Athens Journal of Psychology 2025, 1: 1-13
https://doi.org/10.30958/ajpsy.X-Y-Z

The Ethical Imperative in the Theoretical Modeling of the Concept of Psychosis: Historical Review and Contemporary Assessment

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The field of meaning of psychosis has been relatively thoroughly investigated from a scientific point of view, with its theoretical and practical perspectives. Occupying a nodal place in psychiatry and clinical psychology, difficult to penetrate and with a wide range of content, the malady provokes dogmatic disputes, exchanges of opinions and active, even aggressive polemics in multi-volume editions with a colorful bibliographic bias. This text attempts to conceptualize the multidimensionality of psychotic disorder, placing it within a psychodynamic framework, with the aim of provoking reflection on the ethical hurdles that those working with psychotic patients inevitably face. Referring to the trailblazers and fundamental discoverers in the field of psychosis, who although paradigmatically belong to different currents in psychology and psychiatry, this theoretical review seeks to emphasize the need for an interdisciplinary approach in the study of this multifaceted affliction to date. The innovative authors rely on the bridging of differences through a reasonable, healthy eclecticism between traditions, which is based on credible evidence and allows the overcoming of natural intellectual divergences, the removal of dividing lines and the closest convergence of disciplines, will lead to the formation of complexity in the assembled material. The emphasis on the deontological ethics imperative is highly necessary because of the deficient state of public concern for those experiencing psychosis.

Keywords: *psychosis, ethics, clinical psychology, psychiatry, psychodynamic framework*

Introduction

The theoretical grounding of psychotic suffering in the field of the psychiatric and psychoanalytic doctrines provides a constructed framework in which the primary focus is on enhancing the quality of life and slowing the progression of the condition (Fusar-Poli et al., 2017). The absence of a significant analytical study, combined with a clinical one (looking at the big picture but also delving deeper into certain psychotic features) which offers an exchange of ideas between collaborators in helping professions, created the need to generate the present study. The authors of the present paper are aware of the transformative and humanizing aspect of psychological science and believe that making sense of and redefining ethics while

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sharing practical approaches and experiences is a sort of an invitation for further research in the face of the ever-changing social, economic, and cultural factors.

The creation of strong teams and a positive working environment in specialized institutions (Van Bogaert et al., 2013) and the introduction of valuable practical guidelines for working with people in a weaker and more vulnerable position would only take place in the coordinated system of such texts. The fundamental contribution to knowledge on nosology of scholars such as Theodor Heller, Michael Rutter, Emil Kraepelin, Eugen Bleuler, Adolf Meyer, Jacques Lacan, Frieda Fromm-Reichmann, Ronald Laing, Karl Abraham and Ludwig Binswanger confronts us with significant theoretical content in which definitions such as *"psychosis"* (Julayanont, Suryadevara, 2021), *"schizophrenia"* (Tandon et al., 2013) and *"madness"* (Foucault et al., 1995) stand out.

It is incumbent upon us to distinguish the phenomenological expanse of "madness" from the forensic rigidity of "insanity." In the conceptual scheme of psychosis, "madness" (as conceptualized by Foucault and Laing) denotes the subjective, existential rupture - the lived experience of unreason that retains a semantic content. "Insanity," by contrast, is the silence imposed by the asylum; it is the medicalization of that experience into a disease entity that strips the subject of agency. The ethical imperative, therefore, lies in the clinician's dismissal to reduce the patient's "madness" (a meaningful, albeit tortured, way of being-in-the-world) to mere "insanity" (a biological error to be silenced). "Madness" (*Folie*) and "Insanity" (*Aliénation*) operate in distinct registers.

Drawing upon the work of **Michel Foucault** (1995), we need to express that "Madness" historically referred to a human experience - a phenomenon of the soul that, while disordered, retained a dialogue with reason and truth. In the Renaissance, as Foucault describes in *Madness and Civilization,* madness was engaged with; the "ship of fools" was a vessel of passage, not merely containment. Madness had a language, however cryptic *(Foucault, 2006)*. "Insanity," conversely, is a juridical and medical construct that emerged with the Enlightenment and the "Great Confinement." It represents the silence of madness. When the psychiatrist defines the patient as "insane," they are often stripping the patient of their status as a moral agent and a legal subject. "Insanity" is the condition of being *alienated* from society and from oneself, requiring management rather than dialogue.

The embeddedness of pejorative elements in these formulations and their different interpretations in all human societies seem to desensitize the awareness of the obligatory nature of respect for individual diversity and empathy. The commonality in the plethora of theories that can be dissected to a more complete thread of individual doctrines which gives a comprehensive description and categorization of the psychotic spectrum should be a prime objective in interdisciplinary studies, but contrary to expectations, the stability of the terminological register still remains only implicitly stated, at the expense of pleading in favor of one research position on the matter or another. The organic understanding and perception of psychosis, the "mapping" of conceptual categories used to make sense of it is the pre-stated research direction we are taking, and the integration of networks of solidarity and organization in institutional and therapeutic work with patients, as well as the construction of moral boundaries to clearly define what "psychosis" means, are the

contributions of creating such shared values and discourse. Perhaps psychosis is a much broader concept than is assumed, which determines the need to appropriately exploit the available theory and reconsider counseling and therapy programs when working with this group of patients (without pretending to be exhaustive).

Theoretical Overview

It is prerequisite to delineate the boundaries of this inquiry before considering exploring it further. While "psychosis" is a transdiagnostic symptom appearing in bipolar disorder, major depression, and organic states, this review privileges the intersection of psychosis and schizophrenia. This focus is selected because schizophrenia remains the paradigmatic condition for the theoretical models under review. For pioneers like Kraepelin, Bleuler (psychiatry), and Lacan (psychodynamic psychology), the "schizophrenic" structure was the primary enigma that necessitated the modeling of the fractured psyche. To understand their ethical and theoretical contributions, one must engage with psychosis in its most structural and enduring form, as traditionally represented by the schizophrenic spectrum.

An unusual framework laid out by Arciniegas (2015) redefines psychosis as "a common and functionally destructive symptom of many psychiatric, neurological, and neurodevelopmental medical conditions." Although too general, this 'sketching' of the condition is still a good reference point when discussing the need to understand the specific needs of patients. Such a contemporary perspective situates psychosis in a radically different field from that of the notions proposed by the fathers of psychiatry and psychodynamic psychology. While valuable, this perspective is considerably distant from the direction the current text is heading, and will therefore simply be mentioned here to explore the different layers and specificities in differentiating and more clearly conceptualizing this malady. It is important to note that registering ambiguity as early as in the conceptual harnessing of the problem towards its correct labeling and derivation of relevant diagnostic and prognostic criteria is a debating point in the present conceptual attempt to grasp the multidimensionality of the suffering. It is with such intention that we have further marked, for example, terms such as "schizophrenia" and "madness" (used as scientific expressions, not as fatalistic diagnoses), as well as philosophical and psychiatric-nosological positions figuratively approximating psychotic pathology to autistic one.

Among the basic studies in the field is that of the Viennese psychologist **Theodor Heller** in 1907. The trajectory of Heller's *dementia infantilis* illuminates a fundamental truth in nosological ethics. Originally conceived as a psychosis or dementia, this condition of catastrophic regression is now recognized within the DSM-5-TR as a severe phenotype of Autism Spectrum Disorder. This reclassification is not merely administrative; it is ethical. It shifts the treatment paradigm from the containment of "psychosis" (often involving heavy sedation) to the developmental support of "autism." By correctly modeling the concept – moving it from the psychotic to the neurodevelopmental spectrum – we alter the life trajectory of the child.

The individuals he studies suffered from retardation in intellectual functioning, and among them was found a group of children with an early history of rapid, abrupt onset of developmental decline (over a period of 3 to 9 months), which by the age of three or four years had proceeded within the stretching limits of the statistical norm. Heller postulates that such a decline could be accompanied (though not necessarily) by violent symptoms such as anxiety, disobedience on the part of the child, as well as negativity or fears and transient hallucinations. The condition is indistinguishable from idiopathic with complete loss of speech, but is without impairment of motor functions, without development of focal neurological symptomatology and preservation of usual intellectual expression. The six cases initially described, followed by twenty-two more (in 1930), led the author to delineate a distinct nosological entity, which he called "infantile dementia" also popular later as Heller's dementia/Heller's syndrome (Kurita, 1988). The prognosis is poor, profound dementia is present in a short time, and the state of regression is irreversible. This development could be discussed in close relation to childhood schizophrenia, although he considers it more of an age-specific dementia syndrome. The similarity between the clinical picture thus described and early schizophrenia with a malignant course is in the precipitous transition to dementia. The differential diagnosis proves challenging, but in Heller's syndrome there is no characteristic "autistic withdrawal" of the individual in early schizophrenia, some emotionality is retained in the child, which is primitive (without the affect being quite extinguished, however), and there is satisfactory motor coordination.

In even larger contexts are the studies of the English psychiatrist **Michael Rutter** in 1972 and 1979. Michael Rutter's contribution signifies an ethical watershed. By empirically distinguishing "infantile autism" from "childhood schizophrenia," Rutter unburdens a generation of children from the stigma of psychosis and the fatalism of the "schizophrenic" label. His critique of the "maternal deprivation" hypothesis also served an ethical function, dismantling the blithe assumption that maternal separation was the sole architect of psychopathology. Rutter demonstrates that theoretical precision is a form of ethical care; distinct diagnoses lead to meticulous, and more humane, interventions. Known as a visionary and the father of child psychology, he engages with the problems of early childhood autism and psychotic conditions in childhood and adolescence from a more distinct theoretical perspective. Rutter is a proponent of the biological strand of the science, although he is not quite willing to identify schizophrenic manifestations in children with those in adults (Rutter, 1978). In his research, the empiricist turns to the question of the general pathogenetic mechanism of early psychosis, arguing that it is a specific syndrome with a monopathogenetic character. Exogenous factors (chemical, physical, biological noxae) affecting the central nervous system are considered to be turning points in autism and psychosis in prepubertal age. Consistent in the implementation of his ideas, Rutter nevertheless also looks carefully at social characteristics, managing to capture and emphasize that his autistic patients came primarily from the two extremes of society - they were either those with a high standard of living (e.g., intellectual parents - cold and significantly ambitious, committed mostly to their professional advancement, but measured in their attitude towards their offspring), or with very low

social status (disengaged families, alien to any responsibility, allowing their children to grow up in an environment without clearly defined boundaries).

The problem is posed allegorically - neglectful parental behavior seems to condition the children's lack of self-awareness. In his classic work for the field of child care "Maternal Deprivation Reassessed", Rutter reveals the crucial role of motherhood in normal child development by examining the short- and long-term effects of early separation from the mother on the psyche of his examinees (high stress, hence the isolation of certain aspects of the traumatic experience through defensive exclusion, to partial or complete disorganization in the attachment system), which brings him closer to John Bowlby's ideas of an inextricable link between events of a negative nature in the infant's life and the later development of psychiatric symptomatology (Bretherton, 2013). Other forms of deprivation found in institutional care are also highlighted here, and it is suggested that anti-social behavior in some of the cases is more likely to be related to the presence of dissonance within families (e.g. discord and disagreements leading to separations). Thus, Rutter is only partly opposed to psychodynamic claims, since he signifies the importance of familial abnormalities as a vulnerability factor in unleashing dramatic psychic suffering, but completely rules out the possibility that they are the causative force. The course he adopts to arrive at knowledge is cataphatic (from the root cause). His theory of autism is a perceptual one, positing that the underlying disorder is the child's inability to integrate auditory stimuli coming to him, leading to his autistic isolation from others and the world. Rutter conducts catamnesis examinations in order to detect signs of early stage disease that may be associated with a good prognosis. The results suggest that high IQ on the relevant test during the period of early illness correlates most strongly with quality social adjustment in adulthood. The worst prognostic feature, according to Rutter, is the absence of expressive speech until the age of five. Less important factors in the long-range prognosis of development are: sex, at what age the disease itself began, and the order of the child in the family (a feature emphasized with research passion by the Austrian scientist Alfred Adler in his creation of individual psychology).

On principle, we as researchers dissociate ourselves from such statements, but we are obliged to mention them. From our perspective, precise skill is required in handling a conceptual apparatus whose lexical basis is firmly grounded in the label "psychosis", yet we are also obliged, for the sake of a more comprehensive theoretical inquiry, to focus our attention on as many perspectives as possible, even at the risk of an ideological clash. This gradually opens up insights into ethical questions still relevant to this day about the evaluative professional and public stance (often with critical, negative overtones), about the overglorification in identifying a group of sufferers with persons who are virtually doomed, and in particular about the underlying principles and methods of prevention and intervention of this condition. We summarize the theme of these attitudinal questions, contradictions, and even problems by introducing the "ethical imperative" model, in other words, the ethical prism through which we should view the modeling of the concept of psychosis, beginning with the pioneers in this area of thought and ultimately reaching contemporary psychiatric and neurological perspectives, trying not to repeat the numerous reviews and analyses of this voluminous literature, but to present a viewpoint that we believe is often overlooked but by no means less significant.

The revolutionary description of **Emil Kraepelin**, to whom we owe the nosological formulation dementia praecox (early deterioration of the psyche), is in fact the theoretical foundation of the question of psychotic disorders in childhood, adolescence and adulthood. Although in his early biomedical developments the German psychiatrist linked the aetiology of the disease to the endocrine glands (respectively to an onset in puberty), it was not long before he admitted the possibility of a premature suffering, well before the tenth year of the individual's life (Kraepelin, 1919). It was he that developed the first academic distinction in the field (a dichotomous differentiation of mental illnesses into two predominant nosographic domains - premature dementia and manic-depressive psychosis), which was supplemented and refined. Thanks to the invaluable discoveries of Kraepelin, the scientific world has concentrated its attention and intensified its interest on this psychopathological problem. Gradually, observations accumulated and further significant works in the same scope appeared, which, however, argue against Kraepelin's generalized and persistent disturbances in almost all areas of mental and social functioning in the so-called dementia praecox (presented as an endogenous incurable disease caused by brain damage, a speculative interpretation that has caused confrontation on various levels, and which has been met with reasonable scepticism in the clinical community).

Historically, the term "schizophrenia" was first proposed by another famous member of the research circles the Swiss **Eugen Bleuler**, in 1909. Bleuler's formulation drew attention to the fragmentation of the psyche and the loose interconnections of mental processes (Bleuler, 1950). By dealing with the problems of soul, he reached a depth in his work unprecedented at the time, rejecting then-conventional ideas of the obligatory chronic course of dementia praecox and replacing them with his extended theoretical concepts of intervals in which the disease is not active (remissions), a heterogeneous clinical picture of suffering, and a "group of schizophrenics" to the already distinct hebephrenic, catatonic and paranoid forms, a simple form of the illness is added. At the core of his doctrine, Bleuler delineates a problematic thematic nest for the four primary symptoms of schizophrenia - associative splitting (alogia), autism, affect blunting, and ambivalence: the first one is a disorder in the patient's thinking, more precisely in his associative process (associations on non-essential features as well as those between judgments are reported); autism here is a loss of contact, but as part of the large-scale schizophrenic picture; ambivalence has the character of a pathological tendency towards simultaneous negative and positive attitudes towards the object, in other words "lack of synthesis of opposites", and affect blunting also found as emotional levelling in a voluminous body of established medical literature) can be noted in patients who are visibly indifferent and apathetic to their surroundings. According to the author, these basic symptoms of the nosological entity "schizophrenia" (the four "A's"), originate from an organic brain damage (one looks for the main brain substrate, whose involvement is responsible for the occurrence, such structures are the reticular formation, the frontal lobes of the brain and the limbic system) or from hormonal abnormalities. Autism as a symptom is of major importance for the diagnosis.

Starting from the position of hybrid theoretical forms, with the affirmation of the existence of a close interrelation between the biological and the psychic (body

and soul), one of the most influential and erudite psychiatrists, the Swiss **Adolf Meyer**, strongly opposed the already mentioned Kraepelin formulations of an organic substratum of dementia praecox (Meyer, 1922). Seemingly influenced by the works of Sigmund Freud and his well-known disciples Alfred Adler and Karl Abraham, he argued that psychic experience itself could have an extremely powerful impact on physiological processes. Meyer defines the psychic (subjective inner world) and the corporeal (external shell) as a unitary whole that should not be considered, much less intervened upon, separately, compartmentalized in strictly differentiated theoretical overviews and clinical studies. The scholar attaches great importance to the personal psychological history of the patient and the help it would give the specialist in uncovering the causality of the disorder (Meyer's assumptions seem to be more in line with the understandings of names like Jacques Lacan, Anna Freud and Sandor Ferenczi, who hypothesized a biographical conditioning of psychosis and criticized medicine for its disinterest in the individuality of character and its search for quick generalizations, rather than with the conclusions of his contemporaries in neuroscience). According to him, in childhood the schizophrenic patient has not learnt basic life techniques for coping with social demands and pressures, the deficit is mainly in the area of life perception, without excluding possible somatic adversities, such as disorders in the functioning of brain stem structures. There has been a revisionist debate regarding the role of hereditary factors in the onset of schizophrenia (greatly exaggerated in the past), making the almost fatalistic understandings of Meyer's genealogy sound quasi-scientific.

The research characterization of French psychoanalysis and psychiatry, of which **Jacques Lacan** is a prominent representative, is considerably similar to Meyer's ideas, especially in its overall view of the problems of psychotic suffering. His well-known Seminar III, entitled "Psychoses", referees Lacan's authoritative treatment of the subject (Miller, 2000). In order to express the groundlessness of the traditional Kraepelinian understanding of the psychotic disorder as dementia praecox, Lacan did not stay within psychiatry by revolutionizing the word "madness" (Vanheule, 2017), going even further with his landmark statement "We are all mad", that has no unethical connotation.

We are inclined to assume, however, that Lacan is thematically related to Eugen Bleuler because he admits the existence of primary disorders in psychosis and separates them from delusions, which, as we have already noted, for Bleuler are merely an attempt by the disturbed organism to respond to the physiological change that has occurred. Lacan's conceptual approach is as canonical as it is alternative as a manifestation of psychoanalysis because of his belief in the main role of language and the family system as an "initial fact" in psychosis. Influenced by the most popular psychoanalytic idea – the "unconscious" (something that is not the object of consciousness in the patient's psyche), Lacan positions this unconscious "on the surface" (Lacan, 2004) of psychic reality, where it acquires the status of the conscious in the psychotic – as if the psychotic does not really know his native language. Lacan is convinced that the speech of the deluded is riddled with neologisms, which are in fact words of particular emphasis and meaning for the patient, and they usually refer to a completely different meaning from that which the therapist attaches to a particular word. On the basis of Freudian theoretical

conclusions, combined with principle Lacanianism, in the French tradition the field of verbosity in the psychotic is a measured concept of value to the clinician – the patient's speech spontaneously reveals the phenomenology of psychosis (e.g. verbal hallucinations).

According to **Frieda Fromm-Reichmann**, a German psychiatrist and analyst, those most bizarre and illogical thought products of a schizophrenic patient actually have an underlying meaning (which the therapist must derive from the patient's life path) and are not result of organics. She turns to psychotherapy of psychotics, ignoring doubts about the necessity and effectiveness of such a method in that field. Under the influence of one of the aforementioned psychiatrists, Adolf Meyer, Reichmann insisted on an understanding of schizophrenic patients` early socialization. She created the "analytic therapy for psychosis", guided by the belief that they represented the individual's attempt to self-heal from the insanity (rooted in early childhood). Her interpretation is that in the treatment of psychosis, therapist and patient search together for a way back from madness, which is, however, extremely difficult to find, and the treatment period could last at least several years. Reichmann explains the psychotic genesis by a failure of socialization already in the earlier background of the patient. For her, childhood narcissism is dangerous – that self-sufficiency seen in some children who do not seek contact with an adult or with their peers, do not play with toys, but are usually preoccupied with some part of their body (first significant signs of pathology). Later, the emerging obsession with power, fame, wealth and greatness (megalomania) is interpreted as a compensatory phenomenon – through it, the patient conceals his acute sense of inferiority and inability to fit actively into the environment. "The patient's language" (Reichmann, 1989) is what the analyst calls everything that is demonstrated by the patient (linguistic errors, neologism, perseverations, stereotypes, stupor, dysphoria). She explains such manifestations as simple expressions of the intense psychotic fear that the patient, unable to find a place in the world, experiences. In this part of the Reichmann's principles, she is semantically close to the Lacanian concept of the psychotic language, taking researchers to scientific field with wide-ranging and innovative clinical analyses.

As a desirable outcome of treatment, Reichmann distinguishes bringing the sufferer to the possibility of finding sources of satisfaction and security in life on his own. Schizophrenia is a personality status with individual life forms in her psychoanalytic understanding. The clinician assists the patient in constructing a new, more worthy way of being, without necessarily aspiring to the field of the health norm. The degree of cooperation between the analyst and the person with schizophrenia is important, highlighting the presence of a genuine desire on the part of some sufferers to feel well, suggesting a certain insight.

The Scottish psychiatrist and therapist **Ronald Laing**, renowned for his humanistic approach and unique way of interpreting the problems of mental suffering (in particular the experience of psychosis), conducted in-depth psychological studies of the families of patients (because of their, in his view, primary importance in the emergence of psychotic illness), and from these he was able to draw the controversial conclusion that no patient becomes psychotic per se. His ingenious treatment of the schizophrenic (Laing, 1965) goes beyond the dimensions of

psychodynamic psychiatry, treating him as a "product hatched from a psychotic family" who chooses escape into the self over the inability to function in complex and confused relationships with loved ones. The patient's personality does not seem to have been given the opportunity for a complete unfolding of itself. In the background of each psychosis, going back to the period of earliest childhood, the researcher found a marked deficit of acceptance and affirmation in the mother-child relationship. This psychogenic explanation is a contingent opposition to major figures such as Bleuler and Kraepelin (unfolding the biological etiological premises), opening space for scientific divergences – Anti-Psychopathology and existential philosophy. Laing does concede that some "somatic triggering" is possible with respect to the onset of the mental illness, but the main causes lie in psychotraumatic events during the socialization period at a very young age. Beyond rational science is his romantic-literary definition of schizophrenia as "a broken heart" (strongly influenced by existential phenomenology, to which it turns to characterize the nature of human experience of the surrounding world and of the self). As a divergent scholar, Laing finds that in the schizoid type of person, one can quite clearly see the avoidance of contact when confronted with real life, as well as the lack of authenticity (the destroyed relationship with the self) – a life project filled only with fear and despair. Such a sufferer does not experience himself as a complete person, but rather as "split" in various ways (perhaps as a mind that is more or less connected to the body, even as "two selves"). Ronald Laing put a twist on then-prevailing notions of madness, considering his patients to be playing a role that was almost impossible for them, even though to the others they were doing a decent job of adjusting to life's conditions. There is a "phantom existence" until a triggering factor occurs, through which we witness the breakdown in the patient's overall personality. Laing attributes the sufferers' increased self-awareness, introspection and self-reflection to the sufferers' lack of connection to the world.

With his theory and practice, the author introduces the battle with classical psychiatry (claiming that it could serve as a brainwashing technique, correcting personal behavior even through torture) because of his pieties towards existentialism. Laing belongs to the eminent representatives of so-called "Anti-psychiatry", which explains the excessive extremity and provocativeness of his ideas. Laing's contribution to elucidating the existential nature of madness and the process of going mad in their social context is undeniable.

The influential German psychoanalyst and a collaborator of Sigmund Freud – **Karl Abraham** also emphasizes the subject's troubled relationship with the others in a psycho-dynamic plan. Outlining its conceptual field, the author develops the idea of the psychotic as someone who has connected with the disorder – so they are no longer themselves – but their disorder. In his first publications with psychoanalytic orientation, Abraham, however, offers a completely different perspective on the problem, going too far in his assumptions about the role of childhood sexual abuse as a predisposition for the development of dementia praecox (still adhering to a large part of what Kraepelin had already described). According to the author, such abuse is common in the early memories of neurotics and psychotics seeking professional help at the clinic in Zurich. Freud later abandoned this hypothesis, himself confirming that in a large number of cases, it was not about real traumatic experiences, but about

fantasies of patients. Having later become Bleuler`s assistant, Abraham revised his views and advocated the psychiatric formulation "splitting of the ego", naming the main symptoms of this type of suffering – paradoxicality and peculiarity (which later in the development of psychoanalysis and phenomenology is expanded to the concept of "eccentricity" in the works of Binswanger, for example). The patient`s consciousness is clouded, memory functions are severely impaired, actions are often meaningless and behavior could be dangerous. These actions are marked by ataraxia, which for Abraham is a kind of imperturbability in the performance of sometimes cruel acts against oneself and others (Abraham, 2018). Although Abraham`s practice is more focused on depression as a clinical problem, his undeniable scientific discovery of the withdrawal of libido inward became the basis for the psychoanalytic position regarding psychotic suffering. With his final understanding of the disease, he remains faithful to his teacher Sigmund Freud, referring to psychosis as "Narcissistic neurosis". The affected person`s relationship with their surroundings is disrupted: patients can no longer love the world, and the ego is pathologically exaggerated, resembling megalomania (due to the mentioned disorders in the sphere of libidinal psychic energy, which is now mainly redirected to the ego, thus causing an imbalance due to the minimal amount of energy left towards society). Libido has detached from its objects, simultaneously redirecting and returning to the subject, resulting in "emotional impoverishment". The German analyst adheres to the belief that the psychotic reconstructs his delusional and hallucinatory world into reality. Such a reconstruction of misdirection or inadequate discharge of libido manifests as e delusional production in terms of mental functions.

The anthropocentric theory developed by Swiss psychiatrist and psychotherapist **Ludwig Binswanger** is no less colorful. The author delves into the idea of eccentricity as the fragile core of every person experiencing some deep mental suffering. For him, it creates a unique barrier between the person and the reality around them. The mannerism in the expression and behavior of patients distances them from meaningful communication with others, seems greatly exaggerated and makes them unattractive and undesirable for qualitative communication. In line with Bleuler`s traditional psychiatry, Binswanger defines mannered behavior (a peculiar gait, atypical greeting on a new acquaintance or meeting, inept dialogue, excessive eating) as a compensatory manifestation of weakness, insecurity, fear and low self-esteem (Basso, 2012). It seems to validate the difficulty of a normal reaction of the individual in ordinary, everyday and purely human activities (almost to the point of impossibility). Using brightly colored behavior (delusional), the patient seems to symbolically increase his importance in front of others and distances himself from the mass, with its gray and boring world of social "normality". The bold talk of a primordial "madness" in the schizophrenics observed by Binswanger (whose emergence he explains by the lack of love in the life story of each of them), again refers us to the Lacanian worldview, with its typical conceptual apparatus. From the early childhood of the schizophrenic person, in a purely biographical sense (according to Binswanger), the absolute emptiness of their existence can be traced. Their mothers (the psychogenetic term is "schizophrenogenic mothers") replace affection in interactions with their children with excessive care, which increases narcissism, transforming it into an almost megalomaniacal feeling.

Such a phenomenological scientific perspectivism, emphasizing the need for intensive psychotherapeutic work with patients, broadens the scientific horizons to a mirror between psychotic and neurotic suffering (especially in that part that insists on the search for "meaning" in the symptoms, for the discovery of their origin and purpose in the patient`s life) despite their enormous diversity. Psychosis (like neurosis) could be traumatic (a consequence of an event that is impossible for mental processing, which "marks" the patient), even senile, and why not postpartum (neonatal).

Discussion

We posit that the primary ethical imperative in the theoretical modeling of psychosis is the mitigation of *epistemic injustice*. As defined by Fricker (2007), this injustice occurs when a speaker receives a credibility deficit due to identity prejudice. The psychotic subject, labeled as "mad" or "insane," is the ultimate victim of such injustice; their speech is recognized only as symptomatology, never as testimony. The theoretical models of Lacan (who viewed the psychotic as a "martyr of the unconscious") and Fromm-Reichmann (who sought the "meaning" in the bizarre) are not merely clinical tools but ethical instruments. They restore the *hermeneutical* standing of the patient, allowing the "mad" discourse to be heard as a desperate communication rather than a biological glitch.

The broad range of causes for psychotic suffering, its progression, crucial prerequisites for a better prognosis, and treatment issues proposed in this theoretical review could become the foundations of a comprehensive clinical program oriented toward practical benefits for the afflicted. Questions of the authors' scientific future are the impact of remissions in therapy, the search for and enumeration of all possible factors determining the suffering, and catamnesis follow-ups of patients that offer the possibility of studying their functioning in conditions of deinstitutionalization. Conclusions aimed at improving ethical principles in practice, drawn from the findings of major scholars (psychiatrists and psychoanalysts) could serve as a conceptual core in the planned program aimed at clinical psychologists, health consultants and social workers. An integral component of the program's architectonics would be the ethical one, and its centerpiece - case studies. We are not referring to a pre-programmed matrix here, but to encourage and arouse professional interest in schematizing therapeutic efforts and outlining a broad field for seeking characteristics and methods of intervention applicable to the problems of clinical practice. The search for the most resilient part of the individual, hardly susceptible to disease changes, and the patient's grounding in reality through therapy (rehabilitation of psychoanalytic techniques) are only a fraction of the possible working model. The proposed guidelines would be aimed at provoking dialectical thinking in therapists - to discover the complex and contradictory nature of the phenomena, and to subordinate their practical views to the ethical imperative derived as a conglomerate from the postulates described above.

Conclusion

The authors of the current text take the liberty to formulate the idea of "anchoring the meaning" - the effective participation of professionals in encouraging the desire for growth in patients, the formation of additional strengths and resources in them, as well as their deployment in the future, in order to register improvements in the psychotic state, we should not only look at the pathology, but at the hypothetical set of components of the future program with its specific parameters - time, space, full acceptance of the patient, intellectual mobilization of the professional - all of this in pursuit of a complete comprehension and reconciliation of the fragmented soul. We can think of no surer predictors of a good outcome from the implementation of the programme than the empathy, commitment and compassion of psychiatrists and psychologists. It is those working in this humanistic field who must address the problem of accepting otherness, using patients' existing strengths, and encouraging them to partner with others.

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