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К вопросу о психологической структуре синдрома отчуждения и механизмах негативного контента «голосов»

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АННОТАЦИЯ

Цель. Обсуждение исторических традиций, современных подходов и данных экспериментальных исследований синдрома отчуждения, включающего явления психического автоматизма, деперсонализации, «голосов»; осмысление соотношения явлений отчуждения и диссоциации.

Результаты и выводы. Проанализированы данные классических патопсихологических экспериментов исследования психологической структуры синдрома отчуждения. В патопсихологической школе Б.В. Зейгарник изучены аспекты ситуации обследования, включающие умственное напряжение, наличие заметных испытуемому ошибок, как модераторы динамики синдрома Кандинского–Клерамбо. Показана роль фактора социального оценивания как значимого источника усиления или ослабления симптомов. Проявления отчуждения часто воспринимаются как негативные воздействия, имеющие власть над человеком, управляющие им, ставящие в унизительное положение, оскорбляющие, «создающие помехи» в работе. Слуховые галлюцинации — не столько аудиальное событие, перцептивный дефект, сколько психосоциальное диалогическое явление, воплощающее интернализованные, часто негативные паттерны социального взаимодействия. Современные виды психотерапии слуховых галлюцинаций включают понимание роли метакогнитивных стратегий, социальных эмоций, негативного контента и особенностей взаимодействия с «голосом».

Ключевые слова: *патопсихология, синдром отчуждения, слуховые галлюцинации, «голоса», синдром Кандинского–Клерамбо, социальная тревога, стыд, руминации, самосфокусированное внимание, диссоциация.*

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On the psychological structure of alienation syndrome and the mechanisms of negative “voice” content

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ABSTRACT

AIM. To discuss the historical traditions, modern approaches and experimental research data of the alienation syndrome, including the phenomena of mental automatism, depersonalization, “voices”; to comprehend the correlation between the phenomena of alienation and dissociation.

RESULTS AND CONCLUSIONS. Data from classical pathopsychological experiments which investigating the psychological structure of the alienation syndrome are analyzed. In the pathopsychological school of B.V. Zeigarnik aspects of the examination situation, including mental tension and presence of errors perceptible to the examinee, were studied as moderators of the dynamics of the Kandinsky–Clerambault syndrome. The role of social evaluation factor as a significant source of strengthening or weakening of symptoms was shown. Manifestations of alienation are often perceived as negative influences exerting power over the individual, controlling, humiliating, insulting or “interfering” with performance. Auditory hallucinations are not so much an auditory event, a perceptual defect, as a psychosocial dialogic phenomenon embodying internalized, often negative, patterns of social interaction. Contemporary psychotherapies for auditory hallucinations include an understanding of the role of metacognitive strategies, social emotions, negative content, and patterns of “voice”: interaction.

Keywords: *pathopsychology, alienation syndrome, auditory hallucinations, “voices”, Kandinsky–Clerambault syndrome, shame, rumination, self-focused attention, dissociation.*

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Modern trends in psychiatry and pluralism of concepts of schizophrenia as a signal about the importance of developing the pathopsychology of psychotic experiences

Discussions in scientific society are intensifying about the development of the concept of complex psychopathological phenomena, the study of factors, conditions for the development and complication of symptoms, and the development of effective methods of pharmacotherapeutic and psychotherapeutic intervention. There is no doubt about the significance of reaching an agreement between a pathopsychologist and a psychiatrist on an integrative understanding of those mental events, particularly psychotic experiences, that have long been excluded from psychological research. Psychiatric and pathopsychological knowledge are both related and complementary because professionals share a shared aim: to aid a suffering person, which may be accomplished by resolving contradictions while preserving their research subject.

The transition from a categorical approach to a dimensional approach to the classification of mental illnesses, as well as the spread of network analysis in psychiatry [1], demonstrates the inadequacy of viewing psychopathology as a stable set of symptoms specific to a certain nosology, which is consistent with the observed high comorbidity of mental disorders and erases the boundaries of diseases. The boundaries are flexible not only between psychopathologies but also between normal and pathological variants of mental manifestations. The concept of revealing the psychological processes of psychopathological events refers to the pathopsychological fundamental premise of the unity of patterns of mental activity in normal conditions and pathology [2, 3].

Because the analysis of the place and significance of schizophrenia in the system of various mental illnesses reflects the level of development of knowledge about psychopathology in general, the problems of the psychological study of psychotic symptoms are closely related to the historical context of understanding schizophrenia. Modern advances in psychiatric diagnoses of schizophrenia lead to its inclusion on an equal basis with other psychoses, making the high occurrence of psychotic symptoms in nonpsychotic diseases understandable [4].

Kandinsky–Clerambault syndrome [5, 6] is a type of hallucinatory-paranoid syndrome that includes auditory hallucinations (AHs or voices), delusions of influence, and the syndrome of mental automatism in Russian psychiatry. It is considered a psychopathological phenomenon particular to schizophrenia and has the status of a common functional diagnostic tool. Along with this, the subject of clinical and psychopathological analysis was verbal hallucinosis, which occurs not only in schizophrenia but also in organic psychoses [7].

Numerous descriptions of the vivid syndrome can be found in the literature, primarily in terms of generalizing subjective descriptions, precise findings, and symptoms of Kandinsky–Clerambault syndrome discovered “by sight.” Particular attention should be paid to the systematization of concepts and characteristics patients use in relation to unusual experiences. However, this logic of analyzing the phenomenon does not result in discovering the phenomenon’s mechanisms.

Despite scientific advances in the study of the nature of psychotic disorders, when analyzing the manifestations of Kandinsky–Clerambault syndrome, researchers and practitioners have primarily relied on patient self-reports, the outcomes of conversations, and observations while ignoring experimental methods for studying mental disorders. Simultaneously, a special impairment of self-perception and self-awareness during mental automatism is a circumstance that complicates the reliability of descriptions. There is most likely a large disparity between the signals presented in a conversation, visible through direct observation, and mental disorders’ objectively existing characteristics. There is a scarcity of modern studies of the structure and patterns of disorders in the syndrome of mental automatism or analog states, which are described in science by alternative nomenclature (feeling of agency and sense of self) [8].

Mehrabyan [9] proposed that the pathology of the subject’s self-perception of mental processes or, as Grule noted, a disorder of “consciousness of the self.” Mehrabyan explains the syndrome as a disruption in the work of so-called gnostic feelings, which interact between self-perception and self-awareness and the emergence of higher automated skills due to the generalization of sensations and perceptions.

Gnostic feelings are characterized by their ability to generalize knowledge about objects in a sensory form, convey a sense of authorship over the mental processes of the "self," and include specific emotional tones and characteristics. In the initial stage of alienation syndrome, which included the phenomena of depersonalization and mental automatism, facts of "disintegration of sensory functions" and distortion of object identification were revealed, whereas, in the case of psychosis, complete alienation of mental processes occurs.

The term "dissociation" refers to a variety of altered states of consciousness and perception, including relatively normative forms of psychological "disconnection" as well as distressing experiences, such as derealization, depersonalization, and identity changes associated with one of the stages of development of the mental automatism syndrome, which is consistent with data on disruption of the "minimal self" in schizophrenia spectrum disorders.

The literature discusses the relationship between alienation and dissociative mental problems. There is a spectrum of severity for dissociative phenomena; extreme circumstances include separation (detachment), compartmentalization, or isolation. If detachment, defined as the non-appropriation of a traumatic occurrence, is associated with derealization and depersonalization, including a loss of the normal interaction between objective reality and one's own body, the reduction of conscious control over mental processes is caused by compartmentalization. On the other side of the spectrum, absorption is defined as a state of reduced attention distinction accompanied by a sense of blending with the surrounding reality [10].

Experience in experimental pathopsychological study of mental disorders in Kandinsky–Clerambault syndrome: Conditions and psychological mechanisms of development, provocation, and dynamics of alienation phenomena

To date, mental activity disorders have not been compared with symptoms of mental automatism; the factors influencing the onset and evolution of mental automatism, as well as other categories of psychotic experience, have not been well investigated. Without understanding the psychological processes of the condition, scientifically based intervention is complex. However, outdated ideas about psychotic symptoms as a "stable" deficit directly induced by biological causes, as well as thinking disorders allegedly "typical" for the nosologies of the categorical approach [11], can be determined by comparing symptoms with the structure of mental disorders.

Brain injury does not dictate the type of symptom; it must be researched experimentally. Avoiding experimentation and depending excessively on observational talent make it easy to reach arbitrary conclusions that do not allow attaining the phenomenon essence required for scientific advancement.

In the 1960s, the Laboratory of Experimental Pathopsychology conducted groundbreaking research on the psychological structure of Kandinsky–Clerambault syndrome. Under the supervision of the head of this laboratory, the founder of the pathopsychological school, B.V. Zeigarnik, Klimusheva [12] conducted a series of studies to explore the psychological patterns of mental automatism and identify the variables that enhance and weaken the syndrome manifestations.

Klimusheva agrees with A.A. Mehrabyan's views on explaining the nature of mental automatism and combining it with the phenomenon of depersonalization into one general alienation syndrome but considers these categories to be insufficiently differentiated, and his idea about the adequacy of mental processes in mental automatism is debatable and requires clarification. Sharing the idea of thinking disorders "typical" for schizophrenia, specifically manifested at different stages of the disease, corresponding features of mental activity were predictably revealed in an experiment with patients in the later stages of the syndrome (diversity and reliance on "weak" signs), which, according to the description of the experimental results, manifested themselves weakly in the early stages, becoming more prominent when working with affective.

In addition to the primary clinical method of patient research, Klimusheva conducted an experimental psychology study using procedures that changed mental load, such as memorizing 10 words, counting, naming 60 words, pictogram, classification, comparison of concepts, simple analogies, and the Vygotsky–Sakharov approach.

The test circumstance generated compensatory mitigation of cognitive impairments in the group with early indications of mental automatism syndrome. In contrast to the later symptoms of the diseases, the relationships here were marked by emotional intensity. Patients frequently describe feelings of "thought intrusion," which are easily recognized in self-reports.

An experimental study by Klimusheva demonstrated the well-known dynamics of the phenomenon, which does not coincide with subjective complaints. Thus, signs of mental automatism appeared and strengthened during some evaluation techniques but were not observed during other tasks. The syndrome manifested itself through practices that induced the experience of difficulty in solving a problem, in which "the mistakes and failures were noticeable to them" and "required a certain intellectual tension." Experimentally induced phenomena of an "alienated" explanation of failure were typical in the later stages of the syndrome.

The psychopathological phenomenon associated with severe manifestations of alienation as a stable defect turned out to be a dynamic phenomenon depending on the psychological characteristics of the task and the subject's perception of the task as challenging, revealing failure and mistakes, that is, provoking corresponding experiences of internal and external shame and awkwardness, which are perceived as "external influences" when alienated. The condition that provokes the phenomenon of mental automatism (in mental activity) is "a subjective feeling of effort, tension of mental work, where the difficulty and incorrectness of decisions can be noticeable to the patient himself" [12]. Mental automatism is not caused by cognitive difficulties; it is an impairment of self-perception and self-awareness caused by psychosocial variables, among other things. The experiment demonstrated the role of the social evaluation factor as a substantial cause of intensification or mitigation.

In the context of researching the impact of isolation [13] on a person's mental state in various life situations, circumstances were discovered that cause an "abnormal" syndrome of mental automatism. These reactive psychoses were not always pathological and reduced when people returned to normal conditions. These circumstances include geographic isolation, relative social isolation, and long-term forced solitary isolation deprivation.

Experiments in which subjects were placed in solitary soundproof chambers for extended periods of time are instructive in understanding the mechanism of mutual influence of psychological elements and situational variables in the process of genesis of the phenomenon of alienation. The condition entailed constant monitoring of a person, impersonal interaction with the experimenter, and a forced lack of typical control over activities, emulating public loneliness and creating psycho-emotional stress.

Because a person is immersed in an environment full of stimuli in everyday life and the psyche is ready to detect and respond to them, sensory deprivation, combined with the situation of uncertain expert social assessment, contributes to an excessive concentration of the patient's attention on self-perceptions. The participant, for example, mentioned "the feeling of the presence of a stranger," which the researchers characterized as an incorrect interpretation of an external stimulus (airflow from the ventilation system) as a result of skin sensitivity under sensory deprivation, the person tends to rely on internal mental processes when making a decision.

The issues of motivation, selectivity, and communication processes in schizophrenia have traditionally been investigated in Russian pathopsychology. At present, Kholmogorova et al. [14] are researching social cognition disorders, particularly anhedonia, as a defect in its motivational component, mentalization properties, and disorders of the schizophrenic and affective spectrums disorders, as well as developing and implementing active training in psychotherapeutic activities for the development of social and communication skills and goal setting and goal achievement skills in patients with schizophrenia.

Tkhostov and Zhuravlev [15] study the semiotic-psychological mechanisms of "non-appropriation" or alienation of one's mental products in the syndrome of mental automatism, comprehending the process of violation of the laws of the subjectivity constitution, which is embodied in the separation of "horizontal" (self-other) and "vertical" (individual–supra-individual) relationships. Loss of conscious mediated control over one's thoughts, sensations and emotions, and motor acts should be interpreted in light of the

concept of a subject capable of realizing oneself as "an active, unified, self-identical integrity" and experiencing "mental events as one's own or those of other person" [p. 63]. The clinical manifestation of the loss of voluntary control over one's thoughts, which can be AH, can be understood through the theory of "object" and "subject" introspection, where the first type of introspection consists of focusing on oneself as an object and the latter type consists of introspection on objects of the external environment [16].

Alienation is widespread among those who have endured traumatic situations. Several cross-sectional and longitudinal studies indicating a consistent relationship between trauma and dissociative experiences in children and adults have provided strong empirical support for dissociation as a response to trauma to minimize distress when faced with irresistible life circumstances. The loss of the implicit body image and self-perception, which is responsible for a person's background presence in the situation, is distorted due to the collapse of viewpoints from the first (subjective body) and third (object body) persons. Excessive absorption in personal experiences increases depersonalization in patients with symptoms of psyche alienation; AH is intense self-focusing on thoughts, which can lead to a paradoxical protective effect of distancing from them and one's own internal experiences, particularly if they are associated with trauma memories [17].

Alienation as a psychosocial event: the role of social anxiety, shame, trauma and metacognitive strategies in the formation of negative content of "voices"

Auditory hallucination can be found in a variety of psychiatric diseases as well as in the general nonclinical population. The content and the manner in which the "voices" emit (their content) determine the requirement for medical assistance [18]. The negative content of the "voice" is a predictor of differentiation between the clinical and nonclinical groups. Beliefs about hallucinations, such as the power of the "voice" and its hostility/benevolence, were considered a central component that caused intense distress in the early cognitive models of AH, but it is now vital in science to pay attention to the negative content of the "voice" [19]. The emphasis on the content and characteristics of "voices," dialogical functions, and the meaning of the phenomena is becoming a global trend in the research of AH, both conceptually and from the standpoint of psychotherapy [20].

Auditory hallucination is psychologically conceptualized as a complex cognitive-perceptual activity of anxious-focused listening with both an "object" of perception and a perceiving active subject. Recent research confirms the relationship between AH and negative detached socio-emotional experiences. The latter frequently produces negative content of "voices" (criticizing, insulting, shaming, and hostile "voices"). "Voices" are decontextualized intrusive memories of them, a dissociative reaction to an unresolved internal conflict.

A person develops a relationship with the "voice" by embodying his abilities and engagement methods in real-world interactions with others. Those who hear "voices" frequently experience the social environment as utterly oppressive, not satisfying needs, and the person feels passive and open to interpersonal threats. People who have had AH often expect a negative assessment of themselves and their actions and critical comments, where "voices" are induced in solitude and loneliness and even in big crowds.

The "re-expansion of inner speech" in a stressful environment before the production of hallucinatory statements and its incorrect perception and interpretation as alien are actively addressed. Individual unpleasant, unacceptable, recurring ideas often become an object of concern, generating estrangement [21].

Psychotic experiences are often seen as negative, frightening, disturbing, disruptive, interrupting thinking, controlling, and driving one to perform something undesirable in clinical samples. An objective analysis of the decontextualized linguistic content of "voices" (actual words) supports the presence of negative content in around one-third of AH [22].

Large-scale studies of the AH phenomenology highlight the characteristics and nature of the content of "voices." Yet, content rated objectively as "neutral" is often subjectively regarded as unfavorable by the "voice" hearer [23].

Other factors, such as the interpersonal context and the tone of the "voices," have a role in the perception of the valence of voice content. Defining the content of a "voice" as hostile or offensive rather than negative has ramifications for whether components of the meaning linked to the "voice" are better viewed as secondary judgments and more fundamental characteristics of the experience [19]. There is significant evidence that alienation symptoms in psychosis reflect a basic self-perception of low social rank when the individual perceives himself as in an unwanted subservient position, subject to control and humiliation by others.

Childhood trauma and bad events decrease the negative narrative of "voices" related to feelings of shame and social anxiety [24]. AHs hypersensitive to social threats and anxiety may be part of a larger class of "voices" that signify intrusions of highly meaningful content into consciousness. What is meaningful to us is related to a threat to our physical integrity or social value, which may explain why the AH content is often negative. The experience of social threat following trauma, represented as shame, can contribute to the development and content of "voices" [25]. The emotion of shame in situations that reveal inconsistency, fallacy, and inappropriateness is one of the most "hallucinogenic" emotions because it triggers dissociative processes, increasing depersonalization, the object position of self-perception, and fragmented coding of experience.

When the effect of rumination over the content of video material with violent events in forming AH was investigated, it was found that they did not increase AH [26], implying that the experimental material was not emotionally significant for the participants. Although rumination does not contribute to the development of AH, it is important in symptom maintenance and mediates the condition's deterioration [27].

The influence of rumination on the incidence of AH was studied in a norm group with a "voice" identification task (provoking an unusual perception) to clarify the model of AH maintenance, according to which distress from "voices" is considered the result of negative interpretations of intrusions that trigger rumination, which indirectly strengthens "voices." However, no significant differences were found when comparing the two types of induced behavior concerning the individual elements and mechanisms that cannot be isolated in the cognitive model of psychosis because AH is only sustained by their systemic interaction. The negative content and emotional valence of the AH were not considered when comparing the two procedures [28].

The "distraction" task worked as a variant of suppression/inhibition of intrusions, increasing compulsive thoughts about AH, which maintains hallucinations and leads to distress [29]. The counter-strategy to rumination distraction, characteristic of AH, actually led to the opposite result, such as a decrease in the ability to cope with the "voice," embodying avoidance and suppression, which, on the contrary, strengthen the "voices."

Self-focused attention is a characteristic linked to investigations of the formation of AH and the persistence of social anxiety [30]. Empirical models have confirmed that the connection is indirect and mediated by depersonalization [31]. At the level of the pattern of cognitive distortions, there is a strong association between self-focused attention, absorption, and depersonalization in those with AH or a high susceptibility to it. Patients with "voices" exhibit high levels of self-focus, absorption in personal experiences, and depersonalization, with all variables interconnected.

Patients with psychotic symptoms in the form of AH showed higher self-focused attention indices than the nonclinical group in this study but did not vary from patients with psychosis without hallucinations. Dissociative experiences were more common in patients who experienced hallucinatory experiences in this group, and they were connected with self-focused attention. Self-focus correlates positively with "voices" but also with delusions and depersonalization, with the latter moderating the relationship between self-focus and AH but not with delusions.

Obsessions have a strong relationship with absorption, a dissociative phenomenon characterized by impaired attention distinction, displayed as excessive absorption of internal processes and external stimuli.

Self-focus can have adaptive and detrimental impacts depending on the learned processing style [32]. There are two modes of self-focusing of attention: (a) the "evaluative" mode, which includes the assessment of thoughts, sensations, and feelings in relation to the self and (b) the "mindful" mode (voluntary attention not involved in evaluation), which assumes self-awareness of the current experience of

nonjudgmental thoughts and feelings. The mindful mode is adaptive and reduces discomfort. The "evaluative" mode results in inadequate processing and maintains and worsens distress [33].

Rumination is an evaluative style of self-focused attention that includes a negative judgment of oneself, emotions, behavior, situations, life challenges, and their overcoming. Excessive self-absorption and rumination represent a pattern of unreflective self-focused attention that contributes to the formation and maintenance of the alienation phenomenon of the psyche, AH, and a nonclinical sample in the presence of recent trauma.

The process through which ruminative self-focus maintains a psychotic experience is still unknown. In depression, this mode of self-focus leads to memory overgeneralization, unpleasant autobiographical recollections, and reduced problem-solving abilities [33]. As a result, AH ruminating on paranoid beliefs may result in overgeneralized memories of past negative events, increased retrieval of negative memories related to relationships with others, and trouble coping with the idea of how to respond to these experiences. Rumination as an evaluative mode of self-focus is not realized due to mindful self-focused attention. This should be considered when developing intervention programs for alienation problems [34].

Effective evidence-based psychological intervention strategies for "voices" and dissociation: Metacognitive strategies for processing adverse, traumatic experiences as a target for psychotherapy

Targeting the psychological processes that increase sensitivity to psychotic experiences in individuals exposed to traumatic experiences represents a promising approach to developing therapeutic therapies [35]. Posttraumatic symptoms mediate the relationship between trauma exposure and psychotic experiences. Some probable posttraumatic effects that influence vulnerability to alienation include cognitive–behavioral avoidance, vigilance, and re-experiencing symptoms. Dissociation is being investigated as a possible mediator of the relationship between trauma and psychotic experiences, AH.

Cognitive–behavioral therapy, which is the contemporary best practice in the treatment of distress—"voices," has a minor but significant effect on the severity of "voice" hearing [23]. Cognitive–behavioral approaches to "voices" often entail a joint assessment and formulation of variables contributing to the client's distress and a tailored intervention targeting these issues with various cognitive–behavioral strategies. Interventions often focus on strengthening coping ability and removing undesired ideas about "voice," which are experimentally derived goals contributing to "voice"-related distress. These cognitive–behavioral therapy intervention components may address mechanisms implicated in negative "voice" content, such as negative schematic beliefs and hypervigilance to social threat, and explicitly target the negative "voice" content.

Treatment efficiency studies have focused on the overall severity, incidence, and distress of the "voice" or compliance with "voice" demands and beliefs about the "voice" as the outcomes of interest. There have been no psychological treatment studies for "voice" distress that examine the content of the "voice" as a primary outcome. Given that negative "voice" content may play a role in "voice"-related distress, there is emerging agreement that negative AH content is an important predictor of therapeutic success [19]. Indeed, our clinical experience reveals that clients often come to psychological therapy hoping to change the negative content of their "voices" [36].

When dealing with trauma memories or hypervigilance to social threats, compassion- or trauma-focused therapeutic methods may be promising interventions [36]. Interpersonal interaction interventions, such as relationship therapy [37], the Talking to Voices approach [38], or AVATAR therapy [39], are indicated when relationships with "voices" reflect past experiences of discrimination. Adverse life events are at the root of the negative content of AH, and this relationship may be mediated by mechanisms such as social anxiety, decreased social rank, shame and self-blame, dissociation, and impaired processing.

According to compassion-focused treatment, the failure to relieve guilt or achieve self-soothing may prolong the threat [40]. Shame and guilt experiences may underpin the negative content of the "voice," working with these emotions in treatment may result in the affective valence of people hearing the "voice."

According to the boomerang effect, the metacognitive approach of "nonthinking," "suppressing the thought," and the seemingly rational, milder forms of

suppression of mental events in the form of “distraction” have the opposite impact, intensely retaining “voices” and increasing distress. Modern psychological intervention considers the metacognitive and cognitive factors of maintaining AH and is based on a task nearly the inverse of experience reduction or exclusion because such a task and the corresponding tools for solving it have the opposite effects.

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