Review

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Posted Date: 20 June 2025

doi: 10.20944/preprints202506.1750.v1

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 doi:10.20944/preprints202506.1750.v1

Review

Understanding Psychosis: Integrating Phenomenology and Descriptive Psychopathology

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Abstract

Psychosis constitutes a profound alteration in the individual's relationship with the self and the world, expressed through symptoms signalized by loss of reality testing. Mainstream psychiatric approaches often rely heavily on descriptive psychopathology, which may overlook the multifaceted subjective experiences of affected individuals. This paper outlines an integrative framework to enhance the understanding of psychosis, bringing together phenomenology – the study of structures of consciousness as lived from the first-person perspective - with descriptive psychopathology, which represents the clinical categorization of symptoms. Drawing on phenomenological philosophy, we examine disturbances in the basic structures of selfhood and the perception of the outer world that underpin the observable features of psychotic symptoms along with their clinical course. Through the transdiagnostic description of psychotic features in both primary and secondary psychosis, we aim at bridging the inconsistencies between standartized evaluation and the personal narrative of the individual affected. By focusing on the interplay between symptoms and experiences, we examine the psychopathology of psychosis as a dynamic phenomenon of fundamental disruption in the individual's experiential framework, which is reflected in the clinical manifestations already present from the initial stages of the disorder. The alignment of phenomenological insights with structured clinical observations, enriches the conceptualization and assessment of psychotic phenomena. Moreover, on the basis of an established scientific knowledge regarding recognition and treatment of psychotic disorders, the incorporation of an intersubjective empathic communication in the psychiatric interview further supports a person-centered therapeutic orientation. Integrating phenomenological insights and descriptive psychopathology into assessment and care may advance early intervention, therapeutic alliances and effective treatment strategies in psychosis.

Keywords: phenomenology; decriptive psychopathology; subjective experience; empirical observation; psychosis; empathic engagement; patient-centered approach

1. Introduction

The elaboration of psychotic phenomena cannot be conceived outside the biological, psychological and social dimensions of the disease [1]. The etiopathogenesis of psychosis lyies on a compound interaction between structural vulnerability and environmental parameters, that intermingle in a multifaceted way [2,3]. At the center of the clinical interest is the individual who develops the puzzling psychotic symptomatology [4]. In order to reach an actual understanding of the psychotic substrate that is substantiated through symptoms, we need to take under consideration both the empirical observations and quantifiable data as well as the subjective experiences that underlie the psychotic phenomena [5–7].

Psychiatric assessment has been the basic tool in addressing differential diagnosis in mental illnesses, aiming to delineate the distinctive psychopathology that underpin the clinical manifestations. Diagnostic systems have been developed to provide the psychiatric community with a common ground to articulate similar psychopathological syndromes [8]. Descriptive psychopathology is considered the language of psychiatry [9]. It offers the foundation for the

 doi:10.20944/preprints202506.1750.v1

delineation of every mental illness through the systematic collection of clinical information and empirical observation. The detailed account of the clinical features and their course provide the context upon which differential diagnosis and identification of the different mental disorders takes place [10]. However, the plain enumeration of signs and symptoms is not enough to capture the implicit quality of the psychotic phenomena and the impact on the personal narrative of the patient [11]. Every individual has a personal representation of his/her self and of the surrounding world that is constructed at different levels of self-awareness, embodiment, spatiality, temporality, narrativity and intersubjectivity [12]. Ideas, feelings and behaviors are formulated within an internal and external milieu, giving shape to a literal as well as symbolic network of meanings that entail the personal self - world experience [13]. Likewise, in psychosis the subjective experience of the patient constitutes the starting point for the evolvement of symptoms leading to loss of reality testing, that is reflected through delusions, hallucinations, defected range of emotions, behavioral abnormalities and cognitive deficits [6].

Phenomenology confers the perspective of advancing towards clinical phenomena through shifting the spotlight from external manifestations to internal experiences. On the basis of an ample clinical knowledge of the different psychotic entities, the phenomenological underscoring of the patient's lived events as they have been registered subjectively, opens up a more comprehensive view point both in terms of diagnostic clarity, as well as empathetic understanding of the individual suffering from psychosis [14,15].

2. The Concept of Phenomenology in Psychiatry

The concept of phenomenology in psychiatry has not been consistent. While it was coined to designate the examination of psychopathology through the study of subjective conscious events, it has been inappropriately used to denote the description of the symptoms and signs of psychiatric illness derived from empirical observation [16,17]. This shift has created a discrepancy as to the very meaning of phenomenology, since it deprives the study of psychopathology from the immediate experience of the individual affected, allowing only a standardized clinical examination by the psychiatrist to formulate a finite conclusion regarding the individuals state of being. The misapplied employment of the term is unsuitable both on semantic grounds, as well as for obscuring the advancement of psychopathological understanding through the patients' account of events [18].

If we tried to provide a concise definition of phenomenology in the psychiatric field, we would say that it represents a study method to gain knowledge regarding the essence of the psychopathological phenomenon by investigating it through the subjective perspective of the individual who has experienced it [11,19]. The basic aim of phenomenological psychiatry is to give a description and potentially understand the content of the lived experience as well as the way it was imprinted on the consciousness of the individual in order to make sense of the unique unfolding psychopathology and augment psychotherapeutic effectiveness in a patient-centered manner [20,21].

2.1. The Influence of Philosophy on Phenomenological Psychiatry

Given the decisive influence of different philosophical contemplations on phenomenology, it is necessary to make a brief reference to the philosophic predecessors that served as a springboard for the formulation of phenomenological psychiatry. Key precursors to phenomenological thought include Kant's critical theory and Hegel's idealism; these two eminent thinkers developed the philosophy of consciousness, the issue of cognitive function, the reliability of knowledge, and the problem of knowing, which is linked to understanding and explaining [22–25]. According to Kant's critical theory, the question regarding how an object is known should precede the examination of the object itself [26]. For the human cognitive state, the properties of sensation and reasoning are essential, and in their dialectical sequence, they equally participate in the cognitive process [27]. Kant argues that the world within which reality appears is the result of an agent of knowledge, relating the possibility of knowledge to the a priori condition of valid propositions and a self for which the validity of propositions exists [28,29]. On the other hand, Hegel's idealist philosophy opposes the

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theory of knowledge as an instrument and defends the phenomenological self-reflection of the mind, in the sense of the awareness of its self-shaping process [25]. Hegel refrains from any pre-judgment about what counts as science, being skeptical of apparent knowledge. He highlights the crucial relationship between subject and object, suggesting that knowledge is not just a condition of cognitive objectivity, but the culmination of an interplay between consciousness, self-awareness, logic, intellect, art and religion [28,29].

Three of the most important succeeding philosophical figures of phenomenological thinking were Husserl, Heidegger and Dilthey. Husserl emphasized the concept of intentionality and the immediacy of consciousness towards an object, as the necessary conditions for the realization of meaning in a specific way [30,31]. He contended that the approach to Being is only possible as an operation of conscious acts, whose function and content need to be examined. For Husserl, phenomenology consists of a return to a transcendental Self, which constitutes the foundation for the establishment and construction of meaning [32]. This is the fundamental condition for crystallizing the understanding of behavior and how meaning is created. Any given object becomes accessible to the person only to the degree that it has meaning for them and therefore, any being becomes intelligible based on its relation to consciousness [33].

Heidegger attempted to distinguish the discrete meanings that make up personal existential consciousness. He argued that humans, through the ability to question Being, hold a privileged position in relation to other beings, specifically that which grants them the dimension of Dasein (literally, "here-being"), i.e., the awareness of "being-in-the-world" (literally "in-the-world-being") [34,35]. This awareness is realized through the perception that something is happening, something exists and evolves, and that what has already happened influences its development. In other words, the historicity of the individual makes human existence inherently temporal [36]. The mode of Being has a tripartite structure, with elements corresponding to the past, present, and future [37]. The basic principles of Dasein (here-being) — primordially thinking, and reason — are based on its temporalization, from which the future, the past, and the present emerge [38].

Dilthey focused his interest on the concept of lived experience and the process of understanding as the pivotal epistemological and methodological tools for human sciences [39]. He argued that the depiction of the inner reality, which is the internal reconfiguration of external stimuli perceived as the various manifestations of life, forms the basis of experience [40]. In order to understand that experience, it is not enough to activate purely cognitive functions of sense, perception and rational thought; it also requires the process of empathy [41–43], which is signified by the reproduction and reconstruction of the experience of the other. Understanding is a connection between the self and others. The sense of "being with others" follows, i.e., an "empathetic" participation in their emotions. Therefore, what is achieved with understanding is the unity between the knower and the known object, in the case of psychiatry, between psychiatry itself and the mentally ill [44].

2.2. Jaspers' Integration of Phenomenology into Psychiatry

Special emphasis should be placed on the formal introduction of phenomenology into psychiatry, through Jaspers' monumental work "General Psychopathology" [45], where the importance of phenomenological investigation of the patient's subjective experience is emphasized. His ideas are inspired by the need to understand the world in which the patient lives, through an empathic participation in his/her experience [46]. For this type of understanding, the assistance of the patients' confessions, recorded in the most detailed way and with the greatest possible relevance by the therapists, is crucial [47]. Jasper sought the function of the internal reconfiguration of a foreign psyche and the interrelationships of psychic life through the objectivity of transparency, using the derived conclusions for understanding the other based on a communicative intention [40,48].

Jaspers recognized the impossibility of acquiring and assimilating interpersonal experiences objectively [6]. He wanted to overcome the intervention of subjectivity, which would distort the clear image of phenomena, highlighting understanding as the most suitable process for perceiving communicative experiences [17]. His proposal involves the therapist delving into the process of

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understanding from a phenomenological perspective, through persistent and painstaking training to contain their emotions and feelings during interaction with the other [40,43]. The therapist's specific criterion for objectivity would be the experiential transparency of the course of intrapsychic changes, rather than general external criteria [41]. However, the intersubjective exchange is of fundamental importance in achieving meaningful interpersonal communication. Since the objective representation of foreign experience is impossible, interpersonal relationships need to be referred to analogical psychological assessments, the function of which occurs through the empathic process [16,40].

Jaspers points out that every type of understanding contains an element of construction. Thus, he adopted Max Weber's notion of the "ideal type" as a tool for analyzing psychopathology through the typology of mental constructs [49,50]. Based on the above, experiential transparency as an observable internal reconstruction of pathological mental phenomena becomes the necessary condition for verifying the ideal typological correlation [40]. In this way, Jaspers introduced the concept of the experiential uniqueness of the subject into psychiatry, highlighting the importance of understanding pathological mental phenomena through the shared intrapsychic experiences of the patient and the therapist [17].

3. Descriptive Psychopathology

3.1. Definition of Psychosis

The current classification systems provide a definition of psychotic psychopathology in terms of operationalized criteria that represent loss of reality testing, with gross impairement in thought (delusions), perception (hallucinations), speech and behavior and psychomotor functions, with adequate frequency and severity to deviate from expected cultural or subcultural norms [51,52]. Delusions are false beliefs held firmly by the individual even in the presence of evidence that proves otherwise [53]. The type of delusion might differ among patients according to the thematic content. The most common ones are referential and persecutory delusions, where the external environment is perceived as directed at the individual frequently in a threatening way. Grandiose delusions represent unrealistic self-inflated views of one-self. Nihilistic delusions refer to unrealistically grim outlook of the world and the forthcoming events. Somatic delusions are fixed false ideas regarding bodily abnormalities [54]. Another discrimination of delusions is according to the bizarreness of the content. Bizarre are considered delusions that are implausible or impossible in the reality of ordinary experience and physical laws, while non-bizarre delusions are characterized as beliefs highly unlikelly but potentially possible [55]. Hallucinations are perceptions taking place without any corresponding external or somatic stimuli in the absence of awareness regarding their pathologic character, that can affect any sensory modality (visual, auditory, olfactory, gustatory, proprioceptive, tactile) [54,56]. They can appear either in unimodal (involving only one sensory domain), or multimodal way (occuring consecutively or simultaneously in different sensory modalities) [57].

Features of disorganization include formal-thought-disorder and disorganized behavior. Formal-thought-disorder is recognized through deviations in language severe enough to disrupt effective communication (e.g. loosened associations, incoherence, derailment, circumstantiality, tangentiality, neologism, perseveration, blocking, echolalia and word salad) [58,59]. Disorganized behavior refers to inappropriate and frequently unpredictable activity, with varying levels of severity, which obstruct social conduct reflecting incogruent emotional responses, lack of inhibition or lack of impulse control or nonsensical actions [60]. A special type of aberrant behavior is catatonia which is characterized by either extreme negativism or unrestricted excitement [61]. Delusions, hallucinations and manifestations of disorganization are considered as positive psychotic symptoms [62,63].

Other accompanying features of psychosis are negative symptoms and deficits in cognition. Negative symptoms represent volitional and expressive pathology and are recognized as diminished expression of emotions (e.g. blunted affect), decreased motivation (e.g. avolition, asociality) or impaired ability to feel pleasure (e.g. anhedonia) [64,65]. Individuals with psychosis can be

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withdrawn, with lack of drive to sustain purposeful activities and having difficulty in forming and maintaining relationships [66]. Cognitive deficits may present early on in the clinical picture, influencing the onset, persistence, or severity of other psychotic symptoms [67,68]. They occur either as a global impairment (e.g. decreased IQ) or aberrations in specific cognitive domains (e.g. attention, verbal memory, executive function, reasoning and processing speed) often on the backdrop of global impairment [69].

3.2. Psychosis in Different Pathologic Entities

Relative to the aetiopathogenesis, psychosis had been characterized either as functional, corresponding to psychotic symptoms presenting with no identifiable pathologic cause, or as organic representing psychotic features arising from a specific brain or systemic pathology [70]. However, since this dualism could be misleading through equating functional with psychogenic, while ignoring the prevaling scientific understanding of psychosis as stemming from a dynamic interplay between biological, psychological and social factors, the distinction is considered rather unfitting [71,72].

The terms primary and secondary psychosis seem to be more cohesive in attributing causation without disallowing a neurobiological substrate. Primary psychosis (non-affective or affective) represents a group of mental disorders characterized by the presence of psychotic symptoms without a known specific etiology [73,74]. Secondary psychosis refers to the presense of psychotic symptoms on the basis of an identifiable underlying cause, such as a psychoactive drug (substance or medication), or to other somatic pathological condition [70,71]. When considering differential diagnosis of the psychotic manifestations along clinical trajectories, we need to examine the posibility of explaining symptoms in the context of the progressive nature of the disease [75], as well as the potentially diagnosable causes [72].

3.2.1. Primary Non-Affective Psychosis

Primary non-affective psychosis brings together a spectrum of mental disorders characterized by gross loss of reality testing with variation in severity, duration and dimension of symptoms, such as delusional, hallucinatory, communicative and behavioral. In addition, distress and psychosocial impairment such as dysfunction in work, interpersonal relations, or self-care are also considered valuable benchmarks of psychopathological gravity. The two main psychiatric classification systems, namely DSM-5 and ICD-11, recognize schizophrenia as the most prominent member of primary psychosis, followed by schizophreniform (only in DSM-5), schizotypal, delusional, brief or acute and transient and other specified or unspecified psychotic disorders [51,52]. However, depending on the classification system followed, there are some differences regarding the diagnostic criteria, in terms of duration of the different disorders, and presence of specific or concurrent disabling symptoms [74,76,77].

The emergence of primary psychosis is usually preceded by a prodromal phase [78]. It is a critical period where tenuous changes take place, characterized by subtle, self-experienced disturbances in an array of elements that comprise thought processing, language, perception, attention, drive, stress tolerance and affect, collectively called basic symptoms [79]. These aberrations can progressively include false beliefs, perceptive abnormalities or difficulties with speech and disabilities in psychosocial functioning of subclinical severity and with relatively intact reality testing. These manifestations are summed up as attenuated psychotic symptoms and there are reliable psychometric tools for the assessment of the indicative psychopathology (e.g. Comprehensive Assessment of At-Risk-Mental-State [CAARMS]) [14,51,80]. Transition to psychosis is considered when 1 frank positive psychotic symptom has presented for at least 1 day or 1 week, according to DSM-5 or CAARMS criteria respectively [51,80].

In case of deficient response or non-adherence to treatment, first episode psychosis might proceed to incomplete remission or a relapse phase, which could further evolve into chronicity with debilitating residual symptoms [6]. All these changes have a distinct pace for every individual. The clinical course can be either continuous, or episodic with progressive or stable deficits. In case of a

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long term psychotic disorder, such as schizophrenia, clinical and functional outcomes vary. According to a recent meta-analysis addressing prospective studies on schizophrenia, that span at least 20 years of follow-up, a favorable outcome (considered as clinical and social remission in terms of mild or no symptoms and adequate employment, regular social life and sufficient self-support respectively) took place in 35.5 % of the study population, whereas a poor outcome (with severe or erratic symptoms and/or low social functioning) involved 40.3 % of the included individuals, with the rest of the sample being in an intermediate state [81].

3.2.2. Primary Affective Psychosis

Primary affective psychosis represents mood syndromes that have accompanying frank psychotic symptoms, i.e. major depression with psychotic symptoms and bipolar disorder with psychotic symptoms. Schizo-affective disorder has also a combination of affective and psychotic symptoms, though according to DSM-5 and ICD-11 it has been classified as belonging to the spectrum of schizophrenia and other psychotic disorders [51,52,82]. Affective psychosis is a term applied in clinical settings, especially of early intervention services, to address First Episode Psychosis (FEP) patients according to their clinical presentation and not their formal diagnostic classification, in order to recommend the suitable treatment promptly including both dimensions of symptoms [83].

The psychotic symptoms involve delusions and/or hallucinations that are more often mood congruent, although mood incongruent are not unusual with equivocal findings regarding their potentially worse impact in clinical outcome [84,85]. As to formal thought disorder and disorganized behavior, manic syndromes are characterized by increased racing thoughts, rapid speech, erratic activity, and psychomotor agitation [86]. Affective hallmarks of mania are elevated or expansive mood, mood lability, impulsivity, irritability, and grandiosity with poor insight. On the other hand, depression is characterized by deep sadness, anhedonia, feelings of wothlessness and guilt, poverty of speech and either psychomotor agitation with nervousness and fidgeting or psychomotor retardation, where thoughts, somatic activity and reactivity to stimuli decline [87]. As to the presence of negative symptoms in affective disorders, an overlap has been pointed out involving negative and depressive symptoms in the form of lowered ability in experiencing pleasure, lack of engagement in goal-directed activities and diminished energy [88,89]. Differentiating features could be on the one hand poverty of speech, reduced expression and anticipatory anhedonia that lean towards negative symptoms, and on the other hand self-reported pessimism, low mood and suicidal ideation that are more specific to depression [88–90]. It has been suggested that volitional and expressive pathology in the context of negative symptoms can take place in both bipolar and major depressive disorders, with some findings showing a persisting attenuated appearance inbetween episodes of the disorder [64]. Relative to cognition in primary affective psychosis, impairements in attentional processing, learning and memory have been pointed out, with no significant observed differences in the magnitude of the deficits between bipolar and major depressive disorder [91]. Due to the extensive symptomatic overlap between psychotic and affective disorders, the dimensional nature of the disorders has been put forward, further suggesting a transdiagnostic approach for the future classification systems [84,92,93].

Regarding the early phases of affective psychosis, clinical clues could be extreme psychomotor changes, destructive and disinhibited behavior, changes in appearance, racing thoughts or thought slowdown, overvalued self-reproach, marked perplexity, cognitive dysfunction, significant dissociation, attenuated psychotic symptoms and social withdrawal [84,94–96]. The course can be intermittent with remission and relapses as well as with inter-episode residual symptoms [95,97]. It is suggested that the presence of psychotic symptoms have a potential adverse effect in affective disorders [98,99]. However, there are other studies arguing that there is no association between the presence of psychotic symptoms and a less favorable outcome in either bipolar [92,100] or major depressive disorder [101,102], except for better insight and subjective quality of life [82].

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3.2.3. Secondary Psychosis

Secondary psychosis can arise on the basis of any substance or somatic disease that has an effect on the nervous system [71]. Αν overview of the basic medical conditions involved are: head trauma, autoimmune disorders, pharmacologic causes, cerebrovascular incidents, tumors, metabolic abnormalities, nutritional deficiencies, infectious agents, degenerative and demyelinating diseases, seizures, endocrine illnesses and genetic syndromes [70,71,103]. The psychotic symptoms can be delusions, hallucinations, abnormalities in language and behavior, as well as emotional and cognitive deficits.

Certain specific psychiatric features could point towards the direction of a secondary psychosis [104]. For example, visual and tactile hallucinations have a higher rate of presence in secondary compared to primary psychosis, especially in movement, cerebrovascular and neurodegenerative disorders as well as substance abuse or alcohol withdrawal [103,105,106]. Delusional content with misidentifications of other people (e.g. Capgras syndrome), older age of psychosis presentation and more severe cognitive deficits accompanyied by confusion are frequently related to a medical illness [71]. Polymorphic psychotic symptoms allong with emotional, catatonic and cognitive deficits are suggestive of infectious, postinfectious and autoimmune encephalitis [107,108]. Fluctuations in mental state are strongly related to drug toxicity [109]. Rapid onset with transient deficits in mental function, as in delirium cases, are usually caused by medication interactions or withdrawal, metabolic disorders, hypoxia, electrolyte abnormalities, sepsis, sleep deprivation or hospitalization in intensive care units [70].

However, there are no pathognomonic psychotic manifestations that can be attributed solely to a purely psychiatric disorder with unknown etiology or a medical-toxic condition [56,110,111]. Primary psychotic disorders comprise diagnostic entities of exclusion, which means that any identifiable pathology should have been ruled out in order to address the predominant psychiatric disease [109,112]. For that reason, it is imperative to follow the history of the psychopathologic presentation and to complement every newly presented psychotic phenomenon with a thorough physical examination and laboratory investigation, focusing especially on potential neurobiological and cognitive aberrations [70,71]. The course and duration of secondary psychosis is directly related to the treatment of underlying cause [113]. There is a risk of chronicity, if the condition is left untreated, and of progressive deterioration in neurodegenerative disorders [114]. In case of substance-induced psychosis, repeated use in vulnerable individuals can lead to persistent psychotic features or conversion to a primary psychotic disorder [115,116].

4. Phenomenology of Psychotic Symptoms

Descriptive psychopathology offers a reliable anchor point to discern the various manifestations depicting psychosis, and to distinguish among these manifestations the different cluster of clinical features reflecting distinct disorders, that belong to the psychotic spectrum. However, the listing of symptoms and the categorical systems that are cohesively structured do not adequately harbor the ample and multilevel quality of patients' experiences that are pivotal for clinical reasoning in psychosis [75]. The simplified concept of symptoms solely as enduring well-delineated objects overlooks the experiential background with the emotional and cognitive components that traverse the individual's consciousness [14,117]. The perception of self and of the world is further facilitated and consolidated by the relations with others [118], regulating the stream of consciousness and the way the lived experience is conceptualized and verbalized [14]. Any inconsistencies in terms of thought, emotion and behavior are mediated by these mental representations. Consequently, they are inherent in the psychotic manifestations and the personal narrative of the patient. Phenomenology offers a more thorough approach regarding the investigation of the way that these clinical features are being experienced by the patient. The search for understanding psychosis and trying to establish a more empathic communication is mediated by the inquiry into how delusions, hallucinations as well as emotional, behavioral and cognitive deficits are being mentally imprinted

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on the individual. The integration of phenomenology and descriptive psychopathology offers a nuanced understanding of psychosis that transcends traditional diagnostic boundaries.

4.1. Disturbances of Selfhood

It has been argued that a central psychopathologic point of reference in psychosis is disturbances of selfhood, creating a springboard for further aberrations [15,119–122]. These disturbances might affect different levels of Self. The very issue of Self has been central in both philosophical, psychological and neurobiological inquiries. It is assumed that self-representation and self-referential processing in terms of discriminating between related from non-related stimuli to one's own concerns are at the center of what is called self [123]. A phenomenological perspective has suggested 3 levels of selfhood: a) the pre-reflective one (basic-self or ipseity), which is associated with the representation of the self as subject and with the unconscious, transparent and definite awareness that something is "my" experience, b) the reflective self-awareness, which corresponds to a more explicit awareness of self, consistent through time and c) a social or narrative self, which represents the disposition that recognizes the individual for him/herself as in personality, inclinations, habits and style [117,120,124]. A similar neuroscientific proposal divides selfhood into ''proto-self", which refers to the physical or somatic self-awareness involving sensory and motor domains, the ''core or minimal self'', which corresponds to the mental representation of self-referential processing, and the ''autobiographical or narrative self'', which represents the memory domain traversing in unity past, present, and future events to higher-order cognitive processing [123,125–127].

One of the dimensions of selfhood, namely the "core (or minimal or basic) self" has been particularly implicated in the emergence of the psychotic phenomenon [119,120,128]. It has been suggested, that disturbances in this construct of self, in terms of compromised sense of first-person perspective (ownership and agency), self-affection and sense of awareness, represents a central trait marker of vulnerability towards frank psychosis [118,129]. The distorted implicitness of "mineness" and of self-presence, along with the "disturbed grip" regarding the conceptual domain might lead to disordered reasoning and impaired contact with reality [130]. The psychotic quality embedded in these features is confirmed by the absence of insight [117]. Furthermore, there have been research efforts to investigate the relationship of these selfhood disturbances with cognition in the form of aberrant salience, reality monitoring and perceptual disintegration [117,118,131]. Indeed, in recent studies deficits in core-self have been associated with self-monitoring, processing speed, executive function, visual learning, reasoning and working memory, but with no definite causal or explanatory relationship [117,118,132–135]. However, findings are equivocal since other studies have not confirmed the association, suggesting that neurocognitive deficits might represent a rather discrete domain in psychotic disorders [121,136].

4.2. The Psychotic Experience

In psychosis awareness of self in terms of sense of presence, somatic representation, bodily sensations, self-demarcation, time continuity, intentionality and stream of consciousness might be compromised, undermining the framework that delineates purposeful conscious activity [120,122,137]. The patient may experience morphological changes or motor disturbances, perceptualization of inner speech or thought, permeability of ego boundaries accompanied by alterations of thought-agency and ownership, intense reflectivity, loss of "common sense" and solipsistic phenomena [118,119,128,129,131]. Along with the disturbances in one-self as subject-of-experience, psychosis is also characterized by alterations in interpersonal attunement and the way the individual is directed towards the world and the objects [15]. The common self-evident boundary between self and others is disrupted leading to the dysfunction of the dynamic interplay between internal and external reality [122].

In addition, the experiential obscurity is connected to an array of pathological affective reactivity. Explanatory models of psychosis have suggested a straight pathway from emotional alterations to psychotic symptoms [138–141]. In addition, emotional dysregulation and dissociative

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features stemming from developmental traumatic experiences, are increasingly being related to the emergence of psychosis [142–145]. Indeed, emotions seem to constitute the irreducible background that define the way the world is revealed to any individual, with anxiety being the dominant emotional component of the psychotic trajectory, distorting all others in an existential perplexity [42,139,146,147]. During the evolvement of psychosis, the intricate emotional strain with dissociative qualities can take the form of ambivalence, derealization, depersonalization, estrangement, incommunicability, motor inhibition, uncanniness, bewilderment, elation, and psychomotor retardation or agitation [139,142,146]. These manifestations have a disorganizing effect on reflective processes. The diffuse affective state, becomes increasingly self-referential creating a delusional mood. This peculiar affective turmoil of the self – world experience paves the way towards the impending psychotic illness [148].

The intensification of these self- and world-oriented experiences in the context of distorted emotionality, underpinned by psychotic stress, is combined with a cascade of cognitive deficits affecting self-monitoring, reasoning, memory, processing speed, speech and language, creating the framework for the emergence of the frank psychotic symptoms of delusions, hallucinations, formal-thought disorders, passivity phenomena, negative symptoms and disorganized behavior [120,149–151]. A recently proposed psychopathologic concept, encompassing the multifaceted experiential emotional distress with cognitive ramifications, that plays a formulating role in the emergence and maintenance of psychosis is the “psychotic arousal” [141]. In this psychopathologic progression, fragility, instability and the component of uncertainty which is associated with the initial disturbed modalities give way to the pathognomonic crystallized psychotic manifestations [118]. In light of the above, we can consider the importance of the experiential account of the psychotic phenomena on the clinical comprehension. Bridging phenomenology and descriptive psychopathology enriches our understanding of psychosis as not only a clinical syndrome but a profound alteration in consciousness and existence.

5. Discussion

In phenomenology, the object of attention is the scientific knowledge of experiences. The basic experience without interpretations is investigated, i.e., the essence of things, through an impartial description. Based on this method, the Self is revealed, around which everything is meaningfully constituted [44,152]. What is sought is lived reality, i.e., reality as it presents itself in consciousness, where every meaning is constructed and grounded. The center of interest is “phenomena,” i.e., acts of consciousness and the objective entities that are constituted in them. Phenomenology aims to unravel the mental phenomena as they unfold upon the personal narrative of the individual. Likewise, in the field of psychiatry it seeks to disentangle the subjective account of psychopathology through the mental states that the patient reveals.

The emergence of psychosis is not a static phenomenon. It represents a subtle or a more abrupt shift in the person’s sense of the world and of him/herself, which depending on the intensity, duration and life-stage that the psychotic phenomena occur, it can impinge on the identity-formation, the self-realization and the way that the person affected will be socially re-integrated. Psychotic phenomena have pathognomonic features, which constitute the cornerstone to recognize the different entities that belong to the psychotic spectrum of mental disorders. Descriptive psychopathology provides the scaffold upon which empirical observation can be translated into clinical constelations with perceptual clarity. The detailed delineation of psychotic manifestations is a prerequisite for the diagnostic precision and for the qualitative and quantitative evaluation of the distinctive symptoms. Concurrently, the experiential context upon which the symptoms develop is pivotal in understanding the fundamental disruptions in the sense of self and of the world, the grasp of reality and the mental composition of the patient. On the basis of emotional overwhelm, these disruptions manifest as anomalies in self-awareness, such as a pervasive sense of suspiciousnes and alienation, an arbitrary self-referential interpretation of random events and loss of ego boundaries. While traditional psychopathology treats these features as discrete symptoms like fixed false beliefs and perceptual

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abnormalities, phenomenology approaches them as expressions of deeper experiential transformations grounded in an atmosphere of emotional turmoil and phenomena like hyper-reflexivity, diminished self-affection, aberrant sense of agency and altered structures of meaning. The first-person presentation of symptoms is relative to the personal narrative of the individual as well as the context that this narration takes place. The psychiatric examination, based on an updated empirical knowledge of the psychotic psychopathology and through an unbiased intersubjective communication, can formulate the framework to substantiate the multifaceted description of symptoms and translate it into valuable clinical meaning [14,40].

These considerations point out the need for further investigation and synthesis regarding the possibility of integrating the phenomenological perspective with the classificatory approach in psychiatry, so as to enrich the existing diagnostic and explanatory models for psychosis. Indeed, disorders of self have been characterized as core features of psychosis already from the prodromal stage, suggesting that these personal accounts of aberrant self- and world-representations can constitute vulnerability markers for psychosis [128,129,153]. By incorporating phenomenological insights clinicians can better access these subjective disturbances and formulate more comprehensive assessments. In addition, considering the difficultness in articulating the essence of these experiences, an empathetic understanding in the clinical discourse can foster a more insightful and prompt identification of the sensitive subclinical manifestations or of the "psychotic arousal" [14,117,141]. To this end, there is a need of a potentially standardized semantic framework as well as innovative interviewing methods in order to consistently capture the phenomenological conceptualizations and incorporate them into mainstream psychiatric assessment and care [154].

On the basis of recognizing the bio-psycho-social substrate of psychosis, the phenomenological point of view creates the opportunity to advance the interpersonal framework of the psychiatric interview and share a more profound understanding of patient's lived reality [155,156]. The impact of the phenomenological notions are informative not only diagnostically, but also psychotherapeutically, facilitating a patient – centered approach, that enhances individuals to reveal puzzled feelings such as strangeness, perplexity in grabing the common sense of the things and disturbances in social interaction. Psychotherapeutic interplay in a phenomenological context can further strengthen engagement to treatment [129]. This integrative approach promotes a more person-centered psychiatry, encouraging a therapeutic rapport that addresses not only symptom reduction but also the restoration of meaningful self-world relations.

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