding” (ibid., p. 175) – but on the other hand the patient may prompt an “accurate intuition” of what he or she is “actually” going through. Or in the older approach of Rümke, the psychiatrist should examine his or her feelings, “despair”, or “manoeuvres” (sic!) to “find the patient” (24, pp. 337, 336). Basically, the doctor perspective of schizophrenia, potentially suggestive of a certain taxonomy of understanding and (a later possibility of only) sharing.
“cannot find the patient” (and in this approach consequently neither “share” with him), because of a “diminution of the rapprochement-drive” or reduced directness toward other people grounded in “formal chances” in the patient’s “dynamics”, which induce “unease” in the doctor, because of the incomprehensibility, but nevertheless a “specific experience” of diagnostic significance (ibid., p. 341). This specific experience was termed “precox feeling” and described as “the final and most important guideline” in the diagnosis of schizophrenia (ibid., p. 336).

In sum, the strange or incomprehensible is intimately correlated with accuracy of diagnostic specificity.

In the present study, the lay experts actually describe the patient narratives as “strange” and “mystic” (Table 1), and exemplified in the narratives, this strangeness refers to various questions about the narrative task or critical comments on their own narrative manifesting a certain distance (Table 2). Also, explanations such as “only description of pictures”, “mechanical”, “superficial”, “not emphatic enough”, and “enumeration” (Table 1), for example, “then this happened and then this happened”, seem to refer to a somehow distant narrator. Such distance may provoke the traditional habit of mediating the narrative with meaning as far as it is told by somebody, unlike world events which just “happen”.

Consequently, an inappropriate distance manifests, according to the lay experts, both in meta commentaries on an experimental level as well as on the story level “inside” the narrative world, i.e., as a pervasive inappropriateness, which so to speak, does not care about level. Pervasiveness defines the subtle Gestalt of schizophrenia (4). Inspired by Minkowski’s description of loss of vital contact with reality, the lay experts may to some extent actually share the patients’ potential inability to “resonate” with their own narrative and henceforth the lay experts’ ability to “empathize” and be “affected” by the narratives, may also be weakened (4, p. 1123). Or as some lay experts explain, the narratives are “boring”, “tiresome”, “indifference” affects the reader and another evaluator is simply “not caught” (Table 1). Nearly all explanations concerning aesthetics negate its presence with “only”, “not”, and “no” (Table 1) suggesting that something else was expected – e.g., fantasy, meaning, depth, and empathy.

Berze suggested that the basic disturbance in schizophrenia was a “primary insufficiency” of various degrees; in mild forms patients’ reactions appear “strained” and purposeful activity, attention, direction, comprehension, and capacity to think clearly was described as diminished or weakened (26, p. 52).

In general, the lay experts in the present study seem not to have their expectations met, given that negations penetrate nearly all explanations, in particular, formal aspects (e.g. “not fluent”, “not going as a story ought to”) and aspects related to meaning and aesthetics (e.g., “gives no meaning”, “does not understand”, “not clear what he wants to say”, “I do not interpret the same way”, “lack of understanding”, “does not know how the story should be interpreted”) (Table 1). Whether pauses are suggestive of “strained” efforts of purposeful, goal-directed storytelling, is not quite clear since pauses as a spoken language characteristic may “naturally” elicit inappropriateness evaluations of written texts. Explanations like “not going as a story ought to” seem, however, to signal expectation of a certain willful intentionality or creative power. And some formal explanations potentially thematize a basic lack of objectively observable reactivity or affectability stimulated by the elicitation material, “eliciting” only “minimalistic”, “short”, and “not detailed” narratives. Finally, conceptual clarity, luminosity, and “comprehension” are potentially thematized in inappropriateness explanations like “no meaning”, “difficult to follow”, “not clear”.

The lay experts’ evaluations appear somehow in line with Berze’s third-person descriptions; the narratives appear as not sufficient, being too short (a formal aspect) and too emptied of meaning (an aspect related to sense), or, in sum, “too short, gives no meaning” and “short, gives no meaning”. As seen here, “brevity” is not necessarily associated with something (affective aspects like “uncertainty”), but also with nothing or no meaning.

Lack of meaning or understanding is at the center of Sass’ introduction to the listener’s “precox feeling” (25, pp. 174–175). In conclusion, “brevity” may give rise to “no meaning”, which may obligatorily be incomprehensible or even “strange”, “mystic”, or “bizarre”.

Affect and meaning
Schizophrenia is often associated with disturbed reality testing and thinking, conceptualizations that may neglect the fact that affective abnormalities may be among the most central features, in particular because they are intimately related with alternations of personhood, self-experiences, and changes of the

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8Or unlike experimenting-behavioristic narratives – with feigned objectivity.

8On complications; see below.
The initial “uncertainty” is apparently replaced by a forced closure of meaning concretized and elaborated cognitively as a secondary psychotic work. As formulated elsewhere, the “pathic” or affective aspect is prominent as compared to the “gnostic” or cognitive aspect and “In the face of the disturbing uncertainty, the patient searches for solutions or answers” to their problems or questions (32, p. 79).

Petersen (14) found epistemic expressions as well as questions, indicating uncertainty or need for certainty or precision in the potential initial prodrome, first-episode schizophrenia, and younger patients with several admissions manifested by adverbs (e.g., “maybe”, “presumably”, “apparently”), epistemic use of modal verb (e.g., “can be”, “it might be the case”), negated reflection or consciousness verbs (e.g., “I don’t know”, “I think”, “I guess”, “I assume”), and questions like “Is it good enough?”, “What happens here?”, “Are you allowed to give the boy a name?”, “Do you have to give the story a title?”, “Should I tell you what I see or what I experience?”. If patients were asked, sincerely, accurately, and as precisely as possible to relate what they saw in a wordless picture story, these epistemic expressions would be highly appropriate. The patients, however, were asked to “tell a story” from the wordless picture story and in this context these “facts in fiction” seem less appropriate, as appropriateness obviously changes according to context.

Parnas and Sass (33, p. 438) reported an “incertitude” (i.e., polyvalence) in first episode patients with schizophrenia closely bound up with perplexity and a “strange” feeling of not being “really present” associated with a “mechanical” perceptual experience at a phenomenological “observing” distance. This distance is potentially responsible for less serious memory problems given a lack of involvement.

In the present study, the patients’ questions about the narrative game invites an answer even if other narratives already exist as part of our culture – that is, they could implicitly have instructed about a narrative norm or tradition. Questions are usually paradigmatic examples of doubt and uncertainty; you may ask if something is not known (34), but also if you are in doubt and already know the answer. In the last situation, questions may avoid taking the dominant role and in contrast induce the listener to
act – for example, as in help-seeking questions (35, p. 110). In the present study, Narrator F asked several information seeking questions and potentially also avoided to speak for himself by questioning the researcher instead (the narrative task implying a monologue was replaced by a dialogue in Narrative F, see Table 2). In addition, epistemic expressions manifesting (both) uncertainty and certainty appear throughout the directly cited patient utterances in Conrad’s contribution on first episode schizophrenia (exemplified above with “weiss…nicht”, “be- deuten”...“natürlich”).

Whereas the phenomenological studies are based on patients’ subjective rapport, the explanations in Table 1 are first and foremost evaluations of patients by others. And we may add, subjective life or not! The present study is, in other words, well aware that discrepancy may exist between objective signs observable from third-person perspective and subjective complaints reported by the patients in first-person accounts. Already in 1929, Berze (22) described patients, who from an objective observers point of view seemed “indifferent”, and on the other hand were “joyfully” in “resonance” with surroundings as well as “moved” by intellectual considerations. Thus, patient narratives evaluated as inappropriate by the lay experts because the patient is apparently “unconcentrated”, “unfocused”, and “indifferent”, to the contrary, may imply a significant amount of concentration toward another context than that of the narrative, namely the psychotic. For example, the narratives were occasionally told in staccato with pauses of “total” silence, which additionally was so abrupt that taken together these patients seemed both highly attentive toward inner experience (total silence seemed to correspond to total attention) as well as maybe simply being interrupted by these experiences and therefore narrating in an abrupt manner. In a psychotic context in particular, silence may “communicate” in the company of a listener or reader who fills the gap of pauses with interpretations, including various projected content.

In this context, the naïve idea that the word denotes some reality “out there” or “in” the patient, seem especially important and we probably need to move well beyond any naïve referentialism of the word cited directly and consider the direct citations as evidence in language of a preferentialism, or as it were, a dis-preferentialism for the patient narratives, which is a preliminary description of how an early vulnerability trait may be described from the third-person perspective of common people.

In sum, the more cognitively related explanations of inappropriateness (e.g., “unfocused”, “unconcentrated”) should not necessarily be taken at face value, whereas the affective evaluations seem to correspond to several empirical studies on first-episode schizophrenia.

**Clinical implications**

Precise psychiatric descriptions of the core Gestalt are said to clarify differential diagnostic uncertainties and help with the demarcation from other, non-schizophrenia psychotic disorders (37). Phenomenological description, however, does not clarify diagnostics unless the conceptual subtext is already known. And this conceptual history is characterized as a disappearing heritage, as psychiatrists are not taught, and consequently are not aware of, the fundamental Gestalt (4, p. 1128).

Words even do things to people when young psychiatrists are “mesmerized” by the adjective “operational” as if this pointed toward an unambiguous diagnostic entity (38, p. 69).

Wording the world in lay language is probably less unpredictable. Lay language may have a superficial descriptive resemblance to symptoms more characteristic of other psychiatric conditions than schizophrenia (33, p. 438). But this resemblance may in itself be rather predictable. Thus, “uncertainty”, “strangeness”, and various related expressions were continually reported by patients in the phenomenological studies as well as interpreted by the evaluators in the present study.

While “uncertainty” or “nervousness” may sound trivial, it can nevertheless be a significant part of the (person behind the) clinical picture in early stages, including various very human affects. Imagine a family entering the hospital and the mother opens the dialogue by describing her son as “unconcentrated”, “unfocused”, “indifferent”, and “unserious” in school, as being “afraid of what to say”, “in doubt”, “hesitating”, and “nervous” every day he leaves home, and in addition “uncertain” and “confused” about everything [(cognitive-)affective explanations from Table 1]. The first merely cognitively oriented batch of descriptions may be very unspecific and even associated with a typical teenager, the next may be taken to refer to anxiety disorders, and as the magnitude of complaints increases, severe psychopathology may be relevant. If

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7 A discussion on the use of epistemic expressions is found in Petersen (15).

8 Projected contents, however, not open an endless variety of “only” individual projections; human’s capacity for imaginative and interpretive empathy tends to reduce the apparent uniqueness of projective contents (36, p. 69). Also in the present study, the various wording of the patients’ world is relatively uniform or grouped around basic formal or affective aspects or aspects related to meaning and interpretation.
this mother continues, she may admit that others find her son “strange” and “mystic”, because he at times speaks “nonsense”, and his utterances are somehow devoid of “meaning” or basic “understanding” (explanations related to sense, meaning, and interpretation given in Table 1).

Møller and Husby reported “immense communicative barriers” (30, p. 221) in talking about the initial prodromal experiences, but lay language seems unavoidable in first referrals, and potentially even more so in countries where early intervention is recommended. Lay language may, however, hide cosmic proportions – for example, akin to an ontological insecurity suggestive of schizophrenia. Thus, early phases have been summarized as involving an “ontological crisis” for the patient, where “even the most fundamental components of self and world grow uncertain and unreliable” (39, p. 22). In this light, the empirical findings in the present study may be more serious than they seem initially. When the evaluators evaluate the patients as “unconcentrated”, “unfocused”, and “indifferent”, the patient may on the contrary be highly concentrated and focused upon finding answers to their “uncertainty” in an effort to find meaning in the typically un-understandable psychotic. When a patient is described as “unserious”, he may precisely need to be taken very seriously. And when he is described as “uncertain”, “in doubt”, and “hesitating” he may be precisely so, corresponding to the evaluation by the lay experts as well as the subjective rapports in phenomenological studies.

Not much said by the lay experts in the present study can be associated with the radical and traditional descriptions of what has historically defined delusions: extreme, tenacious conviction, absolute certainty, and incorrigibility. Sass critically continues this list: “unshakable”, “beyond argument”, expressed with “extraordinary conviction” and “an incomparable subjective certainty” (40, p. 36–7). In these traditional descriptions, the more complex picture has apparently been lost. Consider, in contrast, Müller-Suur’s description of the distinctive features of the pre-psychotic stages described as characterized by “absolute uncertainty” and “absolute certainty”, in negative comparison:

“According to Müller-Suur (1950) this is the distinctive feature of schizophrenia – i.e., non-schizophrenic delusional patients experience neither the sense of absolute uncertainty (Ungewissheit bewusstsein) in the pre-psychotic stages nor the sense of absolute certainty (Gewissheitsbewusstsein) in psychoses” (32, p. 79).

Familiarity with the subtle phenotypic vulnerability trait may be of crucial importance to early identification and treatment (2, p. 135). Subtle psychopathology is by definition discrete and difficult to demarcate as diagnostic criterion, and in addition, the diagnostic criteria are stipulated at a very high severity level of hallucinations and delusions, capturing only a subset of patients with paranoid schizophrenia (4, p. 1128).

The diagnostic-clinical consequence could therefore result in no identification, because the subtle psychopathology is neither recognized nor described in the diagnostic operational criteria. This double-blind spot could easily dismiss a patient who is neither specific nor dramatic enough. Furthermore, patients describing their experience in an “as-if-mode” run the risk of being dismissed, because their descriptions are not radical enough, even if they are potentially at risk of impending schizophrenia, precisely for this reason – that is, because they basically articulate a reservation, doubts, and uncertainty saying “it is as if I am not myself”.

Generally, the traditional descriptions imply a language modality that can cast a shadow over a potential risk of later development of schizophrenia if the reverse language modality is experienced in the clinic. The risk of overlooking “small” complaints is inherent or even invited in the light of the traditional descriptions, but phenomenological approaches seem to introduce the necessary complex and paradoxical picture. Sass even finds modal qualifiers, e.g., “so to speak” and “impression of” deleted in the English translation of Schreiber’s diary (40). And these expressions change the whole meaning of the sentence.

Finally, knowing that even vague, trivial, or unspecific complaints may potentially hide more “serious” pathology can make empathy and understanding easier in early referral situations. In addition, initial complaints may, despite vagueness, cover sufferings of self-disorders, which is worse than sufferings from psychotic symptoms (21, p. 254). Because vague complaints can thus be out of proportion with the level of sufferings, they could be hiding; the clinician who “discovers” this hidden contrariness can provide an enormous relief to the patients who are “finally” understood.

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**Conflict of interest**

The author declares no competing or potential conflicts of interest.

**Ethics**

Participation in the study was voluntary and the students were allowed to decline participation.
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References

9. Petersen C. The background population’s sensitivity to which narratives were from first episode schizophrenia patients and which narratives were from healthy controls: the “secure”, “disruptive”, “confusing” and “annoying” versus “the good story”. (Submitted 2017).