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EASE: Examination of Anomalous Self-Experience

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The Examination of Anomalous Self-Experience (EASE) is a symptom checklist for semi-structured, phenomenological exploration of *experiential* or *subjective* anomalies that may be considered as disorders of basic or 'minimal' self-awareness. The EASE is developed on the basis of self-descriptions obtained from patients suffering from schizophrenia spectrum disorders. The scale has a strong descriptive, diagnostic, and differential diagnostic relevance for disorders within the schizophrenia spectrum. This version contains interview-specific issues and psychopathological item descriptions (Manual), a scoring sheet (Appendix A), a reminder list of items for use during the interview (Appendix B) and an EASE/BSABS ('Bonner Skala für die Beurteilung von Basissymptomen') item comparison list (Appendix C).

Introduction

Terms and concepts are explained under each section and item.

Goals and Target Populations

The EASE focuses on anomalies of subjective experience that appear to reflect *disorders of self-awareness.* This scale is phenomenologically descriptive and the purpose of description is predominantly qualitative, striving for a detailed account of phenomena that have in common a somehow deformed sense of first-person perspective – in brief, a disorder or deficiency in the sense of being a subject, a self-coinciding center of action, thought, and experience[1].

The scale is mainly designed for conditions in the schizophrenia spectrum, but it cannot be used alone as a diagnostic instrument (self-disorders are not listed by the DSM-IV or ICD-10 as diagnostically crucial or even important features of schizophrenia; derealization and depersonalization are mentioned as nonessential features of schizotypy). The EASE does not cover all potential anomalies of experience, but focuses only on the disorders of the self [in contrast to the BSABS ('Bonner Skala für die Beurteilung von Basissymptomen') [Gross et al., 1987], e.g. perceptual disorders are not explored].

Development of the EASE

The development of the EASE was originally motivated by the clinical work in a day and stationary care unit for patients with first admission to the University Department of Psychiatry of Hvidovre Hospital (over a 4-year period, approximately a total of 100 consecutive

[1] There is, however, a possibility of rating frequency and intensity of anomalous experience.

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patients were interviewed by J.P. and L.J.). The main purpose was to explore and better comprehend the experiential and behavioral manifestations of schizophrenic autism [Parnas and Bovet, 1991]. A striking observation was made that the majority of the patients uniformly reported a long-time persisting identity void or more recently occurring feelings of self-transformation. Two independent, uncontrolled studies conducted almost simultaneously in Denmark and Norway confirmed these impressions in a systematic way [Parnas et al., 1998; Møller and Husby, 2000]. A recent study with 151 first-admission consecutive patients with various diagnoses demonstrated that disorders of the self constitute important aspects of schizophrenia and of schizotypy [Parnas and Handest, 2003; Handest and Parnas, 2005]. Another, separate study showed that self-disorders (recorded on a lifetime basis) distinguish between *residual* schizophrenia and *psychotic* bipolar illness in remission [Parnas et al., 2003]. The most recent analyses show that self-disorders also aggregate among the schizophrenia spectrum cases (schizophrenia and schizotypy) identified in an extended genetic family study [Parnas et al., in preparation]. To summarize, the origin of the EASE was to a large extent clinical phenomenological, based on many interviews with incipient schizophrenia spectrum patients, and subsequently extended by systematically collected empirical data from various samples cited above.

We were also inspired and informed by the classic psychopathological descriptions of these subtle pathological phenomena – e.g. in the work of Pierre Janet, Hans Gruhle, Joseph Berze, Eugène Minkowski, and Wolfgang Blankenburg. We owe much inspiration to the German research group of Gerd Huber, Gisela Gross, Joachim Klosterkötter, Frauke Schultze-Lutter, and their colleagues, who were the few modern psychiatric scientists who took the patient's subjective experience seriously and studied it in systematic ways. We were familiar with Huber's notion of 'basic symptoms' since the late 1980s, and the BSABS became fully translated and published in Danish in 1995. There are some natural overlaps with the BSABS, especially in the domains targeting cognitive disorders, cenesthesias and other single items. In these cases, the original BSABS item numbers are given in parentheses after the item name. However, it is important to scrutinize the definitions carefully, because they are usually *not* completely identical. Our own clinical psychopathological approach is very much informed by the Husserlian approach to phenomenology [Parnas and Zahavi, 2002; Sass and Parnas, 2003].

General Guidelines for Conducting the Interview

Intrinsic Difficulties of the Interview

The experiences that are targeted here are often so strange to the patient that he has never communicated them to anyone else. Often, they have not been mentioned to even closest confidants. The experiences may be *fleeting,* perhaps even verging on something *ineffable.* They are *not* like material objects that one can 'take out of one's head' and describe them as if they were *things* with certain properties, or redescribe the experience at different occasions in exactly the same terms. The patient may be short of words to express his own experiencing. One reason for this is that many of these experiences possess a prereflective quality. They are not explicit in the focus of thematic attention but constitute more the overall background of awareness. Moreover, a patient may at *one occasion* succeed to describe his anomalous experience with a pertinently salient metaphor, which will somehow no longer be available to him at later occasions; consequently, at these later occasions, he will only give vague descriptions (*NB:* We have no systematic empirical information on these issues). The patient's predicament may be comparable to trying to describe his global proprioceptive state. In addition, the distortions of self-awareness undermine the patient's capacity for self-expression. As already mentioned, many patients consider their experiences as being *uniquely private* (i.e., in contrast to auditory hallucinations, regarded as a common knowledge), and therefore the patients see these experiences as embarrassing, 'inhuman' or deeply disturbing.

Use of Metaphor

The patients employ metaphors to describe what they experience; this is also the case with healthy people – it is a universal process. A metaphor is usually defined as a transfer of meaning from one conceptual domain to another, like in the expression: 'life is a journey' (the concept of life is made meaningful by an appeal to a journey, belonging to another domain). In the context of a psychiatric interview, a metaphor should *not* be seen as 'just a metaphor' or 'just a manner of speaking' that somehow, distortingly or conventionally, stands for an underlying (more) true or authentic anomalous experience, i.e., a metaphor is not only a *signifier* (sign), distinct from, and contingently attached to the *signified* content ('signifié' = the sign's meaning). Rather the following is the case: an experience (non- or prelinguistic), especially of the prereflective type, becomes progressively conceptualized, i.e.

transformed into a conceptual (linguistic) format, in order to be grasped by the reflecting subject, thematized and rendered communicable to others. The metaphor should be seen here as a basic functional aspect of this symbolization process, where it operates as a linguistic vehicle or medium through which the experience first articulates itself and so becomes reflectively accessible. The metaphor is therefore the first stage of making a prelinguistic or prereflective experience explicitly accessible to oneself and to the other. The choice of metaphor is linked to the nature of experience in a noncontingent way, i.e., *experience and metaphor are not entirely independent.*

Necessities

To transmit the type of experience investigated here to another person requires a certain intimacy between the interviewer and the patient, and a need on the part of the patient to make an effort in order to explore his own mind or to reflect upon his own experience. It is therefore mandatory to try to establish a neutral, yet caring rapport with the patient, and ideally to provide the patient with the possibility to act as a partner in a shared, mutually interactive exploration. No matter how uncommon or bizarre the reported experiences may seem to the interviewer, he must remain neutral, calm, yet with a restrained interested caring attitude, and tacitly conveying to the patient that he is familiar with the type of psychopathology under investigation (it has usually a strongly positive impact on the rapport). The interviewer should *never* adopt a curious/voyeuristic posture (in which the patient finds himself as a specimen of pathology) or a judgmental/valuing attitude. What is being talked about is *how* the patient experiences himself and his world, and not an objectively or medically prescribed 'reality' or 'morbidity' of these experiences. From the patient's perspective, they are just his experiences and are therefore indisputably *real for him as experiences* (but not necessarily accompanied by specific explicit beliefs about their causes or nature; see 'as if' experiential mode).

Hostile, aggressive, very suspicious patients or patients marked by severe emotional indifference require an extraordinary effort from the interviewer to circumvent dissimulation or guardedness and engage the patient in the interview. *Acutely ill, severely psychotic patients with globally disordered attention and cognition should not be interviewed at such a stage.* One has to await clinical improvement before conducting the interview. Mentally retarded patients are probably unable to yield reliable information (the EASE has not been tested in samples of retarded patients).

Conduct of the Interview

The interview should ideally be performed in a semistructured way. It requires that the interviewer is intimately familiar with the checklist and its distinctions. *The most frequent source of unreliability is the lack of familiarity with these distinctions.* A totally unstructured interview also tends to diminish reliability.

It is allowed to propose to the patient examples of pathological experiences, but it is always necessary to verify the presence of the investigated item of experience by asking the patient to describe in detail in his own words at least one concrete example. *Never score a simple 'yes' to a question as a confirmatory answer.*

In the ideal situation (which is only approximatively possible), the interview consists of a *patient-doctor mutually interactive reflection:* the interviewer poses a question, the patient tries to respond, then the interviewer perhaps reformulates the answer by proposing an example, and becomes corrected by the patient who provides another example of his own and in his own words.

The interviewer tries to capture essential features of the experience in question through further probing and with imaginative variation; this means that the interviewer, in his inquiry and the attempts to represent the patient's experience, may change some aspects of the experience and retain others in order to strip the experience of its accidental and contingent features. The purpose is to grasp the features that are *essential* for this type of experience (e.g. essential differences between thought pressure and rumination). Yet, it is important to recognize the limits to this objectivation process. If pressed excessively by the interviewer, the patient may suddenly find that the conversation topic has somehow changed, drifting into something quite different from the original interrogation and exploration. Moreover, all pathological subjective experiences are never purely deformed isolates, but are always embedded in the patient's self-understanding, thus ultimately demanding from a psychiatrist to explore their subjective meaning and existential enaction – in other words to apply a hermeneutic approach. Thus, if potential connections between different experiences are being explored [e.g. 'what motivated you to study mathematics?' (say, the interviewer is trying to establish whether ambiguity intolerance had played a role)], then it is essential that the inquiry is open-ended and the answers are tried to become validated through rich, detailed, maximally spontaneous descriptions on the part of the patient. It is advisable to tape or videotape the interview for documentation purposes and possibility of reexamination and reliability checks.

Domain and Item Sequence

The EASE should never be performed as the first component of the interview, because intimate rapport with the patient is crucially important. Begin with a detailed *social interview,* which is easy, first because it is factual and second, because most people like to talk about themselves and their lives. Allow the patient to speak freely, but within limits; otherwise the interview becomes interminable. A social interview provides a basic picture of psychopathology: e.g. patterns of interpersonal functioning (e.g. behavior patterns across different ages, isolation, insecurity, suspiciousness, sexuality), educational achievements, work stability, tenacity, flexibility, ability to make choices, professional inclinations, or spare time interests. The question with which part of the EASE one should start should be contextually determined. The current item sequence of the EASE is motivated by interview-technical concerns rather than by theoretical consideration.

As a rule, it is easiest to begin with the section on the 'stream of consciousness' and start to ask about ability to concentrate, remember and think, make plans, then followed by more specific questions on more abnormal phenomena (e.g. thought block, thought pressure). These introductory questions have a quite neutral medical or 'neurological' aura, permitting gradual and progressive probes and extensions into domains that are more emotionally provocative. It is important to collect the maximum of relevant information, *if possible,* when exploring the item in question rather than returning to it at separate occasions (which prolongs the session and may make an unfavorable impression on the patient). If the interviewer senses a good cooperation, the EASE questions may already be introduced at appropriate junctures during the social interview (e.g. if the patients talks about his school problems, it might be natural then to explore possible cognitive dysfunctions). Yet, the interviewer should always keep track of an adequate covering of all sections of the EASE schema *(always have Appendix B in front of you).*

If the EASE is part of a more comprehensive interview schedule, it is advisable to perform two sessions separated by a break or at two different days. The duration of an average EASE interview is approximately 90 min.

Time Period Covered. This varies with the study purpose, and may span from the antecedent 2 weeks to a lifetime exploration. The latter is important for an overall assessment of self-disorders, which tend to decrease in frequency in the advanced illness stages.

Scoring. Items that were not asked about or not answered should be left blank (no information). Otherwise the scoring of frequency/severity follows the rules provided below in Appendix A. For practical reasons, we have simplified the ratings of frequency and severity to a combined one-dimensional score. EASE-targeted kinds of experiences that only *occur in association* with psychotic experiences should be registered separately on the scoring sheet (Appendix B).

Training

The interviewer must possess good prior interviewing skills, detailed knowledge of psychopathology in general and of the schizophrenia spectrum conditions in particular, and he should pass an EASE 3-day training course, comprising (1) a 1-day theoretical seminar, (2) a number of supervised interviews and (3) provisional assessment of reliability. The background of the EASE is phenomenological – especially for grasping the nature of the self and the subject-world relation – and a familiarity with phenomenological description of the structures of human consciousness is indispensable in using the EASE for pragmatic, psychometric purposes. For information concerning EASE seminars contact the project secretary Louise Dahl, Hvidovre Hospital (E-Mail Louise.Dahl@hh.hosp.dk).

The Psychometric Properties

The items of the EASE overlapping with the BSABS have been used in Copenhagen from the end of the 1980s in the Copenhagen High Risk Study [Parnas et al., 1993] and the Copenhagen Linkage Study [Matthysse et al., 2004], with interrater reliabilities for single symptoms between 0.6 and 0.9.

At the end of the construction process of the EASE, we calculated Cohen's kappa reliability coefficients on the basis of videotaped semi-structured interviews with 14 inpatients below the age of 30. The single-item kappa values ranged from 0.6 to 1.0. Test-retest reliability within a span of a 4-week period is currently being examined. Reliability between the raters decreases from (1) live semi-structured interviews performed by one rater, with the possibility of supplementary questions from another rater; (2) semi-structured interviews scored from a videotape, and (3) nonstructured videotaped interviews. We do not have by now any information on the scorings of hospital charts.

With respect to a possible factor structure, we examined 12–14 interview items, representative of the EASE domains, in a sample of 155 first-admitted patients [Han-

dest and Parnas, in press]. No factorial structure could be detected. We repeated these analyses on our genetic/familial sample [Matthysse et al., 2004], likewise without detecting a clear factorial structure.

Domains and Item Descriptions

1 Cognition and Stream of Consciousness

General description of the domain: A normal sense of consciousness as continuous over time, flowing, inhabited by one subject and introspectively transparent (immediately or directly given) in a nonspatial way.

1.1 Thought Interference (C.1.1)

Contents of consciousness (thoughts, imaginations, or impulses), semantically disconnected from the main line of thinking, appear automatically (not necessarily quickly or many), break into the main line of thinking and interfere with it. Such thoughts are often (but not always) *emotionally neutral* and they do not need to have a special or extraordinary meaning. The patient may use private designations to describe such thoughts ('thought tics', 'acute thoughts', and 'surrealistic thoughts'). Thought interference often becomes intensified in frequency ending up as *thought pressure* (1.3) (in this case, both items are scored). Interfering thoughts may also feel anonymous, impersonal [see diminished mineness in distorted first-person perspective (2.2.1) and loss of thought ipseity below (1.2)].

1.2 Loss of Thought Ipseity ['Gedankenenteignung'; Including Distorted First-Person Perspective (2.2)]

A feeling that certain thoughts (usually interfering thoughts: 1.1) may appear as deprived of the tag of mineness [score here distorted first-person perspective as well (2.2.1)]. Thoughts feel anonymous, or otherwise indescribably strange (but not primarily in the sense of *content*), perhaps without a connection to the patient's self, perhaps as if they were not generated *by* the patient ('autochthonous thoughts'), yet the patient has no doubts that these thoughts are generated *in* him, that he is their origin.

Another situation occurs in reading: the patient may feel as if the text is simultaneously being read by someone else (as if another subjectivity somehow participates in the reading process).

The patient does have the rational conviction *that he is the origin* of these thoughts.

Note: It is important to realize that the basic phenomenon in question which is disturbed is *ipseity,* i.e. automatic mineness or first-person perspective. Note, moreover, that it is quite normal to experience thoughts or ideas suddenly popping up in the mind ('Einfall'), ideas that cannot be said to be generated willfully ('unbidden thoughts'). Yet, in these cases, the sense of immediate or prereflective ipseity *never questions itself.*

In the case of thought interference (1.1), the interfering thoughts may have an anonymous quality, as described here. Also, certain ruminative experiences (1.6) may have this feature. In these cases, score all the relevant items.

1.3 Thought Pressure (C.1.3)

A sense of *many* thoughts (or images) with different, unrelated or remotely related meaning/content that pop up and disappear *in quick sequences* without the patient being able to suppress or guide this appearance/disappearance of (ever new) contents of consciousness. Alternatively, all these thoughts seem to the patient to occur at the same time (simultaneously). This symptom involves a *lack of control, many changing thoughts,* but also a *lack of a common theme* and hence a *loss of coherence or meaning* for the patient. The semantic content of the thoughts may be distressing but also neutral or even trivial, without any special personal significance. Often, this phenomenon is associated with *spatialization* of experience (1.8) where thoughts are experienced in a spatialized way, and sometimes even with a subtle *acoustic* quality (1.7).

Examples

- 'My thoughts are pressing on the skull from the inside.'
- 'It feels as if a swarm of bees was in my head.'
- 'My thinking is like an intersection of freeways, with a constant zoom! zoom! noise from the racing cars.'

1.4 Thought Block (C.1.4)

A subjective blocking of thoughts that can also be experienced as a sudden emptiness of thoughts, interruption of thoughts, fading (slipping away) of thoughts or loss of the thread of thoughts. It can be purely subjective but also observable as a gap in the patient's speech.

Subtype 1

Blocking: without a new thought intruding after the *sudden* disappearance of the old one. The old thought is suddenly and completely lost without a new one replacing it. After a while, the thinking resumes.

Subtype 2

Fading: without a new thought intruding after the *slow and gradual* disappearance of the old one. A fading of thought does not have to happen continuously, but can have a paroxysmal, phasic quality, i.e. a thought becomes weaker, dimmed and then becomes clearer and distinct again to finally 'slip' away.

Subtype 3

Fading combined with simultaneous or successive thought interference (score 1.1 as well): old and new thoughts exist side by side, while the new one becomes more prominent (more centered), the old one slowly recedes into oblivion. The old thought gradually and sometimes irregularly dies away (loss of its position in the focus of consciousness = fading) and, simultaneously, there is an intrusion and persistence of the new thought, increasingly coming into the focus. Due to the interference of new thoughts, there is no feeling of emptiness of thoughts.

1.5 Silent Thought Echo

A feeling that one's thoughts become automatically (involuntarily) repeated or somehow doubled.

There is no perceptualization like in 'Gedankenlautwerden' (1.7).

1.6 Ruminations – Obsessions (C.1.2)

(Usually) disturbing persistence or recurring of certain contents of consciousness (e.g. thoughts, imaginations, images): these contents may be associated with any past event. It may have the form of meticulous recapitulation of remembered events, or conversations of the day.

There are four subtypes, which may coexist.

Subtype 1

Primary ruminations: here, the patient is unable to find any reason for his tendency to obsessive-like mental states; he simply e.g. rethinks and relives what happened during the day – apparently *not* motivated by perplexity, paranoid attitude, or sense of vulnerability or inferiority (as in subtype 2).

Subtype 2

Secondary ruminations (perplexity-related or self-referring): the obsessive-like states appear as a consequence of a loss of natural evidence, disturbed basic sense of the self or hyperreflectivity or they appear to be caused by more primary paranoid phenomena (e.g. suspiciousness, self-reference) or a depressive state.

Subtype 3

True obsessions: ego-dystonic (as in obsessive-compulsive disorder, the patient considers them as silly, strange, both because of their content and their involuntary intrusion) with ongoing internal resistance, and a content that is not horrid or macabre.

Subtype 4

Pseudo-obsessions: obsession-like phenomena, which appear more as ego-syntonic (hence there is none or only occasional resistance), frequently with pictorial imaginative character and with a content that is directly aggressive, sexually perverse, or otherwise bizarre. May be anxiety provoking.

Subtype 5

Ruminations/obsessions with rituals/compulsions: any of the four phenomena described above plus rituals or compulsive behaviors. Rate all relevant items.

1.7 Perceptualization of Inner Speech or Thought ('Gedankenlautwerden')

Thoughts or inner speech acquire *acoustic* and in more severe states *auditory* qualities. The patient does not feel that others can hear or have access to his thoughts or he feels it only transiently, and is able to suppress this feeling immediately (e.g. he does not leave the room because of his fear that others may somehow hear his thoughts; if that is the case, then it counts as a psychotic first-rank symptom of schizophrenia). In some patients, the symptom occurs only during reading. 'Gedankenlautwerden' is initially restricted to the subjective lived space, and its first stages may be described as increasing experiential distance between the sense of self and the inner speech: the latter becomes gradually spatialized to a quasi-perceptual level. The patient does not hear his thoughts through the ears (from the outside), but only internally. Eventually, in a severe psychosis, the patient may hear his thoughts being spoken by other people or transmitted to him through the media. Some patients think both in the mode of 'Gedankenlautwerden' and in a 'normal', 'silent' way, whereas other patients have exclusively 'Gedankenlautwerden'. It is often impossible to date the onset of 'Gedankenlautwerden'; in other words, the symptom has apparently always been present and is therefore experienced as being entirely ego-syntonic.

There are certain other phenomena that are similar to 'Gedankenlautwerden', e.g. a patient somehow internally sees his thoughts as being written down, sometimes like on a filmstrip (subtype 2), which may also include a strong

feeling of experiential distance to one's inner speech or a kind of ongoing constant dialogue with oneself, which has an explicit lexical character.

Subtype 1
'Gedankenlautwerden', internal (internally confined).

Subtype 2
'Gedankenlautwerden', equivalents (thoughts as a written text).

Subtype 3
'Gedankenlautwerden', internal as a psychotic first-rank symptom (afraid that others can hear his thoughts, because they are so loud).

Subtype 4
'Gedankenlautwerden', external (or external thought echo, where the patient has a feeling that his thoughts are repeated or somehow resonate) as external auditory hallucinations.

1.8 Spatialization of Experience

Thoughts, feelings, or other experiences or mental processes are spatially experienced, i.e. as being localized to a particular part of the head or brain or are being described in spatialized terms (e.g. location, spatial relation or movement).

Examples
- 'One thought in front of the other.'
- 'Thoughts are encapsulated.'
- Thoughts 'spiral around' inside his head.
- She experienced that her thoughts were in the right side of her head and felt a pressing sensation from the inside of her skull as if there was no more room for her thoughts.
- 'Thoughts always pass down obliquely into the very same spot.'

1.9 Ambivalence (A.5)

Inability to decide between two or more options. Persistent and painful conscious coexistence of contradictory inclinations or feelings. Ambivalence occurs even for very simple or trivial everyday decisions. The patient cannot decide at all, needs more time for his decision, or becomes immediately uncertain about a finally made decision and changes it again. A related phenomenon that is scored here is when the patient complains of having contradictory thoughts or feelings at exactly the same time. This phenomenon may be associated with perplexity and paralysis of action. The indecisiveness occurs in everyday situations such as: what dish to cook, or what to buy, which brand of a product to choose; e.g. the patient may prefer shopping at a gas station due to fewer products to choose from (and fewer other customers).

Not rated here: Difficulties in deciding between different options that have a great impact on the patient's future – e.g. what job to take, whether to buy something really expensive for which a loan has to be raised.

Examples
- She has difficulty in making decisions because she 'considers things in many ways'. Yesterday, it took her 3 h to decide on which gift to buy for her boyfriend.
- At the teachers' college, she reversed her choice of subjects three times but still couldn't make out whether she had made the right choice.
- He is 'snowed under with options'; e.g. he thinks that he probably ought to become a vegetarian even though he loves meat. Such considerations lead him into 'doubleness' and 'silly, blind alleys'.
- Each time I think of something, I get a counterthought on the other side of the brain [score here also spatialization of experience (1.8)].

1.10 Inability to Discriminate Modalities of Intentionality

Brief occasions or longer periods with difficulties in the immediate awareness of the experiential modality one is currently living or experiencing. The patient may be uncertain whether his experience is a perception or a fantasy, a memory of an event or a memory of a fantasy. This phenomenon applies to affectivity as well: the patient may be unable to discriminate between different affects, feelings or moods. He may experience (usually negative) mental states that he is unable to designate or describe (has an experience that he does not know – has no words for it). He may be unsure whether he had spoken loudly or had just thought.

Comment: These phenomena are probably very frequent in the schizophrenia spectrum conditions. Note that in a normal experience, e.g. in a perceptual act, the perceptual act is immediately and prereflectively aware of itself; it is an instance of ipseity. In other words, when I perceive or I think something, I do not become aware of the fact of my perceiving or thinking by some reflective/introspective examination of my current mental activity and comparing it with other possible modalities of intentionality (e.g. fantasizing). Any experience, any intentional act, is normally articulated as ipseity, i.e. it is automatically prereflectively aware of itself. The difficulties in this domain point to a profound disorder of ipseity.

1.11 Disturbance of Thought Initiative or Thought Intentionality (C.1.13)

A subjective disturbance of thought initiative, 'thought energy' and intellectual purpose. This symptom may be a subjectively experienced counterpart of the observable lack of goal orientation, in the sense of mental planning and structuring of a task. Disturbances of thought initiative and 'energy' also show themselves in an impaired ability to self-initiate and structure certain actions such as cooking, or writing an essay.

1.12 Attentional Disturbances

Subtype 1

Captivation of attention by a detail in the perceptual field (C.2.9). A particular visual feature or a part of the visual field stands out from the background, almost isolated and somehow pregnant, so that this single aspect of the field captures one's entire attention. The patient has to stare at this detail, although he does not want to do so (fixation of perception, spellbound) and he has difficulty in moving attention away from it. The perceptual detail usually does not possess any particular symbolic or psychological significance [in contrast to intrusive derealization (2.5.2)].

Subtype 2

Inability to split attention (A.8.4). Difficulty in dealing with demands involving more than one perceptual modality, such as simultaneous processing of visual and auditory stimuli.

1.13 Disorder of Short-Term Memory

Diminished capacity to keep certain things in mind for more than a few minutes. Although the subjects understand the content of a story or a conversation, they are unable to remember and recall it. They report that they are unable to read a book or see a movie, because they forget the beginning as they proceed.

1.14 Disturbance in Experience of Time

A fundamental change in the experience of time, either as a change in the *subjective time flow,* or with respect to existential historical time, like *past versus future* (changes in flow speed elicited by feelings of pleasure or by being bored shall not be included here).

Subtype 1

Disturbance in the subjective experience of time flow: e.g. a sense of time rushing ahead, time slowing down, standing still, or time losing its continuity and becoming fragmented.

Subtype 2

Disturbance in the existential time: e.g. life appears to be restricted to the present, without guiding future projects, or the present is overwhelmed by stereotyped/repetitive reliving of a congealed past, or the experience towards the future is felt as blocked or not available at all *(specify the exact nature of the phenomenon).*

Example

- The patient may feel discordance between a sense of 'inner stagnation' of his subjective life and the forward movement of the surrounding world (subtype 2).

1.15 Discontinuous Awareness of Own Action (C.2.10)

This symptom consists of a break in the awareness of one's own actions. The patient reports that he cannot remember a certain short period of time, during which he was carrying out an action, e.g. he cannot remember how he found himself in the kitchen, or in a certain part of town. The symptom overlaps dissociative fugue.

1.16 Discordance between Intended Expression and the Expressed (A.7.2)

Subjective experience of not being able to express oneself according to one's actual feelings and emotions. The patient experiences that his speech, behavior, gestures and facial expressions are not in line, or congruent, with what he feels; his expressivity is felt to be disfigured and distorted and somehow beyond self-control.

1.17 Disturbance of Expressive Language Function (C.1.7)

Self-experienced impediment of speech, with a deficient actualization or mobilization of adequate words. The patient recognizes an impairment and retardation of his word fluency, precision, or availability. He cannot recall the precise words, or it takes him much longer to mobilize them. Sometimes he recalls words that are only peripherally and imprecisely associated with the context.

The patient may cope with this disturbance by using common, customary and well-known expressions, sayings (cliché language), or by keeping silent and avoiding conversation (secondary autism).

2 Self-Awareness and Presence

General description of the domain: A normal sense of being (existence) involves automatic unreflected self-presence and immersion in the world (natural, automatic,

self-evident). This phenomenological concept of presence implies that in our everyday transactions with the world, the sense of self and sense of immersion in the world are inseparable: 'Subject and object are two abstract moments of a unique structure which is *presence*' [Merleau-Ponty, 1962, p. 430].

This unreflected immersion consists of two interdependent components (moments):

(1) Unreflected self-presence; self-awareness; intact first-person perspective; 'transparency' or 'clarity' of consciousness, intact 'mineness' of experience.

(2) Unreflected presence/immersion/embeddedness in the world.

There is a general agreement in phenomenology that these two aspects are mutually intertwined at a phenomenological level. In other words, a disorder affecting one of the components will leave its imprint on the other components as well. We may speak of a (normal) self-presence whenever we are *directly* (noninferentially) conscious of our own thoughts, perceptions, feelings or pains; these appear in a first-person mode of givenness that immediately reveals them as our own. If the experience is given in a first-person mode of presentation to me, it is given as *my* experience and counts as a case of *basic self-consciousness.* To be aware of oneself is therefore not to apprehend a self *apart* from experience, but to be acquainted with an experience in its first-person mode of presentation, that is, from 'within'. The subject or self of the experience is *a feature or function of its givenness.* This basic self-awareness (ipseity) is a *medium* or a *mode* in which specific intentional experiences, such as perception, thinking, or imagination, articulate themselves. In other words, in a normal experience, there is no experiential distance between the sense of self and the experiencing.

This basic self-presence is normally presupposed in experience; in itself, it does not possess specific experiential qualities. However, the disturbed self-presence is often associated with the following clinical features: diminished clarity or transparency of consciousness, diminished sense of vitality or basic aliveness, diminished activity potential or pleasure capacity, diminished sense of attraction by the world, diminished sense of first-person perspective (mineness or 'zero point of orientation'), disorder of identity, and varying degrees of alienation.

In incipient schizophrenia, the prereflective self-awareness is distorted; this distortion comprises a variety of *qualitative* changes in experience that are different from sopor and from other phenomena that occur in organic conditions.

Anxiety is also explored in this section, although it does not per se reflect self-disorders. There are important practical reasons for this addition: it permits exploration of suffering, often involved in the morbid self-transformation and designated as anxiety by the patient, and second, the item 'ontological anxiety', which is closely linked to self-disorders, cannot be scored unless one has sufficient information concerning anxiety.

2.1 Diminished Sense of Basic Self

A pervasive sense of inner void, lack of inner nucleus, a pervasive lack of identity, feelings of being anonymous, as if non-existent or profoundly different from other people (this difference may sometimes be specified as difference in the worldview, being linked to an existential orientation that is fundamentally different than that of fellow humans). This item also includes a subjective feeling of 'overadaptation', i.e., always, in a given moment, a necessity to accommodate to the others' opinion or their point of view, linked to a dominating feeling of not having one's own inner standpoint ('innere Haltung'; 'Haltlosigkeit'). Lack of basic self may be associated with a pervasively negative self-image, which the subject describes monotonously as a sort of eternal 'shame' or 'sense of inferiority' (i.e. devoid of a comprehensible relation to concrete contexts), 'anxiety', or 'depression'; see Minkowski's 'regret morbide' as being indicative of autism. (See comment on the overlap between 2.1 and 2.2, p. 245)

Subtype 1

Childhood onset: rate here such experiences that have occurred early in life, i.e. already in early childhood or during school age (primary school): the patient has always felt to be profoundly different from his peers.

Subtype 2

Adolescence onset: rate here if the experiences have occurred from adolescence until now.

NB: Subtypes 1 and 2 are *not* mutually exclusive. Often the feeling of being different is primarily presented as isolation/inferiority feelings/social anxiety/feeling more stupid than others or it is ascribed to familial peculiarities (e.g. father's strange occupation). Only after a certain penetration, one may succeed in bringing forth these feelings of difference. These feelings may be associated with solipsistic features described in section 5 (existential reorientation).

In case of doubt of whether the experience should be scored here or, alternatively, under distorted first-person perspective (2.2), score it positively in both.

Examples

- It is as if I am not a part of this world; I have a strange ghostly feeling as if I was from another planet. I am almost nonexistent.
- She feels that her inner nucleus, her innermost identity, has disappeared.
- A feeling of total emptiness frequently overwhelms me, as if I ceased to exist.
- A patient felt 'as if not existing any longer'; 'I have lost contact to myself'.
- A patient feels as if he is a vacuum, which is motionless, while the surrounding world is in motion.
- During his adolescence, he tried hard to 'gain human dignity'. He explained the sense of lacking dignity as a feeling that his own existence was as of a dispensable object, as if he was a thing, a refrigerator, and not a human subject.
  NB: Here, a distorted first-person perspective (2.2.1) should also be scored on the basis of his lacking a sense of being the subject at all.
- He avoids gatherings and discussions, because it becomes painfully apparent to him that he never has an opinion of his own. He feels that he does not have a stable inner nucleus and no fixed point of view. He always agrees with all the arguing parties and finally gets confused.

2.2 Distorted First-Person Perspective

This item comprises *at least* three subtypes of the phenomenon:

(1) Decreased or temporally delayed sense of mineness or decreased sense of subjecthood (of being a human subject).

(2) Pervasive phenomenological distance between the self and experiencing (constant self-monitoring).

(3) Spatialization of the self.

(See comment after the examples on the overlap between 2.1 and 2.2, p. 244)

Subtype 1

Own thoughts, feelings and actions may appear somehow as impersonal, anonymous, and mechanically performed. The sense of immediate 'mineness' of thinking, feeling, and action may be diminished in an even more explicit manner (e.g. the patient says that his thoughts appear as if they were not generated by him, as in certain forms of thought interference) or the feeling of mineness only appears temporally ('split second') delayed.

He may feel as if he is an object, a thing, without subjectivity, is no longer ensouled.

Subtype 2

There may be a profound experiential distance (phenomenological distance) between the (sense of) experience (thinking, action, perception, emotion) and the sense of self. In a normal experience, the sense of self and experience is but one and the same thing; they are completely fused. Also, in a normal introspective experience, the introspecting self and the self that is being introspected are felt as one and the same. In the case of phenomenological (experiential) distance, there is a constant self-monitoring, in which the patient excessively takes himself as an object of reflection. It is associated with turning away from the external world and may prevent the patient from a natural, smooth engagement in the interactions with the world (in other words, anomalous experiencing has tangible consequences). In the phenomenological (experiential) distance, the self is, so to speak, 'observing' its own mental contents and activities and this state may intensify into a sense of having a double or a split self (see hyperreflectivity and I-split). This state must be pervasive[2], and not just occasionally appearing or voluntarily provoked by the patient; the patient must experience the phenomenological distance either as a constant or quite frequent condition or as a problem or affliction.

NB: See the items on hyperreflectivity (2.6) and I-split (2.7). The states of hyperreflectivity, rated later, are less pervasive, less intense or distressing and may be partly subjected to a voluntary control.

Subtype 3

The sense of self as the absolute experiential point of orientation [i.e. as something which does not itself have a precise location (me who is here; the self identical with all experiencing) but to which everything else is spatially related (ego-centric space)] or as a pole/source/focus of experience or action (I-consciousness) may be felt to be at a specific spatial location or to have characteristics of extension, or sometimes being spatially dislocated [in both cases, always rate also spatialization of experience (1.8)].

Examples

To subtype 1

- I have a feeling as if it is not me who is experiencing the world; it feels as if another person was here instead of me.
- My feeling of experience *as my own experience* only appears a split second delayed.
- I have had 'slightly strange experiences of a lacking relation between myself and what I am thinking'.

[2] The introspective tendency is frequent in some schizophrenic patients. The requirements of pervasiveness and/or affliction are introduced here to demarcate the cases where the normal first-person perspective must be considered to be severely disturbed.

- She often has a feeling that it is not herself who performs her own actions (e.g. writing) but she knows that it is not the case.
- A patient feels that she 'disappears', 'fades away', her voice appears alien, 'as if it came from a vacuum'. [This particular experience may also be scored as diminished sense of basic self (2.1), yet here, the feeling of mineness appears as being clearly affected as well].
- I do not really feel as a human subject, as a person with a soul; I feel like a dispensable thing, like e.g. a refrigerator.

To subtype 2

- My first-person perspective is replaced by a third-person perspective (further explained by the patient that he constantly witnesses his own experiencing).
- I constantly regard myself. Sometimes it is so pronounced that I can hardly follow what's going on on TV. Even during a conversation with others, I observe myself to the point of having difficulty in grasping what my interlocutors are saying.

To subtype 3

- My own 'I', as a point of perspective, feels as if it had shifted a few centimeters backwards.

Comment on overlap: The two preceding items 'diminished sense of basic self ' (2.1) and 'distorted first-person perspective' (2.2) overlap clinically at a descriptive level because they are conceptually and phenomenological related. The reasons behind the separation of the two are the following: first to enrich the descriptive properties of the EASE, and second, to separate less characteristic from more characteristic anomalies. A positive rating of diminished sense of basic self may happen on the inferential evaluation of vague complaints about a weak sense of personal identity. There is therefore always a risk that such complaints stem from identity disorders that affect the narrative self (e.g. as in non-spectrum personality disorders), rather than the more fundamental and structural disorders of ipseity and I-consciousness. Distorted first-person perspective, on the other hand, only contains items that specifically reflect an anomalous structure of experience (ipseity and I-consciousness).

2.3 Other States of Depersonalizations (Self-Alienation, B.3.4 Reduced[3])

A pervasive and diffuse sense of being alienated from oneself, one's own mental operations, thoughts, emotions and behaviors, in a way that has not been captured by other items of this section.

Depersonalization described here belongs to the range of phenomena of disturbed self-awareness described in this entire section and with a particular affinity with the disorders of basic self and first-person perspective.

There are two subtypes: melancholiform depersonalization and unspecified depersonalization.

Subtype 1

Melancholiform depersonalization: it is well established that melancholic mood change and the concomitant sense of the altered flow of time are, so to speak, not felt by the ego, but rather happen separately, i.e. in a certain dissociated way. In nonmelancholic depression and in mourning, the ego is depressed – there is no distance between the subject and his tristesse. In melancholia, on the other hand, the ego cannot identify with the simultaneous inner changes consisting of slowing/arrest of vitality (inhibition), blocked orientation towards the future, and immobile mood change. It may be said that the ego witnesses his own feeling disturbance; the melancholic suffering is to no small degree caused by the inability to enter into a relation with these disturbances. The patient has a feeling that he is somehow changing, that something wrong and burdensome is complicating his interior life; he may appear suffering and confused/perplexed. Usually, it requires additional interviewing effort to disclose typical melancholic elements. Note that the symptom must present itself as a *state phenomenon.* There is no disorder of the basic self (as a trait phenomenon) and there is no disturbance in the first-person perspective or mineness.

Example

- I do not feel myself, there is something in me which bothers me; I don't know what it is, but I cannot live like that (the appearance of the patient was of a typically depressed person with troubled, suffering expression. His state was preceded by a hypomanic period of 4 months' duration).

NB: Differential diagnosis between schizophrenia spectrum and affective illness should never be based solely on the qualities of depersonalization.

Subtype 2

Unspecified depersonalization: a feeling of alienation that cannot be specified more concretely in terms of qualitative experiential anomalies.

Example

- I do not feel myself, I feel somehow changed.

[3] The original BSABS item B.3.4 is a composite phenomenon. Certain dimensions have therefore been moved from it into other items. Consequently, the present EASE item 2.3 is a sort of residuum.

2.4 Diminished Presence

A decreased ability to become affected, incited, moved, motivated, drawn, influenced, touched, attracted or stimulated by objects, people, events and states of affairs. This decrease should *not* be understood as active and deliberate withdrawal, but more as something that afflicts the patient and hinders his life. The patient does not feel fully participating or entirely present in the world; he may feel a distance to the world, which may be accompanied by changes of world perception. This item includes both physical and social hypohedonic states as well as apathy (lack of feelings).

Subtype 1

Specified: a pervasive sense of not being affected by the external world, a lack of resonance, lack of natural and spontaneous engagement, impossibility of immersion, complaints of not being properly present in the world. This item includes social hypohedonia, a diminished emotional and cognitive reactivity, apathy (i.e. feeling of not having feelings) or a pervasive sense that everything is or seems meaningless [in this latter case, there is a possibility of overlap with lack of natural evidence (2.12) and derealization (2.5)].

NB: Social hypohedonia should *never* be rated as present in the case of concomitant social anxiety (2.13.4) unless these two appear to occur independently of each other. It is important to assess potential trait-state status of these experiences (the latter are strongly suggestive of schizophrenia spectrum). It is also important to check for clinical depression, especially in subtype 1.

Example

- 'Everything appears utterly indifferent to me.

Subtype 2

Nonspecified: a pervasive nonspecified (quasi-perceptual) feeling of distance to the world, or a sense of a barrier between one-self and the world (a feeling of being enclosed in a 'glass case' or being behind a glass). Yet this sense of distance cannot be specified by the patient in further details, e.g. in terms of specific perceptual/experiential changes (e.g. if the 'glass case' patient seems to experience looking through a glass, then it is subtype 3).

Subtype 3

Including derealization or perceptual change (section C in the BSABS): as subtypes 1 and 2 but accompanied by an explicit change in the perceptual feeling tone (in other words, the sense of barrier can be described by certain explicit properties: e.g. colors are faded; objects are remote) or marked by more specific perceptual disturbances, or derealization (i.e. everything seems to be unreal, lifeless, mechanic).

Comment: All three subtypes are *not* mutually exclusive and may overlap with derealization and other self-disorders. The main difference between diminished presence (2.4) (especially its subtypes 2 and 3) and derealization (2.5) is that in diminished presence, the patient locates the sense or the source of change primarily *in himself,* whereas in derealization it is predominantly the *environment* that appears changed for the subject.

2.5 Derealization (C.2.11)

A change in the experience of the environment: the surrounding world appears somehow transformed, unreal, and strange, may be compared to an ongoing movie. *There is a decrease in the very primary sense of lived reality,* but no decrease of conceptually based reality awareness or of reality testing.

The source of change is not felt as primarily located in the patient.

Subtype 1

Fluid (global) derealization: this is by far the most common subtype of derealization. The change is hard to describe and specify explicitly. There is a dilution or fading out (or even a loss) of the physiognomy (Gestalt meaning) of the surrounding world: the meaning and the significance of the world appear changed, unclear, or ambiguous. The world appears as strange and alien, mechanic, lifeless, or meaningless.

Subtype 2

Intrusive derealization: here, there is an increase or accentuation of the physiognomy of the world or of its isolated aspects or components, thus often occurring together with a captivation by details of perception (1.12.1). Single, isolated aspects of the environment (objects, situations) acquire intrusive or obtrusive experiential quality, with indeterminately increased significance and may be experienced with increased emotional tag.

The phenomenon must not be voluntarily induced through sustained attention (constant staring), although staring may amplify preexisting derealization.

Examples

To subtype 1

- The surroundings appear to me as unreal, changed.

- Things are no longer the way they used to be. They are strange, as if they only were silhouettes.

To subtype 2

- 'The behavior of the dog made a strong impression on me; it was so wild, uncontrolled, so full of pure nature, savage and instinct-driven that I felt warmth in my heart. Also that wild horse, and that old woman, with her face marked by the age; the whole landscape was so authentic, so primordially natural; it was all so moving that I felt an immense happiness' [Matussek, 1952].

NB: Derealization may be accompanied by other and more specific changes of perception (e.g. a change in the quality/intensity of sounds). In the case of a clear perceptual change, score diminished presence as well (2.4.3). Derealization felt just after a panic attack should not be rated here.

2.6 Hyperreflectivity; Increased Reflectivity (B.3)

Occasionally excessive or frequent, even chronic, tendency to take oneself or parts of oneself or aspects of the environment as objects of intense reflection. The patient typically suffers from a loss of naïveté, leniency, and ease. There is an increase in the tendency to reflect about one's own thinking, feelings and behavior, and inability to react and behave spontaneously and carefree; a tendency to excessively monitoring inner life, while at the same time interacting in the world ('simultaneous introspection'[4]). In the case of loss of common sense (2.12) (rated separately), there will be an automatically increased tendency to reflect about the world.

NB: The intensity of hyperreflectivity in this item is less than what is the case in distorted first-person perspective (2.2.2), where the condition is so pervasive and intense that it leads to a constant feeling of phenomenological distance.

Examples

- I had to think about what to think.
- She has always been 'self-reflective' and thought about herself 'in an existential way'.

2.7 I-Split ('Ich-Spaltung')

The patient experiences his I, self, or person as being divided or otherwise compartmentalized, disintegrated into semi-independent parts, or not existing as one unified whole. The patient's complaints must have an experiential quality that may form a continuum from a vague sense of split, 'as if' division, to a split that is elaborated in a delusional way. It does not suffice to score this item in cases where the patient is aware of having, e.g., a 'multifaceted personality'.

Subtype 1

I-split suspected: rate here cases of I-split which the interviewer suspects are present *behind* the patients' complaints, yet without being able to point out specific experiential terms used by the patient; i.e. this rating is based on statements suggesting a split, but which the patient is not able to conceptualize in explicit terms and is therefore vague and unclear.

Subtype 2

The rating of I-split is based on reports of 'as if' experiences.

Subtype 3

The I-split involves a spatialized experience *not* involving delusional quality.

Subtype 4

The I-split involves a delusional elaboration.

Examples

To subtype 1

- After he was transferred to a single room and left alone, he got a thought 'now, we two old chaps are alone together', and the thought surprised him.

To subtype 2

- Approximately, once a week, she had a feeling 'as if she was two', 'as if she was able to see herself from the outside'. 'She splits up into two parts and flies away, composed of those two parts'.
  NB: Score also dissociative depersonalization (2.8).
- She says that her thoughts 'divide themselves', and she feels a split in herself. It is a question of negative and positive thoughts. She feels it as if there were two different parts of her which 'carry out a war with each other'.
- He describes that he often has no contact to his left side; it feels as if he 'was half' only. This feeling can propagate itself into the depth of his body.
  NB: Here, score also somatic depersonalization (3.3).

To subtype 3

- Her right part is much stronger, and able to put up a façade. She feels 'imbalance in the layers of the two sides'.
- She feels herself as a cranium with something inside, 'a little man in a cockpit', as if she had two brains. One part of herself feels somehow dissociated from her normal self and therefore strange. The thoughts belonging to her normal self are localized to the anterior part of the brain, whereas the thoughts that are strange are located in the more posterior part in the brain.
- There are two sides in her: one destructive and one positive. Once, when she was in bed, she got for some seconds a feeling that she was transformed into two persons, who were both lying in the bed.

[4] This is a term borrowed from Japanese psychopathology (M. Nagai).

To subtype 4

- A young female patient (with prior anorectic episodes) explains that she has always 'felt wrong'; from time to time she stopped eating in order to starve the wrong part to death. (In this particular case, the statement approaches a delusional quality).

2.8 Dissociative Depersonalization (Out-of-the-Body Experience)

The patient says that he sometimes feels as if he was 'outside' himself as a sort of a double, watching or observing him or others. The experience must have the 'as if' character (subtype 1), i.e. the patient *does not actually perceive* himself from outside, but only imagines doing so for his 'inner eye'; a kind of 'out-of-the-body' experience.

If there is an instance of self-perception from without, the experience should be considered as a dissociative visual hallucination (subtype 2) (e.g. the patient says that he is literally seeing himself from the outside, or seeing his double next to him).

However, in many cases of these 'out-of-the-body' experiences, it may be impossible to grasp what the patient actually means with the expression: 'watching himself from outside' – perhaps it may even not be an imaginative process but a description of experiental distance (2.2.2) or a 'simultaneous introspection' in hyperreflectivity (2.6).

Subtype 1
'As if' imaginative phenomenon.

Subtype 2
Dissociative visual hallucination.

2.9 Identity Confusion

A feeling as if the patient is somebody else.

Examples

- 'I feel as if I were my own mother.'
- A patient was briefly able to feel as if he was another person, of whom he happened to be thinking. He does not know whether it was a physical or mental experience.
- A patient briefly felt as if he was a dog.

NB: Identity confusion would frequently be associated with a diminished sense of basic self (2.1), distorted first-person perspective (2.2) and transitivism (4.0).

2.10 Sense of Change in Relation to Chronological Age

A fundamental feeling as if being considerably older or younger than the actual chronological age, not clearly understandable because of social relations or interactions.

Examples

- He may feel younger and in flashes he may feel like another person.
  NB: Rate also identity confusion (2.9).
- During a conversation, she says that she feels like a 5-year-old girl. At the next appointment, she repeats that she felt like a little girl.

2.11 Sense of Change in Relation to Gender

Subtype 1

Occasional fear of being homosexual or that others consider one as such.

Subtype 2

A feeling as if being of the opposite sex or a confusion of ones own sex.

2.12 Loss of Common Sense/Perplexity/Lack of Natural Evidence

It is a loss or a lack of automatic, prereflective grasp of the meaning of everyday events, situations, people and objects.

There are different domains in which this feature may manifest itself. The patient may be unable to grasp signification of everyday matters and situations (e.g. he may wonder about colors of traffic lights), may not understand the (tacit) rules of human conduct or interactions, or may become excessively intrigued or preoccupied by semantic issues. The naturalness of the world and of other people is lacking, and that usually leads to a certain hyperreflectivity. This symptom should *not* be rated if the major change comprises a persecutory paranoid threatening coloring of the world ('Wahnstimmung'). The reaction of the patient is of perplexity, curiosity, amazement, and attempts to understand (through reflecting) or to cope. Morbid rationalism and geometrism are sufficient but not necessary to rate this symptom.

Explanation of the Terms

Morbid Rationalism. Refers to a general attitude of the patient, who considers human moves, affairs and actions as being guided by specific rules, rigid principles and schemas: 'A father buys a coffin to his dying daughter as a birthday present, because the coffin is something she is going to need' [Parnas and Bovet, 1991].

Geometrism. Preoccupation with spatial arrangements in the world, symmetry, mathematical or numerical aspects of the world; corresponds to certain lifeless rigid obsessionality.

Morbid Rationalism and Geometrism Overlap. Both represent artificial stiffness versus an adaptive automatic dynamism of 'life' (see Minkowski).

Examples

- All the existential thoughts have mixed up the pieces in my mental system. I don't understand life. The whole image of life has changed. So many questions, so little explanation!! Why are we living?
- He states that 'nothing is relative' in the sense that he finds no connection between things in the world.
- Language represents for her a confusing and overwhelming sea of almost infinite variation of meaning.
- A patient started to doubt the meaning of the most ordinary words. He bought a dictionary to learn these meanings from the very scratch.
- A patient always reflected on self-evident features of the world: why the grass is green, why the traffic lights are in three colors.
- Why do we have two eyes?

2.13 Anxiety

Subtype 1

Panic attacks with autonomous symptoms: the patient experiences attacks of severe anxiety, lasting minutes to hours, accompanied by at least two of the following: trembling, chocking, palpitations, dizziness, hyperventilation, and fear of dying. It may also be accompanied by fear of disintegration or losing one's mind, followed by derealization, or feelings of self-reference. Such attacks may be triggered in a nonspecific way by external stimuli (e.g. being alone).

Subtype 2

Psychic-mental anxiety: a strictly mental feeling of anxiety and tension, perhaps accompanied by fear of disintegration, but *without* autonomous symptoms.

Subtype 3

Phobic anxiety: any anxiety that is provoked by specific stimuli such as open places, heights, small rooms, or certain animals (excluding social stimuli).

Subtype 4

Social anxiety: insecurity provoked by social encounters, others' gaze, close physical contact, parties, crowding (may include self-reference).

Subtype 5

Diffuse, free-floating and pervasive anxiety: anxiety/inner tension/indescribable unpleasant affect, which is nearly constant, and may be provoked by a multitude of stimuli or arise for no apparent reason, making life and relations to others a nearly unbearable and a constantly felt burden or a source of suffering (see also ontological anxiety, 2.14).

Subtype 6

Paranoid anxiety: anxiety of any type linked to paranoid ideation (being exploited, harassed, manipulated, not respected).

NB: In case of overlap, rate all relevant subtypes.

2.14 Ontological Anxiety

A pervasive sense of insecurity, weakness, inferiority, indecisiveness, low anxiety tolerance, persistent low-grade free-floating (objectless) anxiety, or a subtle, pervasive sense of something ominous impending. The lifestyle of a person with ontological insecurity is concerned with *self-preservation* rather than with *self-realization.* The world and the others are not experienced as invariant secure existential foundations, but as enigmatic, unreliable, or threatening. The patient has a pervasive sense of being exposed, and a need to protect or hide himself. Such feelings of ontological insecurity are nearly always associated with a sense of profoundly disturbed identity, ambivalence, loss of natural evidence, or hyperreflectivity.

NB: This feature should be rated very conservatively, and can usually be detected only on the basis of an interview, which includes information on social, interpersonal, educational, professional functioning, interests, motivations, and the exploration of subjective experience. Therefore, the symptom should be scored as present only in addition to anxiety (2.13.1; 2.13.2) or diffuse, free-floating and pervasive anxiety (2.13.5) and there is simultaneous evidence of at least one of the following items: ambivalence (1.9), diminished sense of basic self (2.1), distorted first-person perspective (2.2), depersonalization (2.3), derealization (2.5), hyperreflectivity (2.6), or perplexity (2.12).

2.15 Diminished Transparency of Consciousness

A pervasive or recurrent sense of not being fully alert, fully awake, fully conscious, as if there was some lack of clarity, inner hindrance, or feelings of internal pressure, blocking, opacity. The acts of consciousness or the *very way of being conscious* appear as somehow peculiarly faded, diminished or inefficient.

If the patient complains about a sort of globally unpleasant, but not further describable pervasive mental state, or a global feeling of pressure, oppression, blocking,

and the like, locating these sensations to his head, mind or brain, then diminished transparency should be rated as present, that is if the complaints are *not* caused by a concomitant thought pressure (1.3). Experiences of diminished transparency should *not* be rated if they appear to be secondary, e.g. linked to thought pressure, hallucinatory states, mental exhaustion, clinical depression, seasonal affective disorder, and organic brain disorder (e.g. epilepsy) or drug intake.

NB: Clarity is *not* used here as in the context of delirium, where clarity is usually said to be lacking. Diminished transparency is very difficult to elicit during the interview; it is frequently accompanied by other self-disorders.

Examples
- My feeling of consciousness is fragmented.
- It is a continuous universal blocking, a strain.
- I always feel 'half awake'.
- I always have a feeling of not having slept enough.
- I have no self-consciousness.
- Frequently, I have a strange foggy feeling in my head.

Typical vignette 1: 'I have a feeling as if my brain is shrinking.' (Question: How? Please describe): 'It's like a constant pressure inside my head, as if there was something wrong inside, and sometimes also like a ring or a strap around my head. It hinders me in thinking and in seeing properly'.

Typical vignette 2: A patient says that he is frequently affected by 'dizziness', which means that he is 'only incompletely in contact with the world, only 60–70%. It is, as if there was no hole (no opening) to the world. There is a lack of transparency between me and the world'. He emphasizes: '*It has nothing to do with perception, perceptual impressions or the senses.'*

NB: In this case, there should be scored diminished presence, subtype 2, 'glass case' (2.4.2), but also diminished transparency, because the patient's experience appears to involve diminished transparence of consciousness as a medium of experience (e.g. his insistence on the fact that the problem is not located in the sensory processes/perception).

2.16 Diminished Initiative (A.4)

A pervasive sense that all activity is requiring effort, difficulty in initiating action. In other words, it is not sufficient to score this item on the basis of inactivity, or apathy. The patient must describe his inability to initiate action (e.g. sits 3 h, preparing himself for going to the post office).

Exclusion criteria: as in diminished vitality (2.18).

2.17 Hypohedonia

Hedonia refers to pleasure capacity. Pervasively or recurrently occurring diminished ability to experience pleasure in relation to immediately surrounding 'physical' perceptual or intellectual stimulation [e.g. social anhedonia is scored elsewhere (2.4)].

NB: In contrast to diminished presence (2.4) described above, we are dealing here with self-feelings associated either with circumscribed bodily or mental states in relation to direct circumscribed environmental stimulation (e.g. diminished pleasure in tasting food, taking a hot bath, no pleasure from sex) or in relation to previously pleasurable physical or intellectual activity (e.g. sport, reading books). This definition follows the standard contemporary psychiatric definition. Yet, it is probably doubtful that hypohedonia ever occurs singly, as a completely isolated phenomenon, e.g. unrelated to diminished vitality (2.18), diminished presence (2.4), or distorted first-person perspective (2.2). In the case of overlap, all relevant items should be rated as present.

Examples
- I have lost all pleasure. Previously I loved to jog; now I'm not interested in it.
- I am unable to feel pleasure. Nothing gives me a kick.

2.18 Diminished Vitality (A.3.1)

A pervasive or frequently recurrent sense of inexplicable mental or physical fatigue, dampening of immediate aliveness, diminished energy, spontaneity, 'élan'.

Subtype 1

State-like diminished vitality occurs during exacerbation(s) marked by other coexisting symptoms such as: apathy, inactivity, staying in bed and other symptoms, e.g. ruminations or feelings of bodily changes.

Subtype 2

Trait-like diminished vitality occurs more or less pervasively or as a frequently recurrent and *relatively isolated feature.*

Exclusion Criteria

These phenomena should not be rated as present if they are explicable by other, more primary or encompass-

ing disturbances such as thought pressure (1.3), hyperreflective ruminations (1.6), clinical depression (which includes melancholia and a major depression successfully treated with antidepressants), organic brain disorder or pharmacological side effects.

Faded or absent intentional feelings (apathy; i.e. feelings specifically directed at someone, e.g. family, children) are scored above as diminished presence (2.4). Score both in case of doubt.

Examples
- I have no energy, no inner spark.
- I feel completely empty.
- I always feel tired and exhausted; I saw a doctor but he could not find anything somatically wrong.
- I have lost all form of desire. I have no contact to myself, I feel like a zombie.
- I lost my feelings, making me almost another person.

3 Bodily Experiences

General description of the domain: A normal sense of psychophysical unity and coherence, a normal interplay or oscillation of the body as 'lived from within' as a subject or soul (nonspatial, spiritual 'Leib') and of the body as an object (spatial and physical 'Körper'). In other words, our bodily experience is neither of an object nor of a pure subject. It is simultaneously both.

3.1 Morphological Change (D.9)

Usually paroxystic sensations ('as if') or perceptions of diminishment or constriction of single body parts, or experiences of body parts or the entire body becoming thinner, shorter, contracting, enlarging, being pressed down or diminished.

Subtype 1

Sensations affecting the whole body or part of it and generally paroxysmally.

Subtype 2

The patient perceives a morphological change in his body: e.g. he sees his hands as enlarged (illusions of change).

3.2 Mirror-Related Phenomena (C.2.3.6)

This is a group of phenomena, which have in common an unusually frequent, *and* intense looking in the mirror or avoiding one's specular image or looking only occasionally but perceiving a facial change.

The patients either perceive changes of their own face or they look for such changes, and therefore examine themselves in the mirror often and/or intensely. They may become surprised or frightened by what they see, and even tend to avoid mirrors because of what they see. Sometimes they look in the mirror to assure themselves of their very existence. They might also look at photos of themselves to find out about their own identity.

NB: In that case, score also diminished sense of basic self (2.1).

Subtype 1

The patient only *searches* for change or frequently looks in the mirror for a nonspecified reason, but there is no definite perception of change.

Subtype 2

The patient *perceives* his own face as somehow changed or deformed.

Subtype 3

Other phenomena that may belong to this category (e.g. to assure oneself of one's existence).

Examples

To subtype 1
- Lately, she has felt being somehow strange, not really herself, perhaps absent-minded. Yesterday she had to look in the mirror to check whether her face had changed.
  NB: Here, psychic depersonalization (2.3) should also be rated.

To subtype 2
- She had an experience that her face looked witch-like, and therefore she did not like to see herself in the mirror.
- She saw that her neck muscles were strangely protruding.
- When she looked at herself in the mirror, she focused on the eye, which she suddenly saw as a ball in her head. It was 'surrealistic', and she felt that her face was changed.

3.3 Somatic Depersonalization (Bodily Estrangement) (D.1.1)

The body or some of its parts are perceived as strange, alien, lifeless, isolated, separated from each other, dislocated or not existing.

Examples
- When I look down at the lower part of my body, it constantly feels twisted and displaced to the left, compared to the rest of the body.
- I have a feeling that my left and right forearms have switched places.
- I have a strange feeling that it's somebody else's body.

- It is as if his body was alien. He knows that it is his body, but it feels 'as if it did not hang together', it feels 'as if his head was just fixed to the body'.
- She always feels self-estranged, 'as if there was a little man in her head, steering this big robot'. Sometimes she looks at her arms and hands, and has a feeling that they are not her own.

NB: In contrast to morphological change (3.4), where there is a feeling or illusion of a *specific* morphological change, we are dealing here with global, diffuse experiences.
There are cases where somatic depersonalization (3.3) and morphological change (3.1) are not clearly distinguishable from each other. If so, rate both positively.

3.4 Psychophysical Misfit and Psychophysical Split

The body feels as if not really fitting, as either too small, too big, or otherwise uncomfortable or somehow changed. This is usually, but not always, associated with a feeling that mind and body do not fit or belong together, as if they were somehow disconnected, or independent of each other.

NB: Do not score here a dislike of specifics or concrete aspects of one's appearance, e.g. weight, or height.

Examples
- He lacks a 'healthy self-acceptance' of his body, it is difficult for him to 'possess, take care of it without feelings of inferiority and shame'. It is difficult for him 'just to be in his body'.
- She has difficulty in realizing that she is in her body, and she may be thinking 'it's strange that I am here'.
- He talks about 'a lack of coherence' or split between his physical part, visible to others, and himself, i.e. all that happens in his mind. He feels that his body is a shared property, something anonymous, distanced from him.

3.5 Bodily Disintegration

Feeling of bodily disintegration or dissolution, as if falling apart or going bodily into pieces or disappearing.

NB: This experience may be linked to disorders of demarcation but is placed here for the interview convenience.

3.6 Spatialization of Bodily Experiences

Predominance of experiencing the body or its parts as a physical object (physical/spatial), at the expense of the spiritual-lived, nonspatial, lived bodily experiences.

The patient may here experience a kind of unusual introspective access to normally mute body parts or physiological processes (e.g. the patient *experiences* his internal organs or physiological processes).

Examples
- Her uterus feels as if it was not her own, as if it was somehow detached.
  NB: Somatic depersonalization (2.8) is also rated here.
- I can feel the blood rushing under my skin.

3.7 Cenesthetic Experiences (D.1; 3–9; 11–14)

Unusual bodily sensations of numbness and stiffness: a furry or numb feeling (e.g. in the hands, feet or other parts of the body).

Unusual bodily sensations of pain in a distinct area, not comparable to, completely different from premorbidly known pains.

Migrating bodily sensations wandering through the body.

Electric bodily sensations, feelings of being electrified.

Thermal sensations (feelings of heat and cold).

Bodily sensations of movement, pulling or pressure inside the body or on its surface.

Sensations of abnormal heaviness, lightness or emptiness, of falling or sinking, levitation or elevation affecting the whole body or just parts of it.

Vestibular sensations.

Dysesthesias provoked by sensory or tactile stimulations: inconveniences, i.e. pain that is provoked by an acoustic stimulus. Touch, which feels unpleasant and painful.

Dysesthetic crises: paroxysmal states, lasting seconds or minutes, which involve impaired bodily sensations, central-vegetative disturbances and fear of dying.

3.8 Motor Disturbances

Subtype 1

Pseudo-movements of the body (D.10): the patient experiences pseudo-movements of the body or parts of it, e.g. the limbs (not to confuse with motor interference, where real movements occur).

Example
- A feeling of the body rocking or the leg jerking.

Subtype 2

Motor interference (C.3.1): motor or verbal derailments that occur without or against the patient's intention and typically interfere with intended motor actions or speech. Such derailments are part of usually intended behavior (pseudo-spontaneous movements, e.g. gaze spasm, movement stereotypes, automatosis syndrome) and are not regarded by the patient as being made or influenced by external forces.

Subtype 3

Motor blocking (C.3.2): impediment or complete blockage of intended motor actions. Occurs as a paroxysm. Complete blockages ('Bannungszustände') may appear suddenly, like an attack or paroxysm and disappear quickly. The patient is fully conscious, but is unable to move or speak. These blockages can be regarded as counterpart of the automatosis syndrome (C.3.1).

Subtype 4

Sense of motor paresis (D.2.): a sudden feeling of weakness or paresis of the arms or legs on one or both sides of the body. These 'sensations of paresis' might lead to limping or to things slipping out of the hand, to not being able to hold tools so that work has to be stopped.

Besides short-lasting variants, long-lasting sensations of paresis occur as well (persisting for weeks).

Subtype 5

Desautomation of movement (C.3.3): common everyday, habitual actions (such as getting dressed, washing, shaving, brushing the hair) that have been performed more or less automatically in the past cannot be performed any more or only with great effort of will power. They take more time and have to be performed with maximal and conscious attention.

Partially automated performances (e.g. riding a bicycle, knitting or working in the kitchen) are also disturbed. Action routines that had been effortlessly available are more or less completely lost.

3.9 Mimetic Experience (Resonance between Own Movement and Others' Movements) (C.2.3.7)

Pseudo-movements of perceived objects and humans are experienced, especially when the patient is in motion himself. Therefore, he will often try to avoid moving. Either the patient or the object/human moves first, or both simultaneously, and the patient feels as if there is a strange link between the two.

NB: Mimetic experience has affinities with solipsistic experience (domain 5). It is placed here for the interview convenience, now focused on body and movement.

4 Demarcation/Transitivism

General description of the domain: Loss or permeability of self-world boundary. These disorders are closely linked to disorders of self-awareness and presence, but are listed separately here because of their more articulated symptomatic nature.

4.1 Confusion with the Other

The patient experiences himself and his interlocutor as if being mixed up or interpenetrated, in the sense that he loses his sense of whose thoughts, feelings, or expressions originate in whom. He may describe it as a feeling of being invaded, intruded upon in a nonspecific but unpleasant or anxiety-provoking way. In the extreme degree of the latter, score also 4.3, subtype 1.

4.2 Confusion with One's Own Specular Image

A feeling of uncertainty about who is who or who is where, when looking at his own mirror or another specular image (e.g. in the window panes of the shops), or portrait pictures, and paintings.

4.3 Threatening Bodily Contact

Subtype 1

A feeling of extreme anxiety or unease when standing close to or being touched by another (even by a close person), or being hugged. Bodily contact feels threatening to one's autonomy and existence. Sexual intercourse may be unbearable.

NB: Do not rate this symptom when it appears caused by a paranoid, suspicious attitude.

Subtype 2

A feeling of personal disappearance, annihilation, or ceasing to exist, when being exposed to a close contact with another, e.g. during a sexual intercourse.

4.4 Passivity Mood ('Beeinflussungsstimmung')

A diffuse feeling or mood of being somehow in a passive, dangerously exposed position, at the mercy of the world, in an unspecified and unconcretized manner. It is a sort of being oppressed by something negative that may happen imminently, without any thematic specification (overlaps delusional mood). One's sense of being a volitional autonomous subject is diminished, which may sometimes necessitate scoring of distorted first-person perspective (2.2) as well. The patient has no concrete experiences or delusional ideas about external influences, yet he feels as if he was somewhat constrained by the external world.

4.5 Other Transitivistic Phenomena

Other feelings of inadequate bodily demarcation (also versus inanimate objects), a pervasive feeling of being

somehow 'too open or transparent' or having extraordinarily 'thin skin', having no barriers, or a state in which the patient is excessively preoccupied with the exact mechanisms of self-world and self-other relations/influences, or has a special 'extra layer' covering his body surface.

Varieties of heightened perception, where the patient complains of insufficient barrier against sensory stimuli (mainly optical), should also be scored here.

5 Existential Reorientation

General description of the domain: The patient experiences a fundamental reorientation with respect to his general metaphysical worldview and/or hierarchy of values, projects and interests. Basically, the experiences of anomalies in self-awareness are here enacted and so existentially expressed.

Solipsistic-Like Experiences (Items 5.1–5.6)

The patient in some way feels as if being a *unique* (literally or in the sense of centrality) subject in the world, may have a fleeting sense of extraordinary abilities or powers (as if being a creator), may experience the outer world as a figment of his own imagination (the world becomes mind-dependent), and the patient may feel an experiential access to his own mind's constitutive capacities (experiential access to his 'cognitive unconscious').

5.1 Primary Self-Reference Phenomena (C.1.17)

The subject senses an immediate link between himself and external events or other people, a link that is *not* explained or mediated by a preexisting paranoid attitude, feelings of insufficiency, preceding panic attack or depressive guilt. In other words, we are dealing here with *primary self-reference phenomena that cannot be further psychologically reduced* (i.e. explained in terms of other mechanisms).

Examples
- At a party everything seemed to him to originate from him or depend on him.
- As she saw a group of passengers getting off the bus she had a feeling that they were performing some sort of parody of her actual state.
- When he was having a cup of coffee, he thought that the clouds resembled a man having a cup of coffee.

5.2 Feeling of Centrality

Fleeting feelings as if being the center of the universe.

Example
- A former doctor recalled that when working in a small provincial hospital, he sometimes had a transient 'as if' sentiment that he was the only true doctor in the entire world and the fate of humanity depended on him.

5.3 Feeling as if the Subject's Experiential Field Is Only Extant Reality

Example
- A patient had sometimes a fleeting feeling as if only objects in his visual field existed. Other people and places did not seem to exist. He immediately considered it as nonsense.

5.4 'As if' Feelings of Extraordinary Creative Power, Extraordinary Insight into Hidden Dimensions of Reality, or Extraordinary Insight into Own Mind or the Mind of Others

5.5 'As if' Feeling that the Experienced World Is Not Truly Real, Existing, as if It Was Only Somehow Apparent, Illusory, or Deceptive

Examples
- He experiences other people as robots and everything as a big pot of molecules, and then starts wondering if the world is real.
- As a child she experienced that 'the whole world was built up just for her', like a scene.

5.6 Magical Ideas (i.e. Ideas Implying Nonphysical Causality), Linked to the Subject's Way of Experiencing (5.1–5.5)

Example
- He had the impression as if he could control the weather, as it seemed to change with his mood.

5.7 Existential or Intellectual Change

New or unusual preoccupation with existential, metaphysical, religious, philosophical, or psychological themes. Do not rate in case of hypomanic or manic states.

Frequently reported themes: supernatural phenomena; religion (especially Eastern); mystical experience; philosophy; transcendental themes; meditation; psychology; ancient rituals; symbols; reincarnation; the life to come; struggle between good and evil; universal peace and communication; meaning of existence; fate of the humanity; salvation; alternative approaches to science; related ideas about health and nutrition.

Examples
- New ideas and interests that gradually overtook my life and thinking absorbed me; they left a mark on my entire life.
- Extremely occupied by thoughts about how to be good enough.
- Had to redefine and analyze everything he was thinking about.
- Needed new concepts for the world and human existence.

5.8 Solipsistic Grandiosity

The patient, in speech or behavior, exhibits a sense of superiority over his fellow humans, typically associated with his feelings of possessing extraordinary insights or abilities (5.4). Others are seen as ignorant morons chasing only material (superficial) aspects of existence. This attitude often has a slightly manneristic coloring.

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Appendix A: EASE-rating criteria

Frequency/severity		Score
Absence	absence (definitely absent/ never experienced)	0
Questionably present	perhaps experienced, but either recollected only at few occasions, or very dimly, during the patient's life (questionably present)	1
Present		
Mild	definitely experienced, at least three times in total (usually more frequently), but at irregular occasions; the symptom does not constitute a major problem or source of distress for the patient.	2
Moderate	symptom is present either daily for extended periods of time (e.g. at least daily in one week twice a year) or frequently but sporadically over at least 12 months (may constitute a problem or a source of distress)	4
Severe	almost constantly present (e.g. daily during recent 2 weeks); typically stressful, source of suffering and dysfunction	5
Not scorable	lack of info permitting to make a judgement	blank

Level of presence	Score	Present now, i.e. 2 weeks	Associated with drug intake	Specific provoking factors	Psychotic elaboration
Absence					
Questionably present					
Mild					
Moderate					
Severe					

Appendix B: EASE Item Key List

1	Cognition and stream of consciousness
1.1	Thought interference
1.2	Loss of thought ipseity ('Gedankenenteignung')
1.3	Thought pressure
1.4	Thought block
1.4.1	Subtype 1: blocking
1.4.2	Subtype 2: fading
1.4.3	Subtype 3: combination
1.5	Silent thought echo
1.6	Ruminations-obsessions
1.6.1	Subtype 1: pure rumination
1.6.2	Subtype 2: secondary rumination
1.6.3	Subtype 3: true obsessions
1.6.4	Subtype 4: pseudo-obsessions
1.6.5	Subtype 5: rituals/compulsions
1.7	Perceptualization of inner speech or thought
1.7.1	Subtype 1: internalized
1.7.2	Subtype 2: equivalents
1.7.3	Subtype 3: internal as first-rank symptom
1.7.4	Subtype 4: external
1.8	Spatialization of experience
1.9	Ambivalence
1.10	Inability to discriminate modalities of intentionality
1.11	Disturbance of thought initiative/intentionality
1.12	Attentional disturbances
1.12.1	Subtype 1: captivation by details
1.12.2	Subtype 2: inability to split attention
1.13	Disorder of short-term memory
1.14	Disturbance of time experience
1.14.1	Subtype 1: disturbance in subjective time
1.14.2	Subtype 2: disturbance in the existential time (temporality)
1.15	Discontinuous awareness of own action
1.16	Discordance between expression and expressed
1.17	Disturbance of expressive language function
2	Self-awareness and presence
2.1	Diminished sense of basic self
2.1.1	Subtype 1: early in life
2.1.2	Subtype 2: from adolescence
2.2	Distorted first-person perspective
2.2.1	Subtype 1: mineness/subjecthood
2.2.2	Subtype 2: experiential distance
2.2.3	Subtype 3: spatialization of self
2.3	Psychic depersonalization (self-alienation)
2.3.1	Subtype 1: melancholiform depersonalization
2.3.2	Subtype 2: unspecified depersonalization
2.4	Diminished presence
2.4.1	Subtype 1: not being affected
2.4.2	Subtype 2: distance to the world
2.4.3	Subtype 3: as subtype 2 plus derealization
2.5	Derealization
2.5.1	Subtype 1: fluid global derealization
2.5.2	Subtype 2: intrusive derealization
2.6	Hyperreflectivity; increased reflectivity
2.7	I-split ('Ich-Spaltung')
2.7.1	Subtype 1: I-split suspected
2.7.2	Subtype 2: 'as if' experience
2.7.3	Subtype 3: concrete spatialized experience
2.7.4	Subtype 4: delusional elaboration
2.8	Dissociative depersonalization
2.8.1	Subtype 1: 'as if' phenomenon
2.8.2	Subtype 2: dissociative visual hallucination
2.9	Identity confusion
2.10	Sense of change in relation to chronological age
2.11	Sense of change in relation to gender
2.11.1	Subtype 1: occasional fear of being homosexual
2.11.2	Subtype 2: a feeling as if being of the opposite sex
2.12	Loss of common sense/perplexity/lack of natural evidence
2.13	Anxiety
2.13.1	Subtype 1: panic attacks with autonomous symptoms
2.13.2	Subtype 2: psychic-mental anxiety
2.13.3	Subtype 3: phobic anxiety
2.13.4	Subtype 4: social anxiety
2.13.5	Subtype 5: diffuse, free-floating pervasive anxiety
2.13.6	Subtype 6: paranoid anxiety
2.14	Ontological anxiety
2.15	Diminished transparency of consciousness
2.16	Diminished initiative
2.17	Hypohedonia
2.18	Diminished vitality
2.18.1	Subtype 1: state-like
2.18.2	Subtype 2: trait-like
3	Bodily experiences
3.1	Morphological change
3.1.1	Subtype 1: sensation of change
3.1.2	Subtype 2: perception of change
3.2	Mirror-related phenomena
3.2.1	Subtype 1: search for change
3.2.2	Subtype 2: perception of change
3.2.3	Subtype 3: other phenomena
3.3	Somatic depersonalization (bodily estrangement)
3.4	Psychophysical misfit and psychophysical split
3.5	Bodily disintegration
3.6	Spatialization (objectification) of bodily experiences
3.7	Cenesthetic experiences
3.8	Motor disturbances
3.8.1	Subtype 1: pseudo-movements of the body
3.8.2	Subtype 2: motor interference
3.8.3	Subtype 3: motor blocking
3.8.4	Subtype 4: sense of motor paresis
3.8.5	Subtype 5: desautomation of movement
3.9	Mimetic experience (resonance between own movement and others' movements)
4	Demarcation/transitivism
4.1	Confusion with the other
4.2	Confusion with one's own specular image
4.3	Threatening bodily contact and feelings of fusion with another
4.3.1	Subtype 1: feeling unpleasant, anxiety provoking
4.3.2	Subtype 2: feeling of disappearance, annihilation
4.4	Passivity mood ('Beeinflussungsstimmung')
4.5	Other transitivistic phenomena
5	Existential reorientation
5.1	Primary self-reference phenomena
5.2	Feeling of centrality
5.3	Feeling as if the subject's experiential field is the only extant reality
5.4	'As if' feelings of extraordinary creative power, extraordinary insight into hidden dimensions of reality, or extraordinary insight into own mind or the mind of others
5.5	'As if' feeling that the experienced world is not truly real, existing, as if it was only somehow apparent, illusory or deceptive
5.6	Magical ideas linked to the subject's way of experiencing
5.7	Existential or intellectual change
5.8	Solipsistic grandiosity

Appendix C: EASE/BSABS Comparison

EASE		BSABS
1.1	Thought interference	C.1.1
1.3	Thought pressure	C.1.3
1.4	Thought block	C.1.4
1.6.1	Pure rumination	C.1.2 (partly)
1.6.2	Secondary rumination	C.1.2 (partly)
1.6.3	True obsessions	B.3.2 (partly)
1.6.4	Pseudo-obsessions	B.3.2 (partly)
1.6.5	Rituals/compulsions	B.3.2 (partly)
1.9	Ambivalence	A.5
1.10	Inability to discriminate modalities of intentionality	C.1.15/A.6.2 (partly)
1.11	Disturbance of thought initiative/intentionality	C.1.13
1.12.1	Captivation by details	C.2.9
1.12.2	Inability to split attention	A.8.4
1.13	Disorder of short-term memory	C.1.9
1.15	Discontinuous awareness of own action	C.2.10
1.16	Discordance between expression and expressed	A.7.2
1.17	Disturbance of expressive language function	C.1.7
2.2.2	Experiential distance	B.3.4 (partly)
2.3.2	Unspecified depersonalization	B.3.4 (partly)
2.4.1	Not being affected	A.6.3 (partly)
2.5.1	Fluid global derealization	C.2.11
2.5.2	Intrusive derealization	C.2.11
2.6	Hyperreflectivity; increased reflectivity	B.3.1
2.13.2	Psychic-mental anxiety	D.15 (partly)
2.13.3	Phobic anxiety	B.3.3
2.16	Diminished initiative	A.4
2.17	Hypohedonia	A.6.3 (partly)
2.18.1	Diminished vitality state-like	A.3.1 (partly)
2.18.2	Diminished vitality trait-like	A.3.1 (partly)
3.1.1	Morphological change, sensation of change	D.9
3.2.2	Mirror-related phenomena, perception of change	C.2.3.6 (partly)
3.3	Somatic depersonalization	D.1.1
3.7	Cenesthetic experiences	D.1; D.3–9; D.11–14
3.8.1	Pseudo-movements of the body	D.10
3.8.2	Motor interference	C.3.1
3.8.3	Motor blocking	C.3.2
3.8.4	Sense of motor paresis	D.2
3.8.5	Desautomation of movement	C.3.3
3.9	Mimetic experience	C.2.3.7
5.1	Primary self-reference phenomena	C.1.17

For the sake of completeness, it should be noted that there are certain natural overlaps between EASE and BSABS items; yet definitions need not to be exactly identical. As a rule, the EASE items are described in more phenomenological detail. For the purpose of comparison, the lists of items from both scales are presented. This permits assessment of similarities between the studies using different instruments.