

Rassegna

False Proximate Awareness: an experience at the border of psychopathology

L'Esperienza di Presenza: una condizione psicopatologica di confine

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SUMMARY. The Authors take into consideration a particular psychological experience known as Experience of Presence (Anwesenheit, for the authors of German language, or False Proximate Awareness (FPA), for the authors of English language). Some of the more typical clinical and para-clinical manifestations are discussed. The phenomenon is evaluated and discussed as a “borderline” situation between psychological normality and phenomena that are clearly pathological like hallucinations, autoscopy and delusional experiences. Regarding these other experiences, some useful criteria and finally suggestions for a differential diagnosis are proposed.

KEY WORDS: False Proximate Awareness (FPA), psychopathology, hallucination, delusion.

RIASSUNTO. Gli Autori prendono in considerazione una particolare esperienza psicologica nota come Esperienza di Presenza (Anwesenheit, per gli Autori di lingua tedesca, o False Proximate Awareness (FPA), per gli Autori di lingua inglese). Il fenomeno è valutato e discusso come una situazione di confine fra esperienze ancora normali e situazioni francamente patologiche come allucinazioni, esperienze autoscopiche e deliranti. Vengono proposti anche criteri utili a una diagnosi differenziale fra tutte queste condizioni.

PAROLE CHIAVE: Esperienza di Presenza, psicopatologia, allucinazioni, delirio.

INTRODUCTION

The Experience of Presence, commonly known as Anwesenheit for the German authors, and False Proximate Awareness (FPA) for the English speaking authors, can be considered as a particular psychological condition that happens in subjects without manifested alterations of the general conscience (1-5). It consists of an acquisition, more or less improvised, of the awareness of the presence of another “entity” in the space of consciousness both internal (mind and body) and external. This “presence” makes itself known in a perceptive mixture that is together acoustical, visual and intellectual (2).

Here is the essential nucleus of the experience (**Table 1**). Other characteristics that can be considered accessories must be associated to this nucleus. Those characteristics are not of minor importance in the psychopathological evaluation of the experience. In particular:

- 1) The experience remains in most cases under the voluntary control of the person who is living it. That is, it is lived as deriving from its own subjectivity and not openly imposed externally.
- 2) The “presence” that reveals itself refers to personal beliefs frequented by the subject.
- 3) The fact of consciousness is lived according to a broad range of critical modulation: from the possi-

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Table 1. The Experience of Presence (Anwesenheit)

- a) Unaltered sensory.
- b) Awareness of presence (in the external conscious space) of another identity by itself.
- c) The awareness of which to point b) is supported by multiple perceptions (or subperceptions).

bility of doubt until it reaches the certainty of effective reality of what is “felt”.

- 4) The entity that reveals itself can be felt as if it was motivated by various feelings towards the subject. These can be good and careful, or frankly persecutors, but always frightening (5).

In this work we will suggest, first of all, an overview of clinical and existential situations in which “the experience of presence” is by common comparison. For each single situation we will try to define the peculiar declinations of the experience. During the discussion the psychopathological value of the experience and its clinical limits will be evaluated.

CLINICAL AND PARA-CLINICAL SITUATIONS

The internal presence of the supernatural

We are quoting some passages from Saint Theresa of Avila’s autobiography (6): “... while I was in oration one day, for glorious Saint Peter’s holiday, I saw, or better to say, I felt, Jesus Christ near to me, because neither with the eyes of my body, nor those of my soul, saw anything. He seemed very near and I understood, at least it seemed to me, that it was really Him speaking to me; ignoring in the most absolute way that one could have similar visions, at the beginning I was frightened and I did nothing but cry, even if then only one of His reassuring words was enough to leave me calm and happy as usual, without any fear. It seemed to me that Jesus Christ was walking beside me always and, since it was not an imaginary vision, I did not see in which form, but I clearly felt that He was always at my right side and that He was a witness to everything that I did, and never, if I concentrated a little and was not very distracted, could I ignore that He was always near to me”.

The spiritual life, especially in its mystical dimension, is all inclined toward an internal journey that opens up to an epiphany of the divine. It is a path interwoven with the desire of the meeting and the invitation to reveal itself turned toward the entity that one is seeking (7,8). The prayer appears like the privileged

tool of this path, as an expression of an internal movement toward a personal relationship with God. The climax of the prayer can be described as a monoideism centered on the evocation of the meeting that removes every other reality from the mind to open it only to the divine. In its extreme form (mystical experience) the intellectual tension is such that, every other sensorial experience is expelled, the idea of the Other can be covered with sensations like in Theresa of Avila’s experience described above. So the presence of the divine appears with a semihallucinatory vividness (9). In other words, an internal reality is able to impose itself with such a force that it is “contemplated and understood” in a perceptive mixture that is together acoustical, visual and intellectual (6,9). In a mystic, this experience of presence is the “Meeting” *par excellence* and has the distinguishing marks of grace, of a gift, being accompanied by the critical awareness of the singularity of the event (8). Moreover, the experience of presence comes after a converging course characterized by a decided determination of the subject toward the revelation of the divine presence. The capacity to criticize reality remains, filtered naturally by the cultural and emotional grids of the person who lives the experience (10). They precede the experience and linger after it. These characteristics constitute the requisites for a differential diagnosis compared to a candid hallucination (visual and auditory).

The imaginary companion of children

In children (especially those eidetically gifted) the fantasy of an imaginary companion that “presides” over their own games is frequent enough. Sometimes the imagination is so vivid that it acquires sensory features (11), and, in some cases, the phenomenon is such as to preoccupy their parents about the psychic health of their child. In fact the “companion” often has a name, the child can speak to him and can receive messages from him, he becomes a repository of wisdom and a “hinter” of fears.

The child can calmly smile about his own fantasies and redimension them, or behave according to what his “companion” has suggested to him. The phenomenon verifies itself between three and six years mostly, to physiologically shrink, until it then disappears (11). The experience has all of the subjective (active research, partial criticism, the possibility of entering and leaving in the experience itself) and sensory features (acoustical and visual vividness) that we had indicated in the experience of the supernatural presence. Moreover, it appears as a personal organized belief that nev-

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er reaches the rock-like unmodifiable ability of delusion. In some ways we could define it as a prevalent idea (12,13) with sensory features.

In a progressive viewpoint, the idea of the “guardian angel” can be seen as a result of the experience of the imaginary playmate (7,8). Naturally after it has been sensually softened and intellectually elaborated.

The experience of presence in “extreme” conditions of existence

In individuals submitted to conditions of great psychophysical stress (wars, shipwrecks, life endangering situations) often the experience of a “presence” in the conscious external space is referred. A presence that helps and encourages, but that sometimes acquires persecutory features (13). It can have visual and auditory features, but above all it is intellectual. In some way it expresses the sensorial translation of personal beliefs that, under exceptional circumstances, acquires a great evocative power. It is so in the experiences of presence of a mythical entity like the “Yeti” for the Himalayan explorers (14), or for the “ghost vessels” of shipwrecks, or for the “extrasensory presences” in particular moments or existential conditions (15).

Similar experiences are also referred to in the conditions of the “near death experiences” that one has in the course of prolonged life endangering situations or the entering or coming out of comatose states (16,17).

Literature, accounts of trips, are full of unquestionable descriptions of the experience (14,15). Among these we remember the story of Conrad, *The Secret Fellow Tenant* (18).

Mourning

In literature and in clinical practice cases are frequently related, for example widowhood, in which, after the death of the spouse, the patient begins to experiment the comforting presence of him (19). The experience is, in this case, also described with vivid sensory attributes, mostly in the conscious external space.

His appearance is preceded by a period, prolonged more or less, of monoideism centered on the figure of the deceased, on his physical and psychological characteristics (20,21). Especially during those “attacks of despair” (19) that are physiologically reported in these conditions. This monoideism ends by sweeping away every other sensory experience. All of it to show a coarse similarity (*mutatis mutandis*) with the story of the mystical experience of Santa Theresa of Avila (6).

The experiences of presence in sleeping and awakening

Many patients with sleep disturbances relative to particularly busy existential moments refer to the permeating sensation of a presence in the conscious external space (in their own bedroom mostly) of another person often with disturbing attributes (13,21). This presence is often correlated to specific existential events marked with a great fervor (falling in love, jealousy, anger, hate, ecc.). For example, in our experience, the phenomenon is referred many times from patients with erotomanic delusion (22,23). Telling about the development of their love these refer to the persistent experience, in the conscious external space, of the figure around which the erotomanic delusion was built (24).

Something similar occurs in the experiences of “trance” (hypnotic states, states of ritual “trance”). It is about the internal emergence of a presence who has the characteristics of the entity sought by the individual, alone or with the group that participated in the ritual (20). A similar experience, in cultures other than those of the West, can emerge in states of guilt due to the infringement of socially accepted rules (9,25-28).

The experience of presence in clearly morbid conditions

Up to now we have spoken about the experience of presence in physiological conditions, even though “extreme”. In the environment of the purely psychiatric pathology an experience of presence can easily become of minor importance or even not be taken into consideration (9,29). It is so in patients affected with schizophrenic and affective spectrum disorders in which experience is often concomitant to other psychotic symptoms which are considered hierarchically more important (2,30).

In our personal experience, if carefully investigated, an experience of presence (both in the internal conscious state as well as in the external) is frequently checked especially in the ingoing and outgoing phases of an acute psychotic episode (21). The phenomenon is almost constantly present in some sensitive personality disorders (21,29,31,32) and a wide range of dissociative experiences, experiences of absorption, amnesia and depersonalization are commonly recognized in borderline patients (33).

In the neurological environment the cases of patients with temporary “auras” that produce a typical experience of presence both internal and external are very frequent (34).

The phenomenon has also been observed in the course of intoxication or overdose of drugs with a di-

rect dopaminergic and serotonergic effect like the ergotaminic derivatives (particularly Lysuride) (13). Also certain drugs like psycholobicine can determine massive phenomena like those we are describing (35).

This toxicological and clinical data suggests an involvement in the dopaminergic and serotonergic path in the physiopathology of the phenomenon (13).

DISCUSSION AND DIFFERENTIAL DIAGNOSIS

In psychopathological terms the experience of internal presence or FPA seems to derive from the alteration in an allopathic sense of conscious space (36). When we speak of conscious space we are referring to the theory of M. Merleau Ponty who sees in the organization of this space (in its structure) the key to psychic health (36). And the basic organisation is a distinction, in the space of conscience, between a subjective field (inner, personal, owner of a subjective truth...) and an external field (shared with the other, real with certainty, experienced by the fifth senses...).

In FPA a content of mind, normally situated in the inner (personal, subjective) part of the conscience, acquires a so dramatic vividness to become "real". In other words, this special content of mind enriches itself with sensory features, till the point to tremble the distinction between that is personal and fantastic and that is shared (with the others) and real.

The change that is determined in conscious space with the experience of presence can be considered one of the more typical psychological condition at the borderline between normality and pathology.

When we place our attention on the sensorial components of the experience the need of a differential diagnosis is induced in regards to hallucinatory experiences (**Table 2**). These can be considered as vivid sensory phenomena, accepted with all of the requirements of certainty, even though it is not being objective. Usually the patient lives the hallucinatory experience as an egodistonic (32).

The absence of every corresponding objective is the common fact between the two experiences: both are in fact "objectless perceptions" but in the experience of presence:

- the sensory vividness that is typical of the clearly hallucinatory phenomenon is lacking, being the softer enough fact;
- moreover, the experience of presence is incapable of occupying the entire conscious space of the patient by the senses, as in hallucinatory experience;
- the subjective requirement of the certainty of reality is not always present;
- it is possible instead to notice a critical attitude by the person who has the experience;
- finally in the experience of presence the subject is capable of keeping under control the back and forth movement towards the experience itself;
- therefore, the experience is egosyntonic.

In fact, the active research of the experience itself on behalf of the subject who lives it, exists (see the case of the supernatural experience or of the imaginary playmate) and greatly reduces the allopathic impact of the experience. In other words, the first formal characteristic of the Conscience of the Ego according to Jaspers (Ego as a spring activity, original and not mediated by the senses) (1) is altered, but with the voluntary and conscious contribution of the subject. And this brings a decided drop in the pathological dimension that the experience of presence brings with itself. Finally this active research determines a substantial acceptance of the presence itself that seems very much in line with the Ego's needs. As many authors have pointed out (10,32) this characteristic, in itself, modifies the pathological importance of many psychopathological phenomena.

For many aspects the experience of presence can be matched to autoscopy (26,37,39,40) (**Table 3**). This consists in the projection, in the external conscious space, of the hallucinatory self-image (41).

It is an experience with vivid sensory features which is possible in many conditions which are sometimes

Table 2. Comparison between hallucinatory experiences and experiences of presence

	Experience of presence	Hallucination
objectivity of sensory importance	absent	absent
subjective sensory evidence	mild	pronounced
position in conscious space	marginal	central
subjective "certainty"	critical	absolute
syntony	egosyntonic	usually egodistonic
relationship between subject and experience	often looked for	usually refused
subjective control of the experience	present	absent

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Table 3. The comparison between the Experience of Presence and autoscopia

	Experience of Presence	Autoscopia
type of “presence”	another	the subject itself
syntony	egosyntonic	deeply egodystonic
attitude of the subject towards the experience	searching	fear and refusal

not even clearly morbid (26,41). The phenomenon is experienced by the subject as probably disturbing even if it can be quickly criticized (26). The more noticeable differences between autoscopia and experience of presence (**Table 3**) are the following:

- the experience is vivid and occupies the center of the conscious space of the patient;
- the “presence” (that appears in the conscious space in autoscopia) is that of the subject who lives the experience itself and not of someone unrelated (even if to a high internal value) as in the experience of presence;
- autoscopia, unlike the experience of presence, is always accompanied by a profound sense of anxiety;
- the subject tirelessly tries to oppose the appearance of the phenomenon in autoscopia, instead in the experience of presence the subject actively looked for it (41).

When the attention, rather than on the sensory fact of the experience, is placed on the intellectual aspect, the need arises for a differential diagnosis between experience of presence and delusional states (**Table 4**).

At this point we would not like to go deeply into the infinite close examinations on the endless definitions of delusion. With a simplifying will that doesn’t escape us, or better still that we want to highlight well, let’s take from “the glossary of technical terms” of the DSM-IV (42) the definition of delusion and let’s see how much can be in common with the various experiences of the presence that we have up to now de-

scribed. In the DSM-IV delusion is defined as “a personal false belief based on an incorrect deduction about the external reality, and firmly held despite the opinion almost unanimously shared and of everything that is the indisputable and evident proof to the contrary: it is not about a belief normally accepted by the same group or cultural subgroup to which the patient belongs (i.e. it is not a matter of a religious conviction). When an erroneous belief involves a judgement of extreme value, it is considered a delusion only when the judgement is so exaggerated as to exceed all credibility” (42).

Let’s look at the points that support this definition and compare them with the clinical reality of the experience of presence in our patients.

- 1) In the first place delusion is “a personal false belief based on an incorrect deduction concerning the external reality” and this could adapt itself to all the FPA clinical exemplifications that we have reported.
- 2) In the FPA cases the “consent on behalf of the people who live in the same social-cultural context of the subject” is instead not lacking. This is particularly evident in the beliefs of a religious type, moreover explicitly excluded from the definition of delusion already quoted from the text. This is also valid for the groups which share similar experiences (explorers, children, people in particular conditions of emotional stress, ecc.).
- 3) The FPA is not then “firmly held” as it would be expected for a delusional conviction.
- 4) The truthfulness of the experience of presence is not in any case upheld completely, but subjected to criticism. It means that the subject places itself face to face with the fact of “neoreality” in a firm position, also even a dialectic and flexible position which goes in a completely different direction from the experience of the “incurability” of delusion (1).

CONCLUSIONS

The phenomenical nucleus of the experience of presence is due to the fact that an internal reality (a belief) is experienced in such monoideism and emotional participation that every other sensorial experience is expelled and this internal reality acquires a sensorial vividness of semihallucinatory evidence. The prefix “semi” wants to put an emphasis on some differences regarding hallucinations. In particular on the position of the subject who lives the experience which is of participating search and which always remains a critical consciousness of the phenomenon itself.

Table 4. Comparison between experience of presence and delusion

	Experience of Presence	Delusion
reality of the belief	false	false
approval of the entourage	present	absent
firmness of the conviction	absent	present
critical attitude	present	absent

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In this “critical conscience”, with the admission, at least of the possibility of doubt, lies the critical point of a differentiation compared with a delusional experience.

Moreover, the phenomenon does not have an illusory nature (there is not a basic perceptive data to distort), nor the characteristics of a pseudo-hallucination (this has in fact ample sensory features, in particular a visual kind). It is similar, therefore, to a real and true hallucinatory experience, from which it is separated only by the formal way in which the experience is lived.

In conclusion, the experience of presence seems like a borderline condition that one can have both in normal conditions (mystic experiences, infantile daydreams, prolonged states of stress and fatigue) and in pathological ones (temporal epilepsy, peduncular tumours, intoxication from dopaminergic and serotonergic drugs, acute and chronic psychotic episodes, dissociative experiences). The experience overlaps itself abundantly with hallucinatory (both an auditory and a visual type) and delusional states. A differential diagnosis can be established by paying attention to the permanence of a critical capacity regarding the situation on behalf of the subject who is living the experience as well as from the possibility of “leading” the experience itself. Including the ability of entering and leaving it with acts of the will.

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