

Abnormal Bodily Phenomena questionnaire

Questionario dei Fenomeni Corporei Anormi

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Summary

The *Abnormal Bodily Phenomena questionnaire (ABPq)* is a semi-structured interview that originates from analyses of the clinical files of over 350 patients with schizophrenia. The result provide a rich and detailed collection of patients’ self-descriptions related to subjective, experiential anomalies about feelings, sensations, perceptions and cognitions arising in the domain of the lived body. *ABPq* comprises nine distinctive items, grouped in five categories: demarcation, vitality, coherence, identity and activity. For each item and category, an accurate description and a list of examples are provided. Different intensities of phenom-

ena are assessed through a Likert Scale by rating each item according to its quantitative features (frequency, intensity, impairment and coping). *ABPq* may help to discriminate schizophrenia from other psychoses and cluster A personality disorders from other personality disorders. This scale may also contribute in assessing features of clinical high risk or ultra high risk syndromes.

Key words

Coenaesthesia • Embodiment • Phenomenology • Psychopathology • Schizophrenia • Subjective experience

Introduction

Persons with schizophrenia display a morbidly experienced body. Abnormal bodily phenomena (ABP) are subjective, experiential anomalies in feelings, sensations, perceptions and cognitions arising in the domain of the lived body. ABP are a set of somatic complaints, accessible to the patient’s introspection, which entail mild to severe subjective distress or interference with daily activities. The most represented phenomena include violability, altered shape or structure, false composition and altered regional sensitivity¹⁻⁴. These abnormal phenomena may lead to psychotic symptoms, such as hypochondriac delusions, and typical schizophrenic symptoms, such as delusions of being controlled.

Phenomenology conceives the lived body (i.e. the often implicit experience one has of ones own body), as the centre of the most primitive form of self-awareness. This basic form of self-experience – that is, the implicit, pre-reflexive, immediate, non-conceptual, non-objectifying and non-observational sense of existing as a subject of awareness – is rooted in ones bodily experience. This basic, embodied form of self-awareness is assumed to be the background of the experienced differentiation between self and non-self, my self and the object I perceive, and my representation of that object and the object itself.

Contemporary phenomenological research assumes that the disruption in the basic sense of being a ‘self’ is a fundamental feature in schizophrenia⁵⁻¹⁰. Somato-psychic depersonalisation, loss of ego boundaries and disorders of sense of agency and my-ness are well known clinical features of schizophrenia. It can be assumed that ABP may play a key role in the constitution of an abnormal sense of selfhood in persons with schizophrenia. In schizophrenia, the weakening of the basic sense of self, disturbance of implicit bodily functioning and disruption of body-to-body attunement with others are taken to be manifestations of a fundamental disturbance of the bodily self.

These phenomena are not part of the mainstream diagnostic criteria for schizophrenia. One of the reasons is their quasi-ineffable nature and the lack of sensitive, specific and reliable methods to assess them. Since disorders of the embodied self may be a conceptual framework to understand the psychopathology of schizophrenia, achievement of detailed characterisation and operationalized definition of ABP is becoming a priority.

Construction of the questionnaire

The ABP questionnaire (ABPq) originates from analyses of the clinical files of over 350 patients with schizophrenia. These files reported full-blown schizophrenic symptoms

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(e.g. delusions and hallucinations) as well as “softer” phenomena that are traditionally not included in symptom checklists. These subtle, abnormal phenomena are reported by patients when asked about the way they experience and act in the world they actually live in. Since the patients’ phenomenal universe is not confined to their symptoms, systematic exploration of anomalies in the patients’ experience, e.g. of body, time, space, self, and otherness, may provide a useful integration to a traditional symptom-oriented approach¹¹. These abnormal phenomena can be used as pointers to the fundamental alterations of the structure of subjectivity characterising schizophrenia.

Psychopathological assessment should neither be confined to determining the presence or absence of a given symptom, nor should it simply focus on surface symptoms chosen for their reliability. Rather, it should look for deeper phenomena which may emerge only from careful phenomenological analysis. Especially in persons with a severe mental disorder that may affect their insight and/or their capacity to understand correctly a given item of a rating scale, it is not advisable to assess abnormal phenomena using research tools based solely on yes-or-no answers¹².

There are several reasons to prefer semi-structured interviews such as the ABPq rather than standard rating scale procedures. While using standard yes-or-no rating scales: 1) the stimulus-response process disrupts the specific rhythm of natural conversation, and fragmentation of personal experience occurs. The intimacy of the relationship is affected, and hence the reliability and validity of the interviewee’s responses; 2) shared meanings between interviewer and interviewees are assumed, and not investigated, in the process of the interview itself. Serious questions should be raised about the validity of the assumption of real mutual understanding. The coding of each item of an interview may require interpretation; 3) the pattern of interviewer dominance and respondent acquiescence is emphasised and enhanced. This entails a shift from initial extended self-reports to simple *a priori* “relevant” yes-or-no answers¹³⁻¹⁷.

Abnormal experiences in persons affected by schizophrenia cannot be reliably and validly assessed in the sole form of frequency or intensity. Their assessment requires a precise characterisation of the phenomenal quality of the experience. In-depth, fine-tuned characterisation of the phenomenal quality of abnormal experiences is needed that can only be provided by using more flexible instruments. This characterisation can avoid diagnostic mistakes, e.g. overdiagnosis or underdiagnosis of schizophrenia.

In order to investigate the ABP, during clinical interviews patients were asked questions such as:

- Do you have strange feelings coming from your body?
- Do you sometimes feel you are separated from the ex-

ternal world, or merging with it, or invaded by it?

- Did you ever happen to feel like a robot, or a thing, rather than as a human person?
- Do you feel effective as an agent in the world, or rather as being exposed to or subjugated by the world?
- Have you ever felt like parts of your body were moving away from their usual position?
- Do you sometimes experience a tendency to take an external perspective to your body?
- Do you sometimes feel your body changing, for example, in appearance?
- Do you have strange feelings of pain that you cannot explain?

The result has been a rich and detailed collection of patients’ self-descriptions related to e.g. bodily coherence/fragmentation, body vitality/devitalisation, body-world demarcation/permeability, etc. We created a database using patients’ self-reports from which we later developed categories based on structural similarities among bodily abnormal phenomena. These categories fulfil three formal criteria: reliability (they must comprise consistent findings), discriminant validity (for patients with different psychopathological features) and sensibility (ability to depict different intensities of a phenomenon)¹⁸. This last criterion is achieved by rating each item according to its quantitative features (frequency, intensity, impairment and coping) (Table I) using a Likert Scale.

ABPq comprises nine distinctive items, grouped in five categories: demarcation, vitality, coherence, identity and activity. For each item and category, an accurate description and a list of examples are provided (Appendix 1).

Each item should be queried as to their phenomenal quality, that is, whether it is expressed as an abnormal physical sensation (‘A gas is filling my head’), or in terms of its causes (‘They are blowing my head’), or using a neologism (‘A twutta insided my head’).

The interview may take about 30-60 minutes.

The Abnormal Bodily Phenomena questionnaire (ABPq)

Who: patients with schizophrenia, or suspected to have schizophrenia or schizophrenia spectrum disorders. This scale may help to discriminate schizophrenia from other psychoses and cluster A personality disorders from other personality disorders. This scale may contribute to assessment of features of clinical high risk or ultra high risk syndromes.

What: subjective bodily phenomena. We focus on bodily experiences, rather than on bodily image or schema, or on beliefs about ones body.

When: last three months.

How: assessing quality of phenomena by addressing questions about sensations coming from the body.

TABLE I.
Table of Severity.

	Absent	Minimal	Mild	Moderate	Moderate Severe	Severe	Extreme
Frequency	Does not apply	Questionable	Sporadic not recurrent	Light recurrence weekly or less	Very recurrent more than weekly	Pervasive almost every day	Continuous (every day)
Intensity of subjective arousal or distress		The distress is present but tolerable	The distress is mildly intolerable	The distress is moderately intolerable	The distress is moderately severely intolerable	The distress is severely intolerable	The distress is extremely intolerable
Impairment	The patient is able to have regular social activities	Rare or infrequent need to avoid social exchange	Occasional avoidance of non-essential social activities	Frequent avoidance of non-essential social activities	Occasional avoidance of essential social activities	Frequent avoidance of most essential social activities	Complete avoidance of social activities
Poor coping	The patient is able to solve these problems rapidly	The patient is able to restructure how he thinks	The patient actively avoids it (behavioural strategy)	The patient thinks he has problems most times he can passively avoid (ignore)	It is a problem but there is nothing he can do	The patient has only an implausible version of the problem he has to cope with	The patient thinks there is no problem to him

Subtyping the quality of phenomena

Subtype 1: includes experiences described in terms of their *physical properties or features*; patients often use metaphors to illustrate subjective experience (e.g. “The left part of my brain has been displaced in the back of my head”).

Subtype 2: includes experiences described in terms of their *causes*, i.e. specific forces or energies are violating the body boundaries, or specific objects or entities are intruding into the body (e.g. “Laser beam entering into my skull”).

Subtype 3: includes experiences described in terms of *neologisms* (e.g. “I have the twutta inside-out”).

Assessing quantity (severity) of phenomena

Rate severity, addressing questions about: a) frequency; b) subjective change; c) impairment in daily interpersonal relationships, activities, transactions, situations; d) possibility to cope; rate the highest level reached (Table I).

Items and Categories of ABPq

A1. DEMARCATION

Dynamisation of bodily boundaries

It includes experiences of violation and externalisation concerning ones body (or part of it). *Dynamisation* means that they are *not a static experience*, e.g. a static pres-

ence of splitting of ones body outside its boundaries, or, vice versa, parts of the external world inside ones body. Rather, movement is implied.

A1.1 Violation

Immediate experience of strange, unusual, abnormal, uncommon forces, energies or movements violating from without the surface and the boundaries of the body; in other cases, the patient may refer to a perplexing experience of intrusion or incorporating extra-personal entities, things or objects in their own body.

Examples:

- areas of body where forces enter;
- horse's hair went into body;
- gas filled body completely;
- skin scarred with acid;
- pains in body inflicted;
- ghost entering body at bottom of spine.

A1.2 Externalisation

Body components or sub-components, corporeal movements, vital energies or biological activities are experienced as projected beyond ones ego boundaries into the outer space.

Examples:

- face intermingled with examiner's;

- feeling of sitting on interviewer's knee;
- arms disjointed from body and reaching out;
- vagina half outside;
- legs and arms dropped off.

A2. VITALITY

Morbid objectivisation and devitalisation

The body or its parts are experienced as mere things, thing-like entities, rather than as living flesh. Parts of oneself are *spatialised*, that is experienced as if they were disintegrated from and external to one's bodily self.

A2.1 *Morbid objectivisation*

An increased degree of 'thingness' in the body; parts of ones body that are usually silently and implicitly present and at work become explicitly experienced; in other cases, parts of oneself are spatialised, or experienced as if they were disintegrated from the living totality of ones bodily self.

Examples:

- thoughts arising in the back side of the head;
- parts missing in my heart or soul;
- I feel my sperm;
- I feel the blind part of my brain part of brain;
- head fogged up on left as if it's not working, as if I'm only thinking on one side.

A2.2 *Devitalisation*

The body or its parts are experienced as mere things, thing-like entities, rather than as living silent working flesh; parts of ones body are felt as substituted by some kind of mechanism.

Examples:

- I am a robot;
- she felt programmed like a robot;
- device implanted into back of head to control him;
- bionic arms;
- hands are under somebody's control;
- believes a jinx is on her, makes her do actions;
- pieces of metal in leg.

A3. COHERENCE

Disintegration of bodily construct

Part(s) of the body is moving away from usual position. Their body structure is being disintegrated.

A3.1 *Internal dyamisation*

Experience of unusual, strange, abnormal movements or forces acting inside ones body; in other cases, body components or sub-components are felt as moving away from their usual position, shifting around the usual spatial relationships.

Examples:

- arms sticking out of chest;
- mouth was where hair should be;
- two lobes of brain revolving round and round;
- brain rotating and not working as it should;
- eyes on back of head;
- body collapsing.

A4. IDENTITY

Dysmorphic experiences

Single parts of the body or its appearances are changing through time.

A4.1 *Transformation*

Experiences of a change in ones body or parts of it; the experience involves components or sub-components of the body, including the surface or the inner parts or organs. In these experiences, there is an *on-going* experience of movement and change, not just a change in bodily scheme of which one can only see the final result.

Examples:

- hair getting dry;
- nose changing in mirror;
- face strange when I look at it;
- in the mirror, I sometimes look older and sometimes younger;
- hands getting bigger.

A4.2 *Dysmorphophobia*

A subjective feeling of something going wrong with the body, ugliness, physical defect or disproportion in body parts which the patient feels is noticeable to others (although his appearance is within normal limits).

Examples:

- bust bigger and bones smaller;
- sometimes is physically wrong in me;
- something wrong with throat;
- wisdom teeth make my face uncomfortable;
- skin yellow.

A5. ACTIVITY

Cenesthopathic Flooding

Control over ones body is lost. Strange or painful feelings or sensations emerge. These abnormal phenomena are neither fully developed experiences of passivity or external control nor delusions of external influence.

A5.1 *Dysaesthetic paroxysm*

Feeling oppressed from within by distressing paroxysms of strange, uncanny and incomprehensible bodily sensations *when in front of others*. Patients usually do not acknowledge that these feelings are emotions.

Examples:

- when I am at work and a client approaches me, I start trembling, a pain in the stomach mounts up to my head;
- being with people provokes an internal block, a block of feelings;
- when I look someone straight in the eyes I feel strange vibrations inside... either they like me or they don't want me;
- when I meet with persons, I am overtaken by obscurity;
- it is something in my head, not a pain, I feel suffocated, my mind repressed, like a psychic pain;
- when I look people in the eyes I feel a kind of heat in my head, in my back.

A5.2 Recurrent pain-like experiences

Recurrent painful experiences not substantiated by any medical cause; here there is no ascertainable cause using standard diagnostic procedures; experience may present itself in form of paroxysms or persistent sensations; they are usually characterised by feelings of strangeness and uncanniness.

Examples:

- head red hot all over;
- pains and feeling of being cut up in various parts of body;
- saint's stigmata;
- stinging feelings all over;
- felt gushing torment in body;
- pains in body inflicted.

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APPENDIX 1.
The Abnormal Bodily Phenomena questionnaire (ABPq).

ABNORMAL BODILY PHENOMENA		Frequency	Intensity of Arousal or Distress	Impairment	Poor Coping	NAME: _____
						CODE: _____
		Classify in: (1) Absent; (2) Minimal; (3) Mild; (4) Moderate' (5) Moderate Severe; (6) Severe; (7) Extreme				DD/MM/YYYY: ___/___/_____
1,1	Experience of violation					Immediate experience of strange, unusual, abnormal, uncommon forces, energies or movements violating from without the surface and the boundaries of the body; in other cases, the patient may refer a perplexing experience of intrusion or incorporation in own body of extra-personal entities, things or objects.
	Experience of externalisation					Body components or sub-components, corporeal movements, vital energies or biological activities are experienced as projected beyond ones ego boundaries into the outer space.
2,1	Morbid Objectivisation					An increased degree of 'thingness' in the body; parts of ones body that are usually silently and implicitly present and at work become explicitly experienced; in other cases parts of oneself are spatialised, that is experienced as if they were disintegrated from the living totality of ones body.
	Devitalisation					The body or its parts are experienced as mere things, thing-like entities, rather than as living silent working flesh, parts of ones body are felt as substituted by some kind of mechanism.
3,1	Experience of internal dynamisation					Experience of unusual, strange, abnormal movements or forces acting inside ones body; in other cases, body components or sub-components are felt as moving away from their usual position, shifting around the usual spatial relationships.
4,1	Experience of transformation					Experiences of an on-going change in ones body or parts of it; the experience may involve the entire organism, components or sub-components, including the surface or the inner parts or organs.
	Dysmorphophobia					A subjective feeling of something going wrong with his body, ugliness, physical defect or disproportion in body parts which the patient feels is noticeable to others (although appearance is within normal limits).
5,1	Dysaesthetic paroxysm					Feeling oppressed from within by distressing paroxysms of strange, uncanny and incomprehensible bodily sensations when in front of others.
	Recurrent pain-like experience					Recurrent painful experiences not substantiated by any medical cause; the cause is not ascertainable with standard diagnostic procedures; experience may present itself in form of paroxysms or in form of persistent sensations; they are usually characterised by feelings of strangeness and uncanniness.