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Introduction

DSM and ICD diagnostic classifications (American Psychiatric Association [APA], 2003; Organización Mundial de la Salud [OMS], 2003) require review in light of approaches aiming for a greater understanding of the processes involved in schizophrenia (from the patients' viewpoint) and that make it possible to explain aspects that remain unclear with regard to the trustworthiness of the diagnosis (Kendler, 2008).

These manuals spring from explanatory systems based on diagnostic categories according to a description of the apparent symptomatology, in which the assessment of subjective experience is basically excluded. However, patients' accounts of their own anomalous experiences seem essential for diagnostic accuracy and therapeutic purposes (Fuchs, 2010a).

Diagnosis, in the terms currently proposed, consists in a comprehensive approach to the overall functioning, both mental and bodily, of the person seeking help, encompassing not only symptomatic aspects, but also his or her healthy potential, in addition to the life context. In this way, it seems appropriate to use methods that attempt at developing a "person-centred" approach to diagnosis by employing a more comprehensive and holistic assessment of the patients' condition (Mezzich, 2007).

Simply put, the subject of the study must be the person as a whole. This implies not only an in-depth review of the methodologies underlying traditional "objectivising" diagnostic conceptualisations of mental illnesses, but also a need to develop methodologies for the holistic study of patients, without losing sight of their corporality, complexity and uniqueness (Kendler, 2008).

From this viewpoint, the use qualitative methodologies for the study of schizophrenia and psychosis seem highly appropriate. These are just the clinical pictures that have not been sufficiently tackled from non-objectivising approaches, and there is thus a significant lack of understanding of these phenomena beyond their apparent symptomatology.

Actually, in many cases, it is difficult to confirm a diagnosis of schizophrenia until well into hospitalisation, or even until the illness is advanced. So, by broadening the scope of exploration of the patients' experience to areas not taken into account in the DSM and ICD classifications (APA, 2003; OMS, 2003), new descriptive elements are contributed that could potentially provide clarification for diagnosis.

The dissertation entitled "Study of disorders of the pre-reflexive self and of the narratives of first admitted patients with schizophrenia" is a qualitative study of schizophrenia, particularly phenomenological and hermeneutic, with patients during their first psychiatric hospitalisation. In over-all terms, the study was guided by the research question: *How do patients order, explain, give sense to and make coherent their own experience during the psychotic phase and prodromal stages of schizophrenia, and in the narration of their life stories?*

This dissertation is based on three scientific publications, which considered the following topics:

(1) *Psychotherapeutic implications of self-disorders in schizophrenia*. This paper will provide the definitions of and conceptual distinctions among terms that have emerged from embodied and embedded approaches to the self and its disorders. First, it will offer the distinctions regarding conceptual definitions of disembodiment and hyperreflexivity to differentiate these from other psychopathological configurations and normal conditions. Second, it will present disturbances of the self that arise in the consensual processes of establishing intersubjectivity and manifest themselves in narratives. Third, the paper will present the principles of possible psychotherapeutic interventions for persons with schizophrenia.

(2) *The lived body in schizophrenia: Transition from basic self-disorders to full-blown psychosis.* This paper provides the results of a phenomenological study of patients with schizophrenia during their first psychiatric hospitalization. First, the paper offers a description of the patients' "disembodiment" manifested in acute phases of schizophrenia. Second, it presents a description of the subjective anomalies that may be considered as disorders of "ipseity" or of pre-reflexive self-awareness. Third, the description is extended to encompass secondary disturbances to processes of establishing consensual intersubjectivity that lead to difficulties in shared communication practices and a progressive withdrawal from the intersubjective world.

(3) *The life-world in schizophrenia: Life story analysis of three cases*. The processes involved in schizophrenia are approached from a viewpoint of understanding, revealing those social elements susceptible to integration for psychotherapeutic purposes, as a complement to the medical-psychiatric focus. Firstly, the paper describes the patients' disturbances of self-experience and body alienations manifested in acute phases of schizophrenia. Secondly, the paper examines the patients' personal biographical milestones and consequently the acute episode is contextualized within the intersubjective scenario in which it manifested itself in each case. Thirdly, the patients' life stories are analyzed from a clinical psychological perspective, meaningfully connecting symptoms and life-world.

This dissertation aims at:

First, to clarify aspects related to the diagnosis of schizophrenia[1] and to reach a greater understanding of the illness, with a view to contribute to prevention and psychotherapeutic intervention models that can help patients, and thus promote efficient use of public healthcare resources[2]. This is the hope of, and at the same time the justification for, including this study within the field of phenomenological psychopathology.

[1] In Chile, the prevalence of schizophrenia is 1.4 to 4.6 persons per one thousand inhabitants, being the incidence of 12 new cases per one hundred thousand inhabitants each year (Ministerio de Salud [Chilean Ministry of Health] (Minsal), 2009).

[2] Schizophrenia is an illness included in Chile's Public Mental Health Programme in 2005. Treatment cover is provided from diagnosis of the first episode and uses as its diagnostic guidelines the World Health Organisation's Classification of Mental and Behavioural Disorders (ICD-10) (Minsal, 2009).

Second, the study aims to make a contribution to psychotherapeutic approaches that focus on furthering the patients' self-understanding and on establishing a common communicative basis of patient and therapist. Concerning the latter aim, the combination of psychopathological and narrative interviews regarding self-experience, self-disorders phenomena and patients' life stories promises interesting results to improve psychotherapeutic interventions for persons with schizophrenia spectrum disorders[3].

[3] Clinical guidelines (Minsal, 2009) recommend that the treatment should include the following four components: comprehensive assessment, psychosocial interventions, pharmacological treatment and support services. Art-therapy and cognitive-behavioral therapy, as well as family psycho-educational interventions, are also recommended at any phase of the illness. However, the guidelines do not provide further information regarding the specific procedures of the therapeutic interventions.

1. Psychotherapeutic implications of self disorders in schizophrenia

The ways terms are defined have a significant impact on psychotherapeutic theory, research, and practice. This paper will provide the definitions of and conceptual distinctions among terms that have emerged from embodied and embedded approaches to the self and its disorders. First, it will offer the distinctions regarding conceptual definitions of disembodiment and hyperreflexivity to differentiate these from other psychopathological configurations and normal conditions. Second, it will present disturbances of the self that arise in the consensual processes of establishing intersubjectivity and manifest themselves in narratives. Third, the paper will present the principles of possible psychotherapeutic interventions for persons with schizophrenia. The conclusion states that both ontological (structural) as well as ontogenetic (autobiographical) aspects should be considered in the hermeneutic process of understanding patients. Content should be a significant element of this latter analysis.

Keywords: phenomenology, schizophrenia, hyperreflexivity, disembodiment, psychotherapy

1.1. Introduction

Given that all knowledge involves the knower in a way that is personal, inseparable from the body, from language and from social history, it is especially interesting to understand our way of “being in the world”, and of perceiving our reality and ourselves. This gives rise to the questions of what human experience is like and how our particular way of being human, of enacting (or bringing forth) a world is (Varela, 1990).

Research into consciousness has breached the limits of scientific methodology by stressing the way that its subjective nature is an essential and inherent aspect—the “what is it like?” element (Nagel, 1974). From a nonrepresentational approach emphasis is placed on the sense-making capacities of individuals interacting with the world: far from being an objective representation of a given reality, the world emerges through a history of interactions (Varela, 1990; Varela, Thompson & Rosch, 1991; Maturana & Varela, 1996).

Psychotherapists are in the privileged position to gain access to the direct experiences of others. Psychotherapy, starting from a subjective view of psychopathology and using diverse practices for self-reflection, promotes a greater level of self-knowledge and self-understanding in the person who requests psychological aid. In the therapeutic encounter an understanding of the individual experience is sought. Gadamer (1995,p. 168) notes: “understanding another is, in reality, a difficult art and, what is more, a human task”.

With therapeutic guidance consciousness and reflexion can become tools for overcoming pathogenic behavioural and relational patterns since these must first be made explicit in therapy to be changed. Fuchs (2010a) indicates that a mindful, nonevaluative, noninterventional observation of one’s own experience leads eventually to a self-distancing, which enables one to bear the psychopathological

state and to change it. As such, the polarity of the explicit and the implicit that results from the personal relationship with oneself brings with it the potential for illness as well as healing. However, one key question remains: How does one drift towards one road or the other?

The ways in which terms are defined have a significant impact on psychotherapeutic theory, research, and practice. This paper provides definitions of and conceptual distinctions among the terms that have emerged from embodied and embedded approaches to the self and its disorders. Conceptual analysis will progress from theoretical psychopathology to the practice of psychotherapy:

First, the paper aims to make distinctions regarding conceptual definitions of disembodiment and hyperreflexivity, ones that might (at least) allow readers to discern these unique manifestations in schizophrenia, to differentiate them from other psychopathological configurations, and to contrast them with normative conditions.

Second, I will present conceptualisations of self-disturbances that arise in the consensual processes of establishing intersubjectivity and manifest themselves in the narratives of persons with schizophrenia. The selfnarrative loses the principles of consensual coherence, and thus difficulties arise in dealing with shared communication practices and in understanding others as a secondary disturbance in the "extendend" dimension of self-experience.

Third, I will provide a conclusion regarding the principles of possible psychotherapeutic interventions for persons with schizophrenia, highlighting the relevance of ontological (structural) as well as ontogenetic (autobiographical) aspects in the hermeneutic process of understanding patients. Special consideration is given to psychotherapeutic approaches that focus upon encouraging patients' self-understanding and the establishment of a common communicative base between patient and therapist.

1.2. Disembodiment

Schizophrenia is conceived as a paradigmatic disturbance of embodiment and intersubjectivity, namely "disembodiment" (Fuchs, 2005, 2010b; Stanghellini, 2009). The primary "intercorporality," which is also the basis of common sense, is disturbed (Fuchs, 2001, 2005). Thus, disturbances in the processes of synchronisation with others (commonly generated meanings) arise and lead to difficulties in dealing with shared communication practices and in understanding others.

It is the tacit dimension (the implicit way in which our body functions) or the pre-reflective embodied self-experience that is alienated in schizophrenia. The two levels of self-experience—the implicit and the explicit— can be distinguished by the way in which the subject undergoes them: the former is pre-reflective, tacit or "proximal," whilst the latter involves the subject paying attention to or observing his self-experience in a reflective, thematic or "distal" way (Polanyi, 1967).

"Disembodiment" does not mean an actual (literal) or ontological split of mind and body, but a phenomenological distance from the central or "zero point" of orientation

of embodied self-experience (Parnas & Handest, 2003), resulting in what may be called a “disembodied mind” (Fuchs, 2005; Stanghellini, 2004).

Normally, the body functions as the very centre and medium of subjective experience, it constitutes the central point of orientation in space that permits the perceptual view of the world, whilst it is not perceived of in itself (Fuchs, 2010b). On the contrary, in schizophrenia the body loses its tacit central role and does not serve as a medium of being-in-the-world anymore.

Persons with schizophrenia are vulnerable to disturbances of the mediating processes involved in embodiment. The mediacy of the body is affected as a whole. And rather than being tacit and transparent, the body takes on layers of opacity. The body loses its familiarity, resulting in various forms of self-fragmentation and alienation: Single bodily sensations, movements, feelings, perceptions or thoughts no longer flow naturally as mediating processes of embodiment but appear as obstacles to awareness with object-like qualities (Fuchs, 2010b).

In delusions and hallucinations the emotional-affective meaning dimension of self-experience is “disembodied”, i.e. the patient regards as an external reality something that is, in fact, part of his own fragmented embodied self-experience. Fuchs (2005, 2007a) suggests that, with the progressive loss of agency, the subjective experience becomes externalised (detached from the first-person perspective) and acquires an inverted intentionality in the psychotic states.

In patients prone to delusions, the experience of vulnerability leads to the anticipation of others as dominant or humiliating (Salvatore et al., 2012a). For example, the pervasive fear experienced by patients with paranoid-type schizophrenia becomes the predominant external threat, which acquires the characteristics of a delusion. These patients have a constant fear of being harmed (or killed) by others; somehow it is the world and “the others” that have become unreliable or threatening.

Sass (2007) distinguishes patients with paranoid type of schizophrenia because affective flattening appears less characteristic, and takes notice of the contradictory qualities of affectivity that are manifested among the schizophrenic spectrum. On occasions, patients may even experience both flattening and a certain exaggeration in affective responses (e.g the “Kretschmerian paradox” [Sass, 2007, p. 351]). Thus patients with schizophrenia are heterogeneous with respect to many aspects of affective experience and expression.

Delusions and hallucinations are not external phenomena, but rather symbolic manifestations of the patient’s emotional-affective dimension of self-experience; hence, these phenomena have no understandable sense in a public or broader social context. In psychotic states, one would metaphorically say that there is no “border” between self and others, as would normally be the case. There is a loss of the ability to distinguish between self-created meanings and those created by others, and to realize that inanimate objects cannot actually create meanings or messages (for example, self-referential messages patients discern from what they’ve heard on the radio, watched on television, or read in the newspapers). It could also be noted that there is a pervasive and unnoticed self-referentiality of experience in these cases.

1.3. Hyperreflexivity

Literature is sprinkled with a wide variety of terms that have become grouped together as synonyms of hyperreflexivity. These include selfconsciousness, rumination, metacognition, and even self-focused attention or mindfulness (Pe´rez-A´ lvarez, 2008). However, it seems suspicious not only that these conditions accompany different psychopathological phenomena, but also that the same conditions may be beneficial to individuals (e.g. mindfulness). And any excess involves a degree of instability, thus it is clear that being "hyper" does not necessarily indicate a characteristic condition for a specific pathology.

"Hyperreflexivity" has been posited as a structural aspect in the psychopathological configuration of schizophrenia: a disorder of ipseity or pre-reflective self awareness (Sass, 1992; Sass & Parnas, 2003; Parnas & Handest, 2003; Parnas & Sass, 2008; Parnas et al., 2005; Raballo, Sæbye, & Parnas, 2009; Fuchs, 2010a). Ipseity, which derives from ipse, Latin for self or itself, refers to a crucial sense of self-sameness and of existing as a subject of experience that is normally implicit in each act of awareness. The central phenomenom of the schizophrenia spectrum disorders is a disturbance of the very "mineness" or first-person perspective that characterizes any experience (Sass, Parnas & Zahavi, 2011).

Sass, Parnas, and Zahavi (2011) have recently made clear that hyperreflexivity is not, at its core, an intellectual, volitional, or reflective kind of self-consciousness. The authors explain that it occurs in an automatic fashion and has the effect of disrupting awareness and action by means of an automatic "popping up" or "popping out" of phenomena and processes that would normally remain in the background of awareness. Nevertheless, it seems important to provide further distinctions for the term, ones that might (at least) allow us to differentiate them from other psychopathological configurations when compared to a normal process of reflexivity—like that which can occur in psychotherapy—and in contrast to normal forms of observing our own experience.

Reflectivity implies a stance towards one's self within an articulation of the subjective experience (similar to that which takes place in a psychotherapeutic context). In this way, the reflecting subject gets "closer" to his subjective experience. On the contrary, the person with schizophrenia, instead of articulating implicit processes, views his own subjective experience as something concrete and takes an external observational point of view, objectivizing the experience. Self-observation (from the external point of view) makes the individual a mere "spectator", of his experience, which then loses its first-person mode of presentation that is "from within" (Parnas et al., 2005).

It is possible to argue that no reflectivity takes place in the initial states of perplexity (the realization that "something is going wrong") or confusion about meanings, as often occurs in the preliminary states of psychosis. This self-objectification leads neither to self-regulation nor to self-understanding (as reflectivity would certainly do) but to distress and to anxious feelings of depersonalisation until the psychotic breakdown occurs. This process of objectification finally results in pathological attributions or "explications" of the implicit (Fuchs, 2001).

Brief mention should be made of what is meant by mindfulness to illustrate normal forms of observing our own experience. Traditionally, this mediation process involves two complementary aspects: that of being fully present and focusing attention on direct experience from moment to moment (shamatha), and that of being conscious of the constructions of meaning involved in our experience (vipashyana) (Trungpa, 1991, 1997). This is a method for self-observation that consists in deliberately fixing the gaze on an external point; as a consequence, the embodied experience that arises in the present moment becomes explicit in one's mind.

Various psychotherapeutic models based on mindfulness have been developed. These usually consider mindfulness as a component of manualized clinical interventions (Kabat-Zinn, 1982, 1990, 2003; Linehan, 1993; Teasdale et al., 2000; Segal, Williams, & Teasdale, 2002). Outside of the clinical sphere, this practice is broadly regarded as a path for spiritual development, self-knowledge and personal growth as in the so-called "contemplative therapies" (Wegela, 1988; Thich Nhat Hanh, 1990; Guzmán & Hast, 2008). Chögyam Trungpa (1998) notes that the constant practice of paying attention (being fully present) involves acquiring a global, broad awareness: It allows one to gain a meta-perspective or panoramic vision of being in the world.

When a person practises mindfulness he positions himself as an observer of his own direct experience, paying nonevaluative attention, which implies no reflection at all. Normally, when one deliberately observes one's experience, it appears as separated, discrete content or episodes, although it retains a sense of continuity as "being mine". It is just this tacit sense of continuity of experience, (in Husserl's terminology) "implicit synthesis" of inner time consciousness, which is lost in schizophrenia (Fuchs, 2010b, 2010c). Since this implicit synthesis is necessary to form meaningful patterns (or Gestalten), the patient's subjective experience will appear not only disintegrated or fragmented, but meaningless as a whole.

Therefore, hyperreflexion relates to a circuit of self-observation that is not reflective, but rather is a process of self-observation (monitoring) and paying attention to one's self in an automatic manner. The subject's experience becomes a pervasive object of attention from an external perspective, losing its first-person mode of presentation. The self-experience becomes explicit with an unfamiliar "object-like" quality. From this viewpoint, hyperreflexivity could be better understood as a "hyper-objectification" or self-objectification.

What in this context has been called disembodiment and hyperreflexivity— in the two forms of conceptualisation mentioned above—might together be defined as a characteristic process of "reification", which culminates in the psychotic episode of schizophrenia (Fuchs, 2006; Hirjak & Fuchs, 2010). The word reification, which stems from the German Verdinglichung, means making an idea into a thing or separating something from the original context in which it occurs. Here, it refers to the conversion of an experience that is turned into a thing, treating that which is implicit as something tangible, as if it were a separate object, when it is not the case.

1.4. Intersubjectivity and narratives

It is important to bear in mind that humans experience our world on the basis of meaning-attributions that are derived primarily from individual levels of embodiment. On the intersubjective level, the spontaneous attribution of meanings is not naturally constructed like a theory, but emerges from a dynamic process of interaction and coordination with others. This process of "cocreation" of meaning does not imply perfect synchronisation. On the contrary, as Fuchs and De Jaegher (2009) clearly state, "it is the continuous fluctuation between synchronised, desynchronised and in-between states that drives the process forward" (p. 471). Miscommunications occur when there is a failure to appreciate the meaning of the other's emotional display and, together with the activation of pervasive patterns of disturbed interaction, constitute the conditions for the manifestation of psychopathology.

It is, to a certain extent, possible to understand the intentions of others by means of the "visibility" of intentions-in-action perceived in them. Nonverbal processes of intersubjectivity are necessary but not sufficient to trigger more complex empathic forms, which depend on the congruence of the meaning (or personal interpretation) that each individual assigns to a given situation beyond its common context. Thus in human interaction not only is language involved (with the possibility of the "art of dissimulation"), but also the accessibility to subjective experience and the hermeneutic understanding that incongruence in interaction may require is achieved by means of verbal correlates.

Taking an emotional perspective on the world is natural since we are embedded in it. The world appears through our own emotional and mental states (and meanings) so that it sometimes acquires a dangerous, threatening or desolated quality, and sometimes becomes a calm or beautiful place. The curious thing in the psychotic state of schizophrenia is that the subject views the world through his delusional framework, and also that this viewpoint is irrefutable. There is an inability to enter into an open conversation that takes the other's point of view into account, thereby shutting out the intersubjective dialectic given by the second-person perspective (Fuchs, 2013).

The loss of common sense or natural evidence, regarded as the core characteristic of schizophrenia (Blankenburg, 2001, 2013; Stanghellini, 2011), makes it difficult for the patient to have a natural and spontaneous immersion in daily life. This leads to an alteration in the cocreation of meanings with the others and an artificial, enigmatic and uncanny involvement with the environment (Fuchs, 2001). These difficulties progressively lead to a radical withdrawal from social interaction.

Therefore, self-disturbances arise in the consensual processes of establishing intersubjectivity and manifest themselves in the narratives of persons with schizophrenia. The self-narrative loses the principles of consensual coherence, thus difficulties arise in dealing with shared communication practices and in understanding others. In acute psychosis, the self-narrative manifests itself with a collapse of the temporal dimension of the narrative plot; this leads to a decontextualisation of the patient's self-experience (Holma & Aaltonen, 1995, 2004a). Apart from these manifestations of incoherence, it is important to notice that something is not being

explained coherently (or being explained at all), something remains ineffable for the subject.

It is worth highlighting the creative process of the psychotic episode. Self-narrative as a creative resource makes it possible to construct a “fantastic” world, making use of a range of symbolic elements that are consistent with the meanings of the patient’s personal world. Nevertheless, they appear strange and incomprehensible to outside observers. From this perspective, the contributions of Sass are interesting in that they highlight the creative potential of persons diagnosed with schizophrenia and provide an alternative to the usual emphasis that characterizes schizophrenia in purely negative terms (Sass, 2000–2001, 2001).

Up to this point the disturbance of self-experience in schizophrenia has been referred not only as the structural phenomena of ipseity or prereflective self-awareness, but also as to the alteration in the processes of explicit consciousness (the so-called extended, reflective or narrative self [Fuchs, 2010b, 2010c]) as a secondary disturbance in the consensual processes of constituting coherence and establishing intersubjectivity.

1.5. Psychotherapy

In a psychotherapeutic context, reflectivity generally takes place through the active reconstruction of the affective imbalance on an explicit level of self-understanding. In this context the psychotherapist accompanies the patient, and assumes a second-person perspective, being fully present “here and now” in the interaction. Intercorporality (as the sphere of non-verbal, bodily and atmospheric interaction) is essential in the development of the therapeutic relationship (Fuchs, 2007b).

Moving the focus of therapy towards understanding the patient’s self-experience (the implicit) and his continuous interaction with others is the key to clarifying how to improve and recover his psychological wellbeing. Gradually, the patient extends the focus of attention towards diverse areas of his life that seem relevant to expand upon, and he makes his way back to daily life. Gadamer (2001) states that the final aim of psychotherapy would be to obtain not only symptomatic recovery, but also the recovery of the patient’s sense of unity with himself when rebuilding his capacity of doing and being.

The task of contextualizing the imbalance in the spatiotemporal dimension of the personal history (life story) allows us to take a step back from the immediate experience through the coconstruction of consensual narratives, which facilitate its understanding from a broader perspective. Understanding the person’s relational space and its meanings, his way of life or style of existence, should be oriented to enhance the unity (continuity) of personal identity.

It seems important here to point out that psychotherapies belonging to the nonrepresentationalist paradigm not only support the “primacy of emotion”, but also that the analysis of negative emotions is fundamental (Hersh, 2003). This conceptualisation implies that all human experience is meaningful, thus it is organized and interpreted precisely in terms of those meanings. Also, new meanings

are being created (or are emerging) permanently through new and ongoing situational, perspectival, and contextualized interactions.

From a narrative perspective, noteworthy is the importance of patient being led towards a dialogue, taking into account the story he tells of himself, where his personal experience is explicitly shared on the basis of a common meaning (Holma & Aaltonen, 1997, 2004a, 2004b; Seikkula & Olson, 2003; Seikkula et al., 2006). Interventions for persons with schizophrenia hold that the therapeutic ingredient arises from the effect of an "open dialogue" on the patient's immediate social network, and emphasise immediate attention in the cases of acute psychosis before it becomes chronic (Seikkula & Olson, 2003; Seikkula et al., 2006). In this way, thematic articulation of the clinical forms of psychosis, expressed as narrative creations of the patient's own subjectivity (and meanings), allows for its reappropriation and for the understanding of the psychotic process (Guidano, 1999; Irarrázaval, 2003).

Psychotherapy focused on metacognition promotes a range of activities to develop the capacity for self-reflectivity or "thinking about thinking" (Lysaker et al., 2011a, 2011b, 2011c; Salvatore et al., 2012a; Salvatore et al., 2012b). This orientation has been suggested as a model for the treatment of persons with schizophrenia by assisting them to develop metacognitive capacities (Lysaker et al., 2011a). Patient!s narrativity should improve along different levels of articulation by the recognition of beliefs, the incorporation of emotions, and the reconstruction of different meaningful life events. The therapist should promote the capacity for self-consciousness so that the patient is able to accept feeling uncertain and then to think flexibly about different beliefs that he holds, including delusional beliefs (Salvatore et al., 2012b). However, delusional beliefs constitute the patient's only available form of cognitive and interpersonal organization, so instead of confronting them, the therapist should focus on the difficulty in pragmatically comprehending others and on the experience of vulnerability (Salvatore et al., 2012a).

The second-person perspective, or offering the "I-You" encounter between patient and psychotherapist, has been suggested by Stanghellini and Lysaker (2007) as a crucial step in recovering a sense of subjectivity (first-person perspective) in the patient's relationships with others. The principles of the phenomenological approach to psychotherapy for persons with schizophrenia highlight the dialogic process of co-creation of meaning beyond the mere "normalization" of the patient's experiences and beliefs.

Empathic understanding, the basis for every psychotherapeutic encounter, is certainly fundamental in treating persons with schizophrenia as well. So, taking phenomenology as a framework, other implications that might be considered can be summarized as follows:

1) The main task of psychotherapy is to understand how the patient experiences his world in the sense of the all-embracing framework of meaning in which he is embedded: Who is this person beyond the schizophrenic condition?
2) Reflectivity takes place through the active reconstruction of disturbing interactions to understand how the process of synchronisation with others has been interrupted and to actively create possibilities of restoring it. The patient's experience is explicitly shared on the basis of a common meaning with the psychotherapist

through a dialogical process that takes the other's point of view into account (second-person perspective). In this way, the dimension of consensual intersubjectivity can be re-established, bringing back understandability.

3) Diagnosis of schizophrenia can be sometimes recognized in an intuitive way by clinicians, the "praecox-feeling" (Ru¨ mke, 1990; Parnas, 2011), based on particular difficulties in establishing contact with the patient (affective attunement with the person as a whole). The therapist must be aware of his own embodied experience not only to recognize his owns "intuitions," but also to help the patient restore reciprocity or affective attunement, which is basic for the development of a sense of one's self and for the synchronization with others.
4) It is important to facilitate the realization of the personal perspectives that the patient is taking, from an external attribution to the embodied self experience, i.e. integrating and articulating narratives from "within". For instance, it would be important to explore in the intersubjective context experiences such as the sense of personal value, experiences of loss, separation or rejection, sense of vulnerability, powerless or lack of protection, uncertainty, lack of control, failure, etc. In addition to helping the patient to integrate emotional aspects of his own experience, the therapist should gradually promote the realisation of the overall interpersonal situation affecting him.
5) The spatiotemporal dimension of the personal history allows understandability from a broader perspective, shaping the "concept of the person" himself against the backdrop of his significant interactions. With especial regard to the psychotic state, the patient's personal history could open up a path for the potential understanding of the symbolic elements in the light of significant interactions. It would also help the patient to visualize the self/others or self/environment "border", thus reinforcing his sense of autonomy.
6) Taking into account the story the patient tells of himself improves the articulation of self-narrative. It gradually extends towards diverse areas of his life whose elaboration appears important for him to make his way back to daily life. It is important to articulate the present on the basis of self-experience that takes place in the actual interpersonal context and from there to articulate the future as a horizon of possibilities.

1.6. Conclusion

Human experience emerges from a series of complex interpersonal interactions. These interactions constitute the conditions for the experience to manifest itself: the same is the case for the configuration of schizophrenic symptoms. The disturbance of the natural interrelation between the dialectical processes of the implicit and the explicit manifests itself as a loss of self-coherence or common sense in different domains of intersubjectivity. Thus, disturbances in schizophrenia concern both levels of the self:

1) a disorder of the *ipseity* or pre-reflective self awareness (core or basic self), a primary interruption in the continuity of the natural flow of the first-person givenness of experience, and
2) a disorder of the extended, reflective or narrative self, a secondary disturbance in the consensual processes of constituting coherence and establishing intersubjectivity.

Therefore, both ontological (structural) as well as ontogenetic (autobiographical) aspects should be considered in the hermeneutic process of understanding patients. Content should be a significant element of this latter analysis.

Major disturbances in the processes of synchronisation with others, interactional perspectives, and difficulties in dealing with consensual principles of understandability, would appear to be important variables to consider in the sympomatological description of schizophrenic spectrum disorders. The functionality or secondary gain associated with the symptoms is not clear: this might be revealed by means of a comprehensive analysis of the patient's personal history. Rather than carrying out decontextualized interpretations of the symptomatology, it is more important to specify the conditions of the interpersonal context that are the basis of the symptomatological manifestations, i.e. to contextualise the experience in the interpersonal scenario in which it manifests itself.

Conceptualisations established in isolation from direct experience and made on a theoretical level can give rise to confusion. Psychopathological descriptions on this theoretical level are more consistent with the "literary plot" of a patient's "supposed" experience than with what actually the patient subjectively experiences. This is why it is important for researchers in this field to incorporate the patients' first person accounts as valid sources of knowledge: It is the closest we can come to understanding the anomalous self-experience, and from there we may begin to theorise about it.

If we claim that an essential aspect in schizophrenia is the problem with intersubjectivity, then accounting for the patient's life history seems fundamental. Additionally, an autobiographical approach comes from the interest in recovering the concept of the "person". If there is agreement in considering that the main subject of psychiatry and clinical psychology is the person in its entirety (Mezzich, 2007), and that he or she is the bearer of a history and the creator of the plot of a particular existence, then the importance of life stories in approaching psychological phenomena is well-founded.

Special consideration should be given to psychotherapeutic approaches that focus upon encouraging patients' self-understanding and the establishment of a common communicative base between patient and therapist. What is more, if the loss of common sense is regarded as the core ontological characteristic of schizophrenia, then it is sensible to state that recovering understandability would be a key aspect in overcoming alienation. The world is an enigma for persons with schizophrenia, much as those with schizophrenia remain an enigma for psychiatry: This is certainly a great challenge for a possible "fusion of horizons" (Gadamer, 2003) in the field of phenomenological psychotherapy.

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2. The lived body in schizophrenia: Transition from basic self-disorders to full-blown psychosis

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This paper provides the results of a phenomenological study of patients with schizophrenia during their first psychiatric hospitalization. The study aims at clarify aspects related to the diagnosis of schizophrenia and to reach a greater understanding of the illness, with a view to contribute to prevention and psychotherapeutic intervention models. First, the paper offers a description of the patients' "disembodiment" manifested in acute phases of schizophrenia. Second, it presents a description of the subjective anomalies that may be considered as disorders of "ipseity" or of pre-reflexive self-awareness. Third, the description is extended to encompass secondary disturbances to processes of establishing consensual intersubjectivity that lead to difficulties in shared communication practices and a progressive withdrawal from the intersubjective world. The conclusion states that a structural element, a key part of the personal processes involved in schizophrenia, is the diminishment of self-presence in experience, which manifests on both individual and social levels.

Keywords: schizophrenia, phenomenology, embodiment, self-disorder, intersubjectivity

2.1. Introduction

Traditionally, in the field of phenomenological psychopathology disorders of the self have been stressed as the essential clinical characteristics of schizophrenia. One hundred years ago, Jaspers was already describing them among the dimensions of self-awareness (1). Nevertheless, only in recent years has their importance been widely recognized, probably due to the increasingly significant focus on the early detection and prevention of psychosis (2). Neither there has been any great interest in this field in explaining nor understanding how disorders of the self are manifested on the social level. Again, it is only recently that hallucinations have begun to be considered as elements worthy of research in phenomenological approaches to intersubjectivity (3, 4).

Within the framework of contemporary psychopathological phenomenology, schizophrenia has been regarded as a paradigmatic disturbance of embodiment and intersubjectivity (5–12). It can be argued that its disorders are mainly manifested on two levels (13): (1) a disorder of "ipseity" or of pre-reflexive self-awareness that manifests as a diminishment of the first-person perspective tacitly given in experience, and (2) a secondary disturbance in the consensual processes of intersubjectivity, leading to difficulties in shared communication practices and in finding a place for oneself in the social world.

This paper provides the results of a phenomenological study of patients with schizophrenia during their first psychiatric hospitalization. First, it provides a description of patients' "disembodiment" manifested in acute phases of schizophrenia. Second, it presents a description of the subjective anomalies most commonly experienced by these patients that may be considered as disorders of "ipseity" or of pre-reflexive self-awareness. Third, the description is extended to encompass secondary disturbances to processes of establishing consensual intersubjectivity that lead to difficulties in shared communication practices and a progressive withdrawal from the intersubjective world.

The study aims at clarify aspects related to the diagnosis of schizophrenia and to reach a greater understanding of the illness, with a view to contribute to prevention and psychotherapeutic intervention models. From this viewpoint, it seems appropriate to use methods that attempt to characterize not only the patients' symptomatic disturbances manifested in acute phases of schizophrenia but also the anomalous self-experiences, which precede the onset of positive symptoms, thus broadening the scope of exploration to areas not taken into account in the criteriological manuals of diagnostic systems diagnostic statistical manual of mental disorders (DSM) and international classification of diseases (ICD) (14).

The manuscript is focused on the description of the subjective phenomena manifested among patients in different phases during their first psychiatric hospitalization, taking illustrative examples of three cases corresponding to a variety of schizophrenia subtypes. Cases 1, 2, and 3, as they appear in the paper, correspond to patients with diagnoses of disorganized-type, paranoid-type, and catatonic-type schizophrenia, respectively.

2.2. Materials and methods

2.2.1. Study Design

The study was developed within the qualitative paradigm, it being an explorative–descriptive type of study. This type of studies proceeds with inductive logic: in other words, both hypotheses and analysis categories are developed as the study progresses, and emerge from the data itself [Danhke, 1989 quoted in Ref. (15)].

The so-called "critical case sampling" criteria was used, where the interest in an in-depth approach to the phenomena means working with few cases, with representativeness not being of key importance for these purposes. An in-depth approach allows to access to the essential aspects of the personal experience, aiming at a greater understanding of the phenomena under research (16–18).

Data gathering were performed by means of semi-structured interviews, which are characterized by the use of eminently "open" research questions. Less structured methods allow for the emergence of ideographic descriptions, personal beliefs, and meanings, focusing on "how" the psychological processes occur (19).
The study proceeded with caution to avoid the bias commonly seen as a threat to the validity of qualitative data (20–22) (see Procedures and Analysis). All the interviews were recorded on video and fully transcribed for subsequent analysis. Extracts of the patients' accounts were kept literally in quotes.

2.2.2. Participants

The broad study covered a total of 15 patients with schizophrenia during their first psychiatric hospitalization. All of them were males, aged between 18 and 25. At the time of the interviews, the patients were receiving the usual pharmacological treatment for the diagnosis of schizophrenia.

Additional inclusion criteria were the following: (1) accessibility to the sample, (2) homogenous sample (23), and (3) earlier first onset and higher risk of developing schizophrenia in men (24).

Illustrative examples are provided of three cases, which were selected from the broader homogenous sample due to the variety of subtypes. Cases 1, 2, and 3, as they appear in the paper, correspond to patients with diagnoses of disorganized-type, paranoid-type, and catatonic-type schizophrenia, respectively.

2.2.3. Instruments

In-depth interviews
In-depth interviews were used to gather qualitative data from the first encounter with the patients. These interviews had open questions aimed at allowing for a natural manifestation of the patients' accounts. For the first encounter, the recommendations on interviews for the phenomenological diagnosis of schizophrenia were taken into account (25).

Examination of anomalous self-experience
The examination of anomalous self-experience [EASE; (26)] is a semi-structured interview for the phenomenological examination of disorders of the pre-reflexive self, postulated as early markers or basic phenotype of the schizophrenic spectrum (27). The EASE explores a variety of anomalous self-experiences, which typically precede the onset of positive symptoms and which also often underlie negative and disorganized symptoms (2).

Positive and negative syndrome scale
The positive and negative syndrome scale [PANSS; (28)] is a rating scale used for measuring symptom severity of patients with schizophrenia. The name refers to the two types of symptoms: positive symptoms, which refers to an excess or distortion of normal functions (e.g., hallucinations and delusions), and negative symptoms, which represents a diminution or loss of normal functions.

2.2.4. Procedures and analyses

Five encounters with the patients were carried out. These encounters were coordinated throughout the three following phases.

Phase I
A first encounter to record the patients' self-experiences manifested in acute phases of schizophrenia was carried out 1–2 weeks after hospitalization (30–45 min interview), following the confirmation of the diagnosis of schizophrenia in accordance

with expert judgment and the standard diagnostic criteria of DSM-IV-R (29) and ICD-10 (30).

The patients' accounts of the disturbances of self-experience and body alienations manifested in the acute episodes were summarized in corresponding descriptions containing the essential structure of the transcripts, which were obtained with the "Descriptive Phenomenological Method in Psychology" (31), by following five steps: (1) the researcher reads the entire transcript in order to gain an overall sense, (2) the same transcript is then read more slowly, and underlined every time a transition in meaning is perceived, providing a series of units constituting meaning, (3) the researcher then eliminates redundancies and clarifies the meaning of the units, connecting them together to obtain a sense of the whole, (4) the arising units are expressed essentially in the language of the subject, revealing the essence of the situation for him, and finally, (5) there is the summarizing and integrating of the achieved understanding in a description with the essential structure of the transcript.

Phase II
Two following encounters to carry out the "EASE" (26) took place after 1 month of hospitalization (30–45 min per each interview), when patients did not score with "positive" symptomatology on the "PANSS" (28).

The EASE manual was translated into Spanish by experts in phenomenological psychopathology, and advised by professional translators. The Spanish version was evaluated by the research team of lead author Parnas, who subsequently formally authorized its publication (32).

The interviewer must pass an EASE Introductory Course, which covers the following components: (1) a 1-day theoretical seminar, (2) a number of supervised interviews, and (3) a provisional assessment of reliability. This author attended the EASE Introductory Course on September 12th to 14th, 2011, at the Mental Health Center Hvidovre, Broendby, Denmark (see www.easenet.dk).

Phase III
Finally, two further encounters were held 1–2 months after hospitalization to perform the life story interviews (30–45 min per each interview). Transcripts were analyzed by peer researchers, both clinical psychologists with a specialty in psychotherapy. To avoid bias, each researcher previously made a separate analysis and then met for the co-analysis, ensuring with this procedure the validity of the qualitative research.
Note. More broadly speaking, the study includes a section on the patients' life stories, which has been published in a complementary paper focused on analyzing the interpersonal processes involved in schizophrenia [see Ref. (33)]. Therefore, results of Phase III of the broad research have not been included in this paper.

2.3. Ethical issues

The broad research, covering 15 patients with schizophrenia during their first psychiatric hospitalization, was regarded as entailing no physical, psychological, or social risks for the subjects involved, based on the Declaration of Helsinki principles, the Council for International Organizations of Medical Sciences (CIOMS) 1992 International Ethical Guidelines for Biomedical Research Involving Human Subjects,

and the 1996 International Conference on Harmonization (ICH) Good Clinical Practice guidelines, by the following Ethics Committees: (1) Research into Human Beings Ethics Committee of the University of Chile's Medical Faculty, dated January 19, 2011. (2) Ethics Committee Research of the Psychiatric Hospital, dated August 2, 2012. (3) Ethics Committee Research of the North Metropolitan Health Service (Santiago, Chile), dated August 16, 2012.

The Ethics Committees also approved the patients' and their tutors' (legal representatives) consent documents. In this regard, the following ethical aspects were taken into account: (1) consent was informed and obtained from the patients' tutors by the attending doctor at Phase I of the study, considering that as a patient affected by an acute episode of schizophrenia, his competence or capacity is diminished and he must be authorized to participate. (2) Consent was obtained directly from the patients at Phase II of the study. (3) Pseudonyms were employed to protect the identity of the patients and ensure confidentiality (internal codes were used for each patient to replace their original names).

Note: Careful attention was paid in this paper to the protection of the patients' anonymity. Identifying information such as dates, locations, and hospital numbers was avoided.

2.4. Results

2.4.1. Disembodiment

Phenomenology has developed a distinction between lived body (Leib) and physical body (Koerper), or body subject and body object. The former is the body experienced "from within," my own immediate experience of my body tacitly given in the first-person perspective. The latter is the body thematically investigated "from without," or from a third-person perspective, for example, by natural sciences such as anatomy and physiology (12, 34).

The term "embodiment" does not refer to biological or physical aspects of the body, such as the organs or the functionality of biological systems, but rather to a dimension that could be described as existential or experience-based: the embodied subject with regard to the intersubjective world.

In this regard, the embodiment-related dimension of mental illnesses does not manifest itself as impairment at an organic or biological level, but rather as a disturbance in the experience of one's own body.

The disturbance of embodiment characteristic of schizophrenia has been called "disembodiment" (9, 10, 12). This does not literally imply a division, divorce, or separation between mind and body, but rather a "subjective distancing." The body loses its tacit central role and does not serve as a medium of one's involvement in the world any more (13).

The body loses its familiarity, resulting in various forms of body alienations. Single bodily sensations, movements, feelings, perceptions, or thoughts no longer flow

naturally as mediating processes of embodiment but appear as obstacles to awareness with object-like qualities (10).

In acute phases of schizophrenia, the mediacy of the body is affected as a whole. And rather than being tacit and transparent, the body takes on layers of opacity. The body loses its transparent quality, its tacit experience-based function, turning into an object of observation, of thinking, of concern, and thus ends up being the "thematic" of an impediment or a problem.

Examples:

Case 1. This first example is of a patient with disorganized-type schizophrenia who, although he considers himself to be a "normal" person, begins to recognize a "repetitive failure." It is primarily the mediating process of thinking that has become the main impediment for the patient.

> *The trouble I was having was heart pain, together with headaches, nothing more. I thought that it would be another sort of hospitalisation [not psychiatric]. Now, I admit that my experiences were strange: the voices I hear inside my head. These voices are as if my own voice appeared inside my head saying a lot of terrible things, really bad things, like 'evilisations' (patient's neologism). Also, other things are repeated in my head like an echo, for example, lately, 'discharge me, discharge me soon'. Most of the voices I hear repeat things I don't understand, I don't know what they mean. Also, I get the feeling that there is like a sound repeating itself in my body, in my throat, going like m, m, m, m.*

Patients with schizophrenia take an external position of self-observation, becoming a mere spectator of themselves. This tendency to take external or "disembodied" perspectives with regard to oneself is what eventually leads patients to create pathological attributions or explanations of their emotional processes or of their own bodies (8).

Case 2. The following example illustrates the "pathological" explanations configuring the delusion of a patient with paranoid-type schizophrenia. The patient has not been able to find a convincing explanation for the fear he feels, which has become his major impediment. Instead of attributing the fear to his existential processes or biographical circumstances, the patient assumes an external explanation: the biblical time of the "Tribulation."

> *I wanted to find a way to overcome the fear, but now I don't know what to think any more, what is causing this fear. I think I could be delivered over to the Tribulation –the Tribulation is a biblical time of pain, that I could be delivered over to pain. I'd like to find an answer in the Bible, what I've got to do, how to live and how to face up to the fear, and what's going to happen. However, what I've read in the Bible hasn't been enough: it doesn't show me way, the exact way I should take for the situation I think that I am experiencing. I wish that the Bible could tell me what you do in the Tribulation, if I was in that time, that it told me in light of this fear to do this or that, to face up to it, don't be afraid, I'll be with you.*

In acute phases of schizophrenia, patients' accounts concentrate on (or are limited to) their anomalous self-experiences or body alienations. In other words, patients' accounts lie outside the time-space dimension of the social context and exclude the personal history. Body alienation appears to be the way in which the desubjectivised accounts find concrete form (or are materialised).

Case 3. This example is of a patient with catatonic-type schizophrenia. The body alienations are explained as "demonic possessions," which seems to increase the patient's pathological condition.

> *Well, what happens is that I had strange things, possessions. I got like cramps back in my head, my body began to cramp up, and I began to shout, to cry and to scream like a devil. I feel that someone is possessing my body. I thought it could be a satanic influence. I don't know: I did a bit of research and the spirit gets in when someone is too depressed, when you're depressed is when the spirits get in. That makes me scared. It's something that's out there, something imminent, then it becomes pressing for me, when it begins to talk for me. I even hear a buzzing on my left side, inside my head.*

For instance, the pervasive fear experienced by paranoid patients becomes the predominant external threat that acquires the characteristics of a delusion. These patients have a constant fear of being harmed or killed by others: somehow, it is the world and "the others" that have become unreliable or threatening, as shown in the following example.

Case 2

> *About three months ago I began to feel persecuted, persecuted by people. My house was the only place I felt safe, but for a few weeks now I have even begun to feel unsafe at home. The idea that they can hurt me comes from the fear I feel and I think that the worst thing would be for them to kill me somehow, like stabbing me, for example. Anything can happen these days.*

Something curious about psychotic states is that not only do patients see the world through the framework of their delusions but also that this view is irrefutable to them. This implies a difficulty to enter into an open interaction that takes into account the viewpoint of the other person. In a way, the patient stands outside of the intersubjective dialectic provided by the second-person perspective (35), like in the next example.

Case 2

> *I found it suspicious that my workmates didn't want to have their tea where I had mine, so I thought they had put something in it, some spit maybe, or that they had poured some vinegar in it. I saw a teapot and a thermos, and if I took it out of the thermos, they took it out of the pot, and that seemed odd to me so I threw away the tea. They didn't like me, I thought, because of the way I am, not very friendly or 'chatty'. I asked my workmates if they had put anything in my tea and they said no, nothing, but I didn't believe them. The matter of food is a difficult one for me.*

Besides, in the psychotic state, it could metaphorically be said that there is “no-border” between one’s self and others, as would normally be the case. There is a loss of the ability to distinguish between self-created meanings and those created by others, and to realize, as we normally do, that inanimate objects cannot actually create meanings or messages (e.g., self-referential messages patients discern from what they have heard on the radio, watched on television, or read in the newspapers). It could also be noted that there is a pervasive and unnoticed “self-referentiality” in experience in this state.

2.4.2. Ipseity

Current psychopathological phenomenology has gained ground, emphasizing that the roots of mental illness are to be found in the patient’s pre-reflexive or pre-thematic experience (36). From this viewpoint, it is argued that schizophrenia involves a particular disturbance of basic self-awareness, more specifically a disorder of “ipseity,” normally occurring tacitly or pre-reflexively.

Ipseity (ipse is Latin for self or itself) refers to the fundamental configuration of self-awareness, corresponding to the first-person perspective tacitly given in experience (2, 37, 38). This perspective is oriented intentionally “from within” toward the world, and presupposes an immediate sense of “mineness” of the experience, as “being mine” or as “my own doing,” i.e., a quality of “personally belonging” or of “personalization” (1). The diminishment of this perspective mode of self-experience would lead to characteristic anomalies or basic disorders of the schizophrenic spectrum.

From the phenomenological examination of patients’ experiences (26, 32), disorders of ipseity are predominantly manifested in the domain of “cognition and stream of consciousness.” They are also frequently manifested in the domain of “bodily experiences,” like the sensation and/or perception of a “morphological change” of the body, as well as “mirror-related phenomena” (repeatedly looking at oneself in the mirror). Stereotypical conduct or motor interference, resulting from patients’ losing control of their own experience, is also manifested.

Within the domain of “cognition and stream of consciousness,” patients refer to “thought interference,” i.e., they refer to having experienced thoughts or imaginations that appear automatically, interrupting the main line of thought or interfering with it. Sometimes they intensify, ending up as “thought pressure”: a sense of many thoughts, lacking coherence with one another, appear in quick sequences without the patient being able to control them. Similarly, in some cases, patients have the feeling that their own thoughts are automatically (involuntarily) repeated or being in some way duplicated.

Thoughts are often experienced in a spatially localized way, and also with acoustic/auditory qualities. Frequently, there is a transition from experiencing thoughts on a quasi-perceptual level to external auditory hallucinations. In the beginning, patients hear their own thoughts not with their ears, but as their own voices inside their heads. With the diminishment of the sense of “mineness,” thoughts lose their familiarity, and patients now start to hear other voices inside their

head (which no longer appear to them to be their thoughts). The voices are anonymous (impersonal): patients do not identify them with anyone in particular, and only fleetingly do they realize that these voices could be their own thoughts.

In full-blown psychosis, the experience is externalized, and the voices are heard as coming from the outside, thus acquiring the characteristics of a hallucination. The patient regards as an external reality something that is, in fact, part of his own fragmented experience. It could be said that, in the psychotic state, subjective experience is lived as "not as one's own" and acquires an "inverted intentionality" (9, 39) as is the case of the next example.

Case 1

> *Sometimes I repeat my thoughts as if I were reading them, and I also hear voices on the radio, as if they were saying what I'm thinking: these are voices of unknown people who seem to be talking to me, but I don't not know how or why they do so. Additionally, it sometimes seems to me that some television personalities repeatedly say things to me, all sorts of things, thousands of stupid things that I don't understand, and nor do I understand why they're doing this. Moreover, I heard a young man repeating all the things, I heard them everywhere, in the atmosphere, even with my mouth closed things were repeated any way.*

Up to this point, the transition has moved from disorders of ipseity to disorders of "agency," leading to an externalization of self-experience and loss of demarcation between the self and the environment (40). In this way, the subject gradually loses his self-presence in the experience. This transition occurs from momentary experiences of disembodiment to the more severe "depersonalization" (or desubjectivisation) manifested in the psychotic state. Here, the term "depersonalization" refers to severe self-disorders, i.e., thoughts, actions, or feelings occurring "with the awareness of their not being mine, of being alien, automatic, independent, arriving from elsewhere" [Ref. (1), p. 121].

2.4.3. Intersubjectivity

Patients with schizophrenia display difficulties in naturally and spontaneously immersing themselves in everyday life, and find it particularly hard to grasp the "common sense" of situations (41–43). Generally, patients do not feel that they are fully participating or completely present in the world.

Misunderstandings and confusions about meanings are frequent in patients' interactions with others. Synchronicity in social interaction seems interrupted mainly due to mismatches regarding "meaning coordination" processes (44) and difficulties in incorporating the perspective of others, as shown in the example below.

Case 2

> *It could be, like, someone says a word and, like, it appears bad to the other person: that's what happens to me – words can have a double meaning. Just a while ago I spoke to someone and a slightly odd word came out. Like, he asked me why I didn't have breakfast, and I told him it was because it was a bit of a pain. Then I thought that the person might be thinking that I was saying*

that he was a pain. I worry that the other person may take it the wrong way, because I don't want to be a bother.

To a greater or lesser extent, patients display difficulties in making themselves understood or in explaining to others the experiences affecting them. In extreme cases, those patients that are especially self-absorbed or disconnected from the outside world (such as patients with catatonic-type schizophrenia) have great difficulties in articulating and expressing their experience, which remains to a large degree ineffable. This group of patients displays marked symptoms of affective flattening and autism.

Worth noting are the contradictory qualities of affection that are manifested among patients. Patients with schizophrenia are heterogeneous with regard to experience and expression of affection. Affective flattening appears less characteristic among paranoid patients.

In general, patients appear concerned with and anxious to understand what is happening to them, to recover and to quickly be discharged from their hospitalization. The majority refer to having anxiety crises, suicidal ideations, and suicide attempts. Nevertheless, the latter do not arise from a typically depressed state of mind, but rather from the desperation caused by patients' experiences of self-alienation.

In the two examples below, patients regard their anomalies of self-experience and body alienations as an impediment or obstacle to live a normal life. Disorders of the self extend to include intersubjectivity, leading to a radical withdrawal from the social world, and to the extreme of contemplating suicide to put an end to their alienation.

Case 1

There are times when thousands of things are repeated, almost everything is repeated in my head, and then others when they disappear and things are normal, but then they come back again. Sometimes I couldn't go out on the street, I had to stay in bed, just sleeping to get away from these thoughts. This has made it difficult for me to continue with my studies and concentrate. The situation is annoying and bad for me because I can't live a normal life. It's unbearable for me sometimes, and makes me think of killing myself, of hanging myself.

Case 3

I feel mental pressures, and it's like they squeeze my brain, my entire brain. My thoughts are jumbled up, they're a mess of ideas and thoughts. Reality gets distorted for me, too, I see it in a different way, like it was dream. This makes daily life difficult for me, living like this, living like this every day. I find it hard to relate to other people: in fact, I've really distanced myself from my friends. Because of my mental state, I don't want to do anything: this bothers me, and makes me desperate, deep down. I am worried about my mental health state, not feeling normal. I've tried to kill my self several times. Before they brought me here I was going to jump off a mountain, I wanted to jump off a mountain because of the desperation.

2.5. Discussion

2.5.1. Key Findings

A structural element, a key part of the personal processes involved in schizophrenia, is the diminishment of self-presence in experience. The subject gradually loses his self-presence in experience, which manifests not only on the individual level but also on the intersubjective level, leading to an early withdrawal from the social world.

On the individual level, the diminishment of self-presence in experience is a key element in the transition from basic self-disorders to full-blown psychosis. This transition occurs from momentary experiences of disembodiment to the more severe "depersonalization" (or desubjectivisation) manifested in the acute episode.

In early or prodromal phases, before "positive" symptoms occur, basic self-disorders are predominantly manifested in the domain of "cognition and stream of consciousness," including "thought interference," "thought pressure" and the feeling that thoughts are automatically being "repeated" or duplicated. Thoughts are often experienced in a spatially and localized way, and also with acoustic/auditory qualities.

Basic self-disorders are also frequently manifested in the domain of "bodily experiences," like the sensation and/or perception of a "morphological change" of the body, as well as "mirror-related phenomena" (repeatedly looking at oneself in the mirror). Stereotypical conduct or motor interference, resulting from patients' losing control of their own experience, is also manifested.

On the intersubjective level, major disturbances in the processes of synchronization with others are manifested. Patients do not feel at all participating or entirely present in the world. They show difficulties in dealing with consensual principles of understandability (common sense) and in incorporating the perspective of others (second-person perspective), which would appear to be important variables to consider in the symptomatological description of the schizophrenic spectrum disorders.

Patients with schizophrenia are heterogeneous with regard to experience and expression of affection. Affective flattening appears less characteristic among paranoid patients.

2.5.2. Clinical Implications

It is important to highlight the fact that hospitalization provides the first setting for the patients becoming conscious of their illness. This is the time when the illness is manifested, stemming from an initial psychotic break. This moment, which is critical in the prognosis, is the turning point, since, once discharged, patients return to the "non-place" that they occupied prior to hospitalization and, in a best-case scenario, they will occupy the place of the "sick person," of the "schizophrenic."

Medical-psychiatric intervention, which is the predominant form of intervention in the acute phase of schizophrenia, is mainly oriented toward reducing "positive"

symptomatology. Nevertheless, looked at from a broader perspective, the symptomatological aspect of the acute phase is merely a sign or a signal of the seriousness of the overall situation affecting the patient. Thus, it can be seen that there is a need for diagnosis to involve more aspects of the patient's life, in addition to those symptomatic aspects treated during hospitalization. This latter aim will require the effort of an ongoing interdisciplinary intervention.

Descriptions of disorders of the self would appear helpful in achieving a better understanding of the emergence of acute episodes of schizophrenia, by following the transition from basic disorders of ipseity to full-blown psychotic symptoms manifested in the patients' experiences of "disembodiment." Additionally, it would be also helpful to take into account the interpersonal scenario in which the psychotic episode emerges. This is, to contextualize the symptoms embedding them in the patients' lives. What is more, to ensure a comprehensive understanding the configuration of schizophrenia, it would be necessary to examine disorders of the self in the light of patients' life stories [see Ref. (33)].

Actually, in many cases, it is difficult to confirm a diagnosis of schizophrenia until well into hospitalization, or even until the illness is advanced. So, by broadening the scope of exploration of the patient's experience to areas not taken into account in the DSM and ICD classifications, new descriptive elements are contributed that could potentially provide clarification for diagnosis.

2.5.3. Future Directions

Diagnostic statistical manual of mental disorders and ICD diagnostic classifications require review in light of approaches aiming for a greater understanding of the personal processes involved in schizophrenia (from the patients' viewpoint) and that make it possible to explain aspects that remain unclear with regard to the trustworthiness of the diagnosis. These manuals spring from explanatory systems based on diagnostic categories according to a description of the apparent symptomatology, in which the assessment of subjective experience is basically excluded. However, patients' accounts of their own anomalous experiences seem essential for diagnostic accuracy and therapeutic purposes (14).

Diagnosis, in the terms currently proposed, consists in a comprehensive approach to the overall functioning, both mental and bodily, of the person seeking help, encompassing not only symptomatic aspects but also his or her healthy potential, in addition to the life context. In this way, it seems appropriate to develop methods that attempt at developing a "person-centered" approach to diagnosis by employing a more comprehensive and holistic assessment of the patients' condition (45).

Simply put, the subject of the study must be the person as a whole. This implies not only an in-depth review of the methodologies underlying traditional "objectivizing" diagnostic conceptualizations of mental illnesses but also a need to develop methodologies for the holistic study of patients, without losing sight of their corporality, complexity, and uniqueness (46).

From this viewpoint, the use qualitative methodologies for the study of schizophrenia and psychosis seem highly appropriate. These are just the clinical pictures that have

not been sufficiently tackled from non-objectivizing approaches, and there is thus a significant lack of understanding of these phenomena beyond their apparent symptomatology.

Schizophrenia has been a central topic of research in phenomenological psychiatry, which aims at detailed descriptions of psychopathological experiences, and is committed to the in-depth analysis of symptomatic aspects. In consequence, phenomenological psychopathology research should also be able to illuminate key elements to incorporate in specific psychotherapeutic interventions for persons with schizophrenia.

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3. Intersubjectivity in schizophrenia: Life story analysis of three cases

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The processes involved in schizophrenia are approached from a viewpoint of understanding, revealing those social elements susceptible to integration for psychotherapeutic purposes, as a complement to the predominant medical-psychiatric focus. Firstly, the paper describes the patients' disturbances of self-experience and body alienations manifested in acute phases of schizophrenia. Secondly, the paper examines the patients' personal biographical milestones and consequently the acute episode is contextualized within the intersubjective scenario in which it manifested itself in each case. Thirdly, the patients' life stories are analyzed from a clinical psychological perspective, meaningfully connecting symptoms and life-world. Finally, it will be argued that the intersubjective dimension of the patients' life stories shed light not only on the interpersonal processes involved in schizophrenia but also upon the psychotherapeutic treatment best suited to each individual case.

Keywords: schizophrenia, phenomenology, hermeneutic, intersubjectivity, life stories, clinical psychology

3.1. Introduction

Pathological experiences are usually described as phenomena that are divorced from the life context in which they are manifested. Nevertheless, in the field of phenomenological psychopathology, symptoms have traditionally been considered from a more comprehensive perspective: they are embedded in the person's life thus their contents and meanings can only be understood within the context of that life. In themselves "unhistorical," symptoms become connected meaningfully only within the comprehensive picture of the patient's life as a whole (Jaspers, 1997).

An even stronger argument could be made to the effect that "no mental illness can be diagnosed, described, or explained without taking account of the patients' subjectivity and their interpersonal relationships" (Fuchs, 2012, p. 342). It is clear that psychopathological manifestations cannot simply be reduced to the workings of the nervous system (Fuchs, 2011). For that reason, the recommendation here would be not to establish linear or "cause/effect" relationships, but to approach mental illnesses with the notion of a "circular" mode of causality, regarding their emergence from subjective, neural, social, and environmental influences continuously interacting with each other (Fuchs, 2012).

Contemporary psychopathological phenomenology regards schizophrenia as a paradigmatic disturbance of embodiment and intersubjectivity (Dörr, 1970, 1997, 2005, 2011; Blankenburg, 2001, 2013; Fuchs, 2001, 2005, 2010a; Sass and Parnas, 2003; Stanghellini, 2004, 2009, 2011). From this approach, it seems appropriate to use methods that attempt to characterize not only the patients' symptomatic

disturbances but also the interpersonal processes involved, broadening the scope of exploration to areas not taken into account in the criteriological manuals of diagnostic systems Diagnostic Statistical Manual of Mental Disorders (DSM) and International Classification of Deseases (ICD) (Fuchs, 2010b).

This paper presents the life story analysis of three cases that form part of the corresponding author's doctoral dissertation entitled "Study of disorders of the pre-reflexive self and of the narratives of first admitted patients with schizophrenia" (unpublished), covering a total of 15 patients with schizophrenia during their first psychiatric hospitalization.

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Here, "life-world" refers to the person's subjectively experienced world, which emerges in the process of conceiving one's self and the others through a history of social interactions (Husserl, 1970; Schutz and Luckmann, 1973; Varela, 1990; Varela et al., 1991; Maturana and Varela, 1996).

3.2. Materials and Methods

3.2.1. Study Design

The study was developed within the qualitative paradigm, it being an explorative–descriptive type of study. This type of studies proceeds with inductive logic: in other words, both hypotheses and analysis categories are developed as the study progresses, and emerge from the data itself (Danhke, 1989 quoted in Hernández et al., 2003).

The so-called "critical case sampling" criteria was used, where the interest in an in-depth approach to the phenomena means working with few cases, with representativeness not being of key importance for these purposes. Thus, the significance and understanding emerged by qualitative inquiry have more to do with the richness of the cases chosen and also with the observational and analytical abilities of the researcher, rather than with size of the sample (Patton, 1990; Schwartz and Jacobs, 1996; Creswell, 1998).

3.2.2. Participants

The broad research covered a total of 15 patients with schizophrenia during their first psychiatric hospitalization. All of them were males, aged between 18 and 25. Additional inclusion criteria were the following: (1) accessibility to the sample, (2) homogenous sample (Halbreich and Kahn, 2003), and (3) earlier first onset and higher risk of developing schizophrenia in men (Aleman et al., 2003).

The three cases were selected due to the variety of subtypes to illustrate the interpersonal processes involved in schizophrenia, taking the intersubjective dimension of the patients' life stories into consideration. Cases 1, 2, and 3, as they appear in the paper, correspond to patients with diagnoses of disorganized-type, paranoid-type, and catatonic-type schizophrenia, respectively.

3.2.3. Instruments

In-depth Interviews
In-depth interviews were used to gather qualitative data from the first encounter with the patients and from their life stories. These interviews had open questions aimed at allowing for a natural manifestation of the patients' accounts. For the first encounter, the recommendations on interviews for the phenomenological diagnosis of schizophrenia were taken into account (Dörr, 2002), and clinical biographical focus criteria were used to perform the life story interviews (Sharim, 2005).

Positive and Negative Syndrome Scale
The Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987) is a rating scale used for measuring symptom severity of patients with schizophrenia. The name refers to the two types of symptoms: positive, which refers to an excess or distortion of normal functions (e.g., hallucinations and delusions), and negative, which represents a diminution or loss of normal functions.

The Examination of Anomalous Self-Experience
The Examination of Anomalous Self-Experience (EASE; Parnas et al., 2005) is a semi-structured interview for the phenomenological examination of disorders of the pre-reflexive self, postulated as early markers or basic phenotype of the schizophrenic spectrum (Raballo et al., 2011). The EASE explores a variety of anomalous self-experiences, which typically precede the onset of positive symptoms and which also often underlie negative and disorganized symptoms (Parnas and Handest, 2003).

3.2.4. Procedures

Data gathering was performed by means of semi-structured interviews, which are characterized by the use of eminently "open" research questions. Less structured methods allow for the emergence of ideographic descriptions, personal beliefs and meanings, focusing on "how" the psychological processes occur (Barbour, 2000).
Five encounters with the patients were carried out. These encounters were coordinated throughout the three following phases:

Phase I: A first encounter to record the patients' accounts of the disturbances of self-experience and body alienations manifested in the acute episode (30–45 min interview carried out 1–2 weeks after hospitalization), following the confirmation of the diagnosis of schizophrenia in accordance with expert judgment and the standard diagnostic criteria of DSM-IV-R (American Psychiatric Association, 2003) and ICD-10 (OrganizaciónMundial de la Salud, 2003).

Phase II: Two subsequent encounters to carry out the EASE (Parnas et al., 2005; 30–45 min per interview carried out 1 month after hospitalization), when patients did not score with "positive" symptomatology on the PANSS (Kay et al., 1987).

Note: The results of Phase II of the broad research have not been included in this paper. The results from the EASE exploration will be published in a complementary paper focused on basic self-disorders entitled "The lived body in schizophrenia" (in preparation).

Phase III: Finally, two further encounters were held to perform the life story interviews (30–45 min per interview carried out 1–2 months after hospitalization). The first encounter started with the open instruction "tell me about your self," "tell me about your life," while the second one was focused mainly on the patients' significant social interactions and personal meanings, also including their first image in life, their early dreams (hopes), their self-definition, and their expectations about the future.

All the interviews were recorded on video and fully transcribed for subsequent analysis. Extracts of the patients' accounts were kept literally in quotes.

3.3. Analysis

3.3.1. First Encounter (Phase I)

The patients' accounts of the disturbances of self-experience and body alienations manifested in the acute episodes were summarized in corresponding descriptions containing the essential structure of the transcripts, which were obtained with the "Descriptive Phenomenological Method in Psychology" (Giorgi, 2009), by following five steps: (1) the researcher reads the entire transcript in order to gain an overall sense, (2) the same transcript is then read more slowly, and underlined every time a transition in meaning is perceived, providing a series of units constituting meaning, (3) the researcher then eliminates redundancies and clarifies the meaning of the units, connecting them together to obtain a sense of the whole, (4) the arising units are expressed essentially in the language of the subject, revealing the essence of the situation for him, and finally, (5) there is the summarizing and integrating of the achieved understanding in a description with the essential structure of the transcript.

3.3.2. Life Story Interviews (Phase III)

The criteria of the clinical biographical focus were considered in the life story analysis, which are part of the so-called "clinical human sciences" paradigm (Legrand, 1993; Sharim, 2005, 2011). This approach stresses the life story method, in which the clinical dimension is constantly present, working primordially on singularity: case-by-case, story-by-story.

At the same time, the examination of singularity and heterogeneity of individual situations allows the progressive appearance of common processes that structure behavior and organize these situations (Sharim, 2005, 2011; Cornejo et al., 2008). This method highlights the role of the subject in recounting his life story, giving the possibility to analyze the reciprocal relationship between the subject's determination by his history and his potential to create his own existence (De Gaulejac, 1999; De Gaulejac et al., 2005).

The in-depth analysis of the life stories was developed under a course guided by the co-author of this paper. The course was called "Hermeneutic analysis of biographical material for the study of patients with schizophrenia" and took place during one academic semester at the Catholic University of Chile. The analysis focused on the personal meanings (Fuchs and De Jaegher, 2009) by following the patients' history of significant social interactions.

Therefore, the transcripts were analyzed by peer researchers (corresponding author and co-author of this paper) both clinical psychologists with a specialty in psychotherapy. To avoid bias each researcher previously made a separate analysis and then met for the co-analysis, ensuring with this procedure the validity of the qualitative research (Maxwell, 1996; Morrow, 2005; Fischer, 2009).

Firstly, an individual (case-by-case) in-depth analysis of each narration using a hermeneutic approach was carried out. In this analysis each life story was re-constructed, carrying out a thematic and chronological ordering, which enabled the identification of "biographical milestones," as well as the analytical axes in each life story. Second, a cross-sectional analysis was carried out contemplating the stories all together, revealing the differences, similarities, and shared structural dimensions.

3.4. Ethical Issues

The broad research, covering 15 patients with schizophrenia during their first psychiatric hospitalization, was regarded as entailing no physical, psychological, or social risks for the subjects involved, based on the Declaration of Helsinki principles, the Council for International Organizations of Medical Sciences (CIOMS) 1992 International Ethical Guidelines for Biomedical Research Involving Human Subjects, and the 1996 International Conference on Harmonisation (ICH) Good Clinical Practice guidelines, by the following Ethics Committees: (1) Research into Human Beings Ethics Committee of the University of Chile's Medical Faculty, dated January 19, 2011. (2) Ethics Committee Research of the Psychiatric Hospital, dated August 2, 2012. (3) Ethics Committee Research of the North Metropolitan Health Service (Santiago, Chile), dated August 16, 2012.

The Ethics Committees also approved the patients' and their tutors' (legal representatives) consent documents. In this regard, the following ethical aspects were taken into account: (1) consent was informed and obtained from the patients' tutors by the attending doctor at Phase I of the study, considering that as a patient affected by an acute episode of schizophrenia, his competence or capacity is diminished and he must be authorized to participate. (2) Consent was obtained directly from the patients at Phase II of the study. (3) Pseudonyms were employed to

protect the identity of the patients and ensure confidentiality (internal codes were used for each patient to replace their original names).
Note: Careful attention was paid in this paper to the protection of the patients' anonymity. Identifying information such as dates, locations, hospital numbers, etc., was avoided.

3.5. Results

3.5.1. Individual Analysis (Case by Case)

3.5.1.1. Case 1

Santiago (Santi) is an 18-year-old patient, diagnosed with disorganized-type schizophrenia. He has completed 8 years of basic school education. His father died of cancer 1 month before his hospitalization: until then, he lived with him and his two brothers. He is the middle brother. The patient's mother left home when he was 12 years old.

First encounter

A first interview was carried out after 2 weeks of hospitalization. In this encounter, the patient indicates that although he considers himself to be a "normal" person, begins to recognize a "repetitive failure." It is primarily the mediating process of thinking that has become the main impediment in this case.

The patient indicates that he hears voices, which are as if his own thoughts were repeated inside his head, like an echo, "as if I was reading them aloud but with my mouth closed." Most of the voices repeat meaningless things that he does not understand. He also hears voices on the radio, repeating what he is thinking: these are voices of unknown people who seem to be talking to him. Additionally, it sometimes seems to him that some television personalities repeatedly say things to him, all sorts of non-sense. He does not know how or why they do.

There are periods in which the "repetitive failure" intensifies, to the extent that it prevents him leaving home, and that only by going to bed to sleep is he able to take a break from these thoughts. This has made it difficult for him to progress with his studies or concentrate. He feels that this situation is annoying for him and is harmful because he cannot live a normal life.

At first, the patient figured it was sort of a game, playing with the voices and thoughts, but he could not control it, he could not stop it, he kept on playing. This was sometimes unbearable for him, and has even made him want to hang himself.

Biographical milestones

The life story interviews were carried out after 2 months of hospitalization. The patient was receiving the usual pharmacological treatment and had recently completed 12 electroconvulsive therapy sessions.

“My mum left me when I was 12”
Santi begins his account by indicating that he has had a hard life. He refers to his parents’ divorce, and particularly to when his mother left him alone with his brothers when he was 12. His mother moved away from the city and got married again. “It was very hard, when she wasn’t there and we lacked a mother’s love.”

In addition to being angry with his mother when she left home, Santi also points out that he did not get on with her as a child. He remembers that she used to get very annoyed with him when he and his father sometimes made fun of her.

The mother returned after 2 years for her children. Santi’s brothers agreed to go with her, but he preferred to remain with his father. At the age of 14, he was living alone with his father. However, the brothers returned 2 years later, when he was 16, due to the serious situation with the mother’s new husband, who beat them.

Santi states that he got on well with his brothers; they had an affectionate relationship, one of friends, between them. They helped each other out and shared the housework between them.

“I died in high school”
Santi acknowledges that a significant change took place in his life at school. As a young child, he was a very good pupil and wanted to study medicine, but at the age of 12 he lost interest in his studies, skipped school, and began taking drugs. He had to repeat the last school year twice due to absenteeism. He liked the typical tools of the medical trade and wanted to have a stethoscope. “Now that I have them here (at the psychiatric hospital), I ask myself, why can’t I, if everyone else can?”

He stopped taking drugs at the beginning of this year and returned to his studies. He wanted to study accountancy to earn money. He had recently started the first year of high school when he was hospitalized.

“My dad passed away recently”
Santi states that his first memory is one of being with his family, when he was 7. It is a memory of the time when they were still living with their mother. He recalls it was his father who took them to a pretty square at the center of the city. “Nice memories, everything was nice with my dad.”

The father worked in the public sector and had taken early retirement, the reason for which is unknown. He did not remarry or have a relationship with another woman. Santi has a very positive image of him. He describes him as hard worker, a good father and who liked to go out and play ball with him and his brothers.

Santi displays an empathetic attitude toward his father, even a certain loyalty, which is made clear when he recounts the time when his mother left home, and later when his brothers left. In fact, he decided to stay alone with his father, despite the pain caused by the separation from his mother and brothers. “My dad went through an extremely painful time, to put it one way, he didn’t show it but, inside, he was feeling bad.”

The father passed away 3 months ago, from cancer, at the age of 65. He became ill a month before dying, and had immediately told his sons of his disease, so they were aware of how much longer the doctor had given him. The father was hospitalized at the time of his death.

Santi recognizes that he was very attached to his father, he states that “even too much.” He realizes that he still has not gotten over the death of his father, “because of my illness, I still have not gotten over it. I haven’t realized what it all really means.”

“I see the future as nothing”
Since the last 4 years, Santi has been becoming more and more distanced from the world, to the point where he is extremely isolated. He has no friends, does not study or work, takes no part in social activities and has not embarked on any romantic relationship.

During the week, he helped with some household chores, such as making lunch. Nor did he do anything special during the weekend, except go out to the square with his brother. He spent a lot of time in his room playing on his PlayStation. “I see the future as nothing, the way I’m going. Not doing anything, not studying, because where will I get like this? It’s looking bad, isn’t it? I’m worried.”

Life story analysis

The patient took part in the interviews without any problems. He appeared interested in obtaining more information on his state of health and motivated to seek help to secure a speedy discharge. He interrupted the interviews on a number of occasions to ask what his illness was, if it was very serious and when his attending doctor would discharge him. Generally, he appeared constantly concerned about his state and anxious to put an end to his confinement.

His life story contains a series of events that could be regarded as stressful. It is certainly possible to establish a connection between the death of his father (i.e., the patient’s state of grief) and the emergence of the first acute episode, and also to identify his mother’s leaving home as the crucial biographical milestone in the development of the prodromal stage of schizophrenia. Somehow, the sense of abandonment in the world has come to dominate the patient’s life.

The scale of the emotional impact of the recent loss of a father is obvious: nevertheless, the patient at no time displays any signs of sadness and does not cry. Instead of a spontaneous emotional expression, he rationally discerns the seriousness of the situation and like a “witness” he testifies the tremendous impact this must have on his life.

He manifested an initial perplexity, conveyed with a degree of humor, in light of the apparent oddness and incomprehensibility of the account of his anomalous experiences (“the repetitive failure”). Nevertheless, although he recounts sad events in his life, any actual sadness can only be assumed. To put it one way, it is possible to “intuit” the patient’s suffering, through the loneliness, abandonment and lack of support in his life, rather than by means of an explicitly emotional manifestation on his part.

The patient notices the paradoxical situation involved (of being hospitalized) when he states that he regards himself as a “normal” person, except for his “repetitive failure.” Far from merely being a game, as he previously regarded it, it is now given the name of schizophrenia, a diagnosis that defines him as a seriously ill patient and justifies his compulsory commitment to a hospital. This has led him to realize that what is happening to him is not socially acceptable, and is thus regarded as more serious in his own judgment.

3.5.1.2. Case 2

Angel is a 22-year-old patient, diagnosed with paranoid-type schizophrenia. He has 11 years of basic school education and lives with his parents and the eldest of his three sisters. He is the youngest of the siblings and the only brother. His family are evangelical Christians.

First encounter

A first encounter was carried out a week into his hospitalization. The patient has not been able to find a convincing explanation for the fear he feels, which he recognizes as his major impediment. He thinks he could be delivered over to the Tribulation – the Tribulation is a biblical time of pain.

About 3 months ago he began to feel persecuted by people. His house was the only place he felt safe, but for a few weeks now he has even begun to feel unsafe at home. The idea that somebody can hurt him comes from the fear he feels and he thinks that the worst thing would be that somebody kills him somehow, like stabbing him, for example. This fear is a distressing feeling, of wishing to escape, when he suddenly feels that something bad is going to happen to him.

He is quite concerned about his problem, and thinks a lot about it, and how to solve it. He wants to find a way to overcome the fear. He would like to find a “clear and precise” answer to what he should do, how he should live and how to face up to his fear. He wishes that the bible could tell him what to do in the Tribulation, “if I was in that time, that it told me in light of this fear to do this or that, to face up to it, don’t be afraid, I’ll be with you.”

Biographical milestones

The life story interviews were carried out 1 month into the patient’s hospitalization. He was receiving usual pharmacological treatment and his suitability for electroconvulsive therapy was being assessed.

“When I was a kid I went to school”
Angel woke up one night and found himself alone at home: it was very dark and he started crying. This is the earliest image that he recalls from his childhood. He also remembers that he would sometimes run up the stairs because he thought that someone, “perhaps the bogeyman,” was after him.

He remarks that his grades were not great but things went well for him at school. During his childhood, he felt good because he went out to play and climb trees. He

also liked to fix televisions and take apart toy cars. He stresses the fact that he was more outgoing and playful as a child.

His family was always good to him, and he notes that he had a happy childhood. He was closest to his mother, as she stayed at home and was very attentive and loving toward him. His mother was of good character, and only punished him on a couple of occasions, “because once I hit my sister with a hammer, when I was playing, and my mum punished me, she gave me a slap on the behind”.

“My sisters were very critical of me”
Angel has three older sisters. He has had a difficult relationship with them, and particularly with the eldest. He points out that his sisters criticized him a great deal and made fun of him. Therefore, even as a child, he took great care to say the right thing, so as not to make a fool of himself and feel embarrassed.

He was not only concerned to ensure that he said the right thing, but also with his personal appearance. He was very sensitive about the comments his sisters made about him. He states that he was very shy as a child, and when he was embarrassed by something he would run away and did not want to come back.

“Then I went to high school”
At high school, Angel was unable to make friends. He notes that he changed, became less playful, less “chatty” and more reclusive. He did not play ball so much or join in with classmates as often.

He also comments that he found it difficult to appear in front of his classmates, and skipped school when he had to give a talk to the class on a subject. This got worse when he started to suffer from acne, which made him feel that people were looking at him too much and a little persecuted.

It was because of the acne that Angel began to skip school, until he stopped going completely and became totally isolated. “By this point, the acne wasn’t as bad, but it was the fact I missed school, I skipped class a lot, I was embarrassed that I skipped school so much, and that’s why I stopped studying.”

“Then I went out to work. That’s when it all went wrong”
Angel does not think that his acne is any better, but somehow he learned to come to terms with this concern. He has spent a lot of time at home, in his room playing on his PlayStation. This is what he has mostly done over the last 4 years, as he admits. “I didn’t see anyone except for my family, not friends, because it’s a bit solitary on the PlayStation, you get closed in on yourself when you’re on it.”

After 4 years, Angel went out to work. He notes that it is when everything went wrong. He had spent a lot of time at home, without going out. He notes that he was perhaps unprepared to go out and experience life like that all of a sudden. It was then that he began to feel that people were after him.

“Now, as a person”
In adolescence, Angel wanted to be an air force pilot but he could not apply because he did not finish his studies and was under the required height – “it came as quite a blow, but I was still interested in mechanics”.

Angel does not have a clear vision of what the future holds, principally because he has not overcome the fear of being harmed and the thought that “somebody” will kill him, which is his most serious affliction. Nevertheless, he indicates that, if he can overcome his fear, he would like to work and study mechanics and electronics, which have been interests of his since childhood.

Life story analysis

The patient was very willing to take part in the interviews, although he generally appeared tired and dispirited. He seemed not to have much to say, or not to be ready to recount his story. He is of a religious disposition and a frequent reader of the Bible where, above all, he hoped to find an explanation for the problem affecting him: his fear.

His account is mainly based around the fear of being harmed, which is the subject of his delusion. He even appears, in a way, excited when talking about the problem of his fear and about the different explanations he uses to understand what is happening to him. Aside from this core problem afflicting him, his account barely touched on other aspects of his life, and he appeared to become dispirited, tired, and uninterested when moving away from the subject of his delusion.

He seems concerned that he is unable to find certainty in things, above all with regard to explaining his fear. He feels prey to a fear that is completely restrictive, and is unable to find a satisfactory explanation that would allow him to understand what is happening to him or to give a completely convincing response to overcome the situation. He is aware of the extent of the fear and the significant limitations it causes in his life, and of the lack of any clear orientation as to how to overcome it.

The patient conveys a feeling of “ontological” uncertainty or insecurity. From an early age in his life, the world (and others) acquired a sense of unreliability or threat. Shame and fear of ridicule are the predominant emotional aspects of his experience in childhood. Somehow, later on in adolescence these emotions led to the fear of persecution. Persecution progressively became a fear of being hurt until it reached the extreme point of a fear that he would be killed, which manifested itself in the first acute episode.

3.5.1.3. Case 3

Salvador (Salva) is a 25-year-old patient, diagnosed with catatonic-type schizophrenia. He has completed 12 years of compulsory school education and lives with his father and older brother. His parents divorced 2 years ago.

First encounter

The first interview was carried out when the patient had been hospitalized for close to 2 weeks. He explains that 2 years ago started with an episode of mental illness: “I was getting cramps in the back of my brain.” It was because of the confusion these cramps caused in his brain that he went to the psychiatrist. Then, he was diagnosed with depression and treated with medication for a year but the problem persisted.

He feels mental pressures, and indicates it is as if they squeeze his brain. His thoughts are jumbled up, all messed up with ideas. Reality gets distorted for him as well, as if he were in a constant dream. In addition, he has felt someone possessing his body and explains it as “demonic possession.” He thinks that spirits get in when someone is depressed. It is something he cannot control, something unpredictable, imminent.

The patient is worried about the state of his mental health. It worries him to “live like this,” and he feels a deep-seated desperation. He does not want to do anything and feels depressed, downcast, dispirited, and powerless. Before he was hospitalized, he wanted to committed suicide by jumping off a hill due to the desperation.

Biographical milestones

When the life story interviews were carried out, the patient had been hospitalized for a month and a half. He was receiving the usual pharmacological treatment.

“My interest in religion began at the age of 8”
Salva completed his primary education at a Christian school. He liked the religious part of school because religion was taught in a fun way. When he was a child, he used to go to church with his family. “I liked the teachings about love, love for one another, love for one’s neighbor”.

He points out that he was a very good student and got very good grades. He wanted to be a vet when he was a child, because he liked animals. He describes himself as a gentle, playful, brotherly, sweet boy.

“They moved me to a worldly high school”
The change of school had a negative impact on Salva. His performance suffered, and he went from being an outstanding student to being just an average one. He notes that students at the new school were treated more coldly.

He had wanted to be a vet since childhood but he could not go to university, as he did not pass the entrance exams. He therefore chose to study architectural drawing at a college, but did not manage to complete his first year there.

“My mum was sweet to me when she was Evangelical”
Salva had a good relationship with his mother as a child. He points out that his mother was very loving toward him whilst she was Evangelical. Later, however, for reasons unknown to him, she distanced herself from church. Their relationship deteriorated when he was a teenager.

He got on badly with his mother because, he explains, of their very different characters. His mother ill-treated him and frequently insulted him. This made him feel powerless. “She was really aggressive, and punished and hit me for anything. She used to insult me in all kinds of ways, she called me mentally ill”.

His mother also fought with his father and brother. She drank, and when she did so she became more violent.

“I went through a lot in 2010”
Salva states that he had his first episode of “mental illness” 2 years ago, and has not been able to work or study since then. “I did nothing at home, just playing games on the computer; I’d play on it, football games and PlayStation. I spent a load of time doing that”.

It was in this same year that his mother left home and his father fell ill with diabetes. His brother had had a heart attack at the end of the previous year.

His mother left home to live with a new partner, saying she wanted her independence. At first he missed her, but was also angry. He did not want to see her or be with her after she left.

Salva continued to live with his father and brother. He feels very attached to them, and is concerned about their health. He feels he has a really great father, because he has had to play a double role. He gets on well with his brother too, who he regards as a second father.

“It’s great at church, they treat me really well”
Salva’s current friends are evangelicals and he joins them at church. He likes going to the church because there he got to know beautiful people and had a much closer relationship with God. “I like being in communion with God, praying, singing, that’s how I look for protection”.

He has had four episodes of “demonic possessions,” all of which happened at church. It was at church where he was told that his bodily experiences were “possessions” and that they are somehow “normal.” However, the treatment he was given there was unsuccessful. They carried out “deliverances,” which are a way of getting the devil out the body with prayer.

At the moment, Salva does not know why these episodes have happened to him, or whether they are due to an illness, and has not even talked much about the matter with his attending doctor.

“In the future, I want to study massage therapy”
Over the course of the last 7 years, Salva worked on and off in a number of fields. He took jobs as a shelf stacker in a supermarket, a cleaner at a cinema and a shop assistant. His last job was 2 years ago selling fragrances in a street market.

He has remained socially isolated over the last 2 years, only keeping in touch with his evangelical friends at church sporadically. “I’ve found it difficult to relate to people in recent years. I haven’t worked much or had much of a social life. I’ve been isolated”.

In the future he would like to have children, a wife and work giving massages, although he realizes that he remains scared about his mental state, that he feels vulnerable.

Life story analysis

The patient took part in the interviews willingly, although he did appear very tired and sleepy (he was constantly yawning). The disordered thoughts persist, as do his low spirits, mental pressures and the uncertainty in the face of possible new "possessions." He talks about himself and his life quite candidly and seems naïve, as if recounted by a small child. He speaks calmly, slowly, with little verve. It is a story with few elements told at a basic level of articulation.

He is very religious, a habitual reader of the Bible and a regular churchgoer. Now, although the episodes were "demonic possessions," fear does not appear to be the predominant or explicit emotion: it is rather the loss of control of his bodily experiences and the unpredictable nature of these episodes that make the patient desperate. In other words, his desperation is due to his inability to once again feel normal or healthy.

He left school 7 years ago and has not developed a specific plan to carry out his life. Although he wishes to have a "normal" life, his life project faces a vacuum. However, the lack of a plan does not seem to concern him at all. Instead, what most worries the patient at present is the state of his mental health, that is, the anomalous bodily experiences he is not able to control.

It is possible to make a connection between the emergence of the first acute episode and a series of stressful events that occurred in the patient's life at that time: his mother left home, his father fell ill with diabetes and his brother had heart problems, all in the same year. Although, the negative impact of the change in high school and the deterioration of the relationship with his mother in his adolescence are the crucial biographical milestones identified in the development prodromal stage of schizophrenia.

Besides, what the patient explains as "spirits getting into" does not seem to correspond to a typically clinical depression (as it was diagnosed initially), but rather to a severe "passivity" of his own existence, which finds concrete form in his disembodied experiences.

3.5.2. Cross-Sectional Analysis

The cross-sectional analysis shows that a severe disorder of intersubjectivity starts developing in early adolescence. Beginning at an early stage, the patients progressively distance themselves from the social world. This distancing becomes a structural element, a key part in the prodromal stage of schizophrenia.

It is not an active deliberate distancing, but rather an overall difficulty that hampers the living of a normal life. It implies a progressive "passiveness" of the patients' own existence, which manifests itself not only in the disturbances of self-experience and

body alienations of the acute phases, but also in the patients' radical withdrawal from the social world.

For several years, the patients have not worked or studied, have had no social life, and have stayed shut in at home watching television or playing on their PlayStation for hours at a time. Here, it is important to notice that the acute episode occurred at a time when they were planning to return to their studies or the world of work after a number of years of extreme isolation.

It is possible to make a connection between the prodromal stages of schizophrenia and several stressful events that occurred in the patients' lives. It is also possible to follow a continuity in the experience of vulnerability regarding the main personal meaning configured early in life: the feeling of abandonment, the fear of ridicule and the feeling of powerlessness, corresponding to Cases 1, 2, and 3, respectively.

Nevertheless, the patients' withdrawal from the social world is what eventually leads to the manifestation of their psychosis. Somehow, in their attempts to returning to intersubjectivity, all of a sudden the patients confront themselves with their own "vulnerability" of being in the world.

Although they have some ideas about what to do in the future, the patients are insufficiently prepared, and lack a specific plan to implement them properly. Their life project faces a vacuum. This is what makes their condition so severe: there is an interruption in the patients' normal unfolding of life.

The patients do have a concept of what a "normal life" should be (basically, to study, to have a job, to marry, and to have a family), but they do not seem to possess the factual grounding needed to deal with the world, as if they were lacking the implicit "know how" to carry out the normal life they wish to live.

It should be noted that the patients' life stories feature a series of healthy elements or personal qualities that reflect a certain nobility of character: sensitivity, authenticity, naivety, empathy, and innocence. There does not appear to be any secondary gain associated with the symptoms.

3.6. Discussion

3.6.1. Key Findings

In acute phases of schizophrenia, patients' accounts concentrate on (or are limited to) the disturbances of self-experience or body alienations. In other words, patients' accounts lie outside the time-space dimension of the social context and exclude personal history. Body alienation appears to be the way in which the de-subjectivized accounts find concrete form (or are materialized).

The assessment of the life stories complements the symptomatic descriptions embedding them in the patients' life-worlds, thus incorporating a social horizon. In this way, the dimension of intersubjectivity is illustrated in the patients' history of significant social interactions, discovering the interpersonal elements to integrate in psychotherapeutic and prevention models.

The articulation of the patients' life stories allow to follow the patients' progressive withdrawals from the social world, and also to identify the interpersonal conditions involved at the time of the acute episode's emergence. Thus, the spatiotemporal dimension of the personal history allows the understandability of the interpersonal processes involved in schizophrenia from a broader perspective.

From the individual analysis of the life stories, it is possible to identify the patients' biographical milestones, the personal meanings involved in their significant social interactions, and also continuity in their experience of vulnerability of being in the world, which are useful elements to consider for psychotherapeutic treatment.

The cross-sectional analysis of the life stories shows that a severe disorder of intersubjectivity starts in early adolescence, which should be a useful element to consider for the early detection and on the prevention. Beginning at an early stage, the patients progressively distance themselves from the social world, ending in a radical withdrawal. This distancing becomes a structural element, a key part of the prodromal stage of schizophrenia, as it was found in every case of the broader sample covering 15 patients with schizophrenia.

Social interactions are interrupted prior to the emergence of acute symptoms, possibly due to the threatening or anxiety provoking encounters with others. Nevertheless, the underlying anguish was not measured in this study. Instead, the study shows the personal vulnerability that leads to a psychotic break (or to the culmination of the intersubjective interruption).

3.6.2. Clinical Implications

Psychotherapeutic interventions for patients with schizophrenia have been widely neglected in general. Current treatments are primarily with medication, including elctroconvulsive treatments in acute phases, thus following a medical-biological model that has not been questioned sufficiently. In this context, the intersubjective dimension seems extremely relevant for both the development of psychological treatments and the understanding of the interpersonal processes involved in schizophrenia (as an interruption in intersubjectivity).

From the very start of hospitalization, psychotherapeutic support would appear of fundamental importance. The patients should be accompanied on their return to intersubjectivity, whereas efforts should be made to provide proper emotional support for the realization of the overall problem affecting them. Prior to interventions focused on tasks (for example, successfully performing a social role, such as studying or working), the patients need to experience being in the world with another person, in a synchronous accompaniment of affective reciprocity.

In other words, the intersubjective dimension should be integrated in psychotherapeutic models focusing on the patients' social interactions. These models should be oriented to developing a collaborative encounter between the patient and the therapist, as well as enhancing metacognitive capacities, as it has been shown to be helpful especially for the recovery of patients with schizophrenia in several case studies (Dimaggio et al., 2008; Harder and Folke, 2012; Lysaker et al., 2013).

The process of recovering understandability would be a key aspect in overcoming the patients' alienation. Therefore, special consideration should be given to psychotherapeutic approaches that focus upon encouraging patients' self-understanding and the establishment of a common communicative base between patient and psychotherapist (Holma and Aaltonen, 1997, 2004a,b; Seikkula and Olson, 2003; Seikkula et al., 2006). The idea is that the patient's experience can be explicitly shared on the basis of a common meaning by a dialog process that takes into account the other's point of view (or second person-perspective; Stanghellini and Lysaker, 2007).

Patients' narrativity should improve along different levels of articulation, by the recognition of beliefs, the incorporation of emotions and the reconstruction of different meaningful life events. However, during acute phases delusional beliefs constitute the patients' only available form of cognitive and interpersonal organization, so instead of confronting them, the focus should be placed on the difficulty in pragmatically comprehending others and on the experience of vulnerability (Lysaker et al., 2011a,b,c; Salvatore et al., 2012a,b; Henriksen and Parnas, 2013; Škodlar et al., 2013).

Besides, acute psychosis in schizophrenia manifests itself with a collapse of the temporal dimension of the narrative plot, which leads to a de-contextualization of self-experience (Holma and Aaltonen, 1997, 2004a; France and Uhlin, 2006). From the so called "literacy hypothesis" (Havelock, 1980, 1991), which belongs to studies that follow the transition from orality to literacy in the development of the thematic consciousness, it could be noted that in the acute phase the patients lose the modality of ordering their experience in consensual logical sequences, displaying a narrativity with epic or poetic characteristics (Guidano, 1999).

The re-establishment of the consensual ordering given by the locational/situational aspects of the life story (by articulating the self-experience in thematic/chronological sequences; Havelock, 1980, 1991; Bruner and Weisser, 1991; Narasimhan, 1991; Guidano, 1999; Irarrázaval, 2003; Bruner, 2004; Holma and Aaltonen, 2004a) allows to follow the patients' progressive withdrawals from the social world, and also to identify the interpersonal conditions involved at the time of the acute episode's emergence.

In this sense, the articulation of the patients' life stories, expressed as narrative creations of their own subjectivity (and meanings), allows for the spatiotemporal dimension "re-ordering," as well as for the understanding of the interpersonal processes involved in schizophrenia from a broader perspective. This psychological understanding reveals the intersubjective dimension that connects the emergence of the acute episode with the patients' biographies, taking into account the personal meaning at play in each case.

In the case of Santi, there appears to be a need for emotional support aimed at accompanying him in becoming aware of the magnitude of the loss caused by the recent death of his father and, subsequently, to help him to develop strategies to deal with his feeling of abandonment in the world.

With Angel, his fear of ridicule is a structural emotional trait that dominates his life and is becoming a fundamental part of his worldview. Here, it is most important to deal with his sense of embarrassment and help him to accept himself. The aim is to provide a new, positive meaning to the sense of himself, overcoming his fear of ridicule in his encounters with others, or in other words, recovering the legitimacy of the sense of himself.

Salva requires an intervention in terms of developing a more basic sense of self-embodiment, which would be aimed at reflecting the feelings of "the other," to re-establish primordial reciprocity. Additionally, space needs to be created in which the patient can recover a feeling of protection in the world, overcoming the feeling of powerlessness.

From this viewpoint, taking into consideration the story the patient tells of himself improves the articulation of self-narrative, which should gradually be extended toward diverse areas of his life whose elaboration appears important for him to make his way back to daily life. It would be important to articulate the present considering the experience that takes place in the actual interpersonal context, and from here to articulate the future as a horizon of possibilities.

Therefore, reconstructing the intersubjective dimension of the patients' life stories shed light not only on the interpersonal processes involved in schizophrenia, but also on the psychotherapeutic intervention best suited to each individual case. Moreover, when intervention in acute phases of schizophrenia focuses mainly on reducing "positive" symptomatology, without assessing the psychological and social elements that are part of the overall situation affecting the patient, relapse seems highly likely.

3.6.3. Limitations of the Study

Regarding the limitations of the study, mainstream scientific research in mental health has been dominated by quantitative methodologies and statistical analyses of big samples (representativeness), while the value of in-depth psychological analyses has been underestimated.

There is a predominant excessive confidence in the accuracy of numbers, as if they could not be easily manipulated in data analyses. This tendency has been supported by the illusion that numbers represent exactly (as a mathematical formula) the experience of the subject, rather than the patients' own stories.

While qualitative methodology has been the tradition for research in humanities and social sciences, psychotherapy research has been developed using the methodologies of the medical sciences, which are mostly quantitative, being the randomized controlled trials being the favored design.

Nevertheless, research in psychotherapy should be guided by questions that are relevant to clinical practice. It should not be forgotten that methodologies are only means to carry out scientific research, but should not be the ultimate aim in themselves. Thus in this field of research it seems necessary to incorporate the questions psychotherapists need to answer to improve the practice of psychotherapy (to help patients), and then to choose the most appropriate methodologies.

However, one of the main advantages of qualitative studies is the open, mindful and detailed assessment of the subjective experience, enabling the emergence of the patients' worldview and their personal meanings, which cannot be obtained by means of superficial assessments. Therefore, psychotherapists should also have a voice on the debate of which methodology is best suited to improving the practice of psychotherapy.

3.6.4. Future Directions

Certainly, it would be important to systematize the results of this study in a model of psychotherapeutic treatment for persons with schizophrenia, which should include the intersubjective dimension, starting from the hermeneutic analysis of the patients' life-worlds toward a meaning-based psychotherapeutic practice. This model would eventually require evidence of effectiveness.

Moreover, it would be interesting to explore gender differences in the processes involved in schizophrenia, investigating prodromal and acute stages, as well as life stories of women with schizophrenia. In addition, improvement is needed regarding the differential diagnosis between acute phases of schizophrenia and acute phases of other severe mental disorders, such as major depression and bipolar disorder.

Finally, the future challenge in the field of phenomenological psychopathology would be to develop a comprehensive/unified philosophical framework for an embodied science of intersubjectivity. And, consistently, to continue developing coherent methodologies for empirical research, since this is the closest we can get to the patients' life-worlds.

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Conclusions

Major disturbances in the processes of synchronisation with others (meaning coordination), difficulties in incorporating interactional perspectives (second-person perspective) and in dealing with consensual principles of understandability (common sense), would appear to be important variables to consider in the sympomatological description of the schizophrenia spectrum disorders. There does not appear to be any secondary gain associated with the symptoms.

Nevertheless, a structural element, a key part of the processes involved in schizophrenia, is the diminishment of the self-presence in experience. The subject gradually loses his self-presence in experience, which manifests not only on the individual level, from momentary experiences of "depersonalisation" (or desubjectivisation) to the more severe "disembodiment" culminating in the psychotic episode, but also on the intersubjective level, leading to an early withdrawal from the social world.

Descriptions of disorders of the self are helpful in achieving a better understanding of the emergence of acute episodes of schizophrenia, by following the transition from basic disorders of ipseity to full-blown psychotic symptoms. Moreover, the assessment of the patients' life stories complements the phenomenological descriptions of self-disorders embedding them in the patients' life-world, thus incorporating a personal and a social horizon. In this way, the dimension of intersubjectivity is illustrated in the patients' history of significant interactions, discovering the personal and social elements to integrate in psychotherapeutic and prevention models.

The articulation of the patients' life story allows to follow the patient's progressive withdrawal from the social world, and also to identify the interpersonal conditions involved at the time of the first episode's emergence. Thus, the spatiotemporal dimension of the personal history allows the understandability of the processes involved in schizophrenia from a broader perspective, shaping the concept of the person as an "agent".

From the individual analyses (considering the sub-sample of 5 patients), it is possible to identify the patients' biographical milestones, the personal meanings involved in their significant interactions, and also a continuity in their experience of vulnerability of being in the world, which are useful elements to consider for the psychotherapeutic intervention.

The cross-sectional analysis (covering the total of 15 patients) shows that a severe disorder of intersubjectivity starts developing in early adolescence, which should be a useful element to consider for the early detection and on the prevention. Beginning at an early stage, the patients progressively distance themselves from the intersubjective world. It is not an active, deliberate withdrawal, but rather a global difficulty that hampers the living of a normal life.

Considering the clinical implications, psychotherapeutic support would appear of fundamental importance from the very start of hospitalisation. The patients should be accompanied on their return to intersubjectivity, whereas efforts should be made to

provide proper emotional support for the realisation of the overall problem affecting them. The process of recovering understandability would be a key aspect in overcoming the patients' alienation.

Regarding the limitations of the study, mainstream scientific research in mental health has been dominated by quantitative methodologies and statistical analysis of big samples (representativeness), while the value of in-depth psychological analysis has been underestimated. Whereas qualitative methodology has been the tradition for research in humanities and social sciences, psychotherapy research has been developed using the methodologies of the medical sciences, which are mostly quantitative, being the randomised controlled trials the favoured design.

Nevertheless, research in psychotherapy should be guided by questions that are relevant to the clinical practice. It should not be forgotten that methodologies are only means to carry out scientific research, but should not be the ultimate aim in themselves. Thus in this field of research it seems necessary to incorporate the questions psychotherapists need to answer to improve the practice of psychotherapy, and then to choose the most appropriate methodologies.

However, one of the main advantages of qualitative studies is the open, mindful and detailed assessment of the subjective experience, enabling the emergence of the patients' worldview and their personal meanings, which cannot be obtained by means of superficial assessments. Therefore, psychotherapists should also have a voice on the debate of which methodology is best suited to improving the practice of psychotherapy.

Schizophrenia has been a central topic of research in phenomenological psychiatry, which aims at detailed descriptions of psychopathological experiences, and is committed to the in-depth analysis of symptomatic aspects. In consequence, phenomenological psychopathology research should be able to illuminate specific psychotherapeutic interventions for persons with schizophrenia.

Certainly, it would be important to systematize the results of this doctoral research in a model of psychotherapeutic intervention for persons with schizophrenia spectrum disorders, starting from the hermeneutic analysis of the patients' life-world towards a meaning-based psychotherapeutic practice. This model would eventually require evidence of effectiveness.

Besides, it would be interesting to explore gender differences, investigating acute and prodromal stages, as well as life stories of first admitted women with schizophrenia. In addition, the differential diagnosis between acute phase of schizophrenia and acute phases of other severe mental disorders, such as psychotic depression and bipolar psychosis, seems to be a difficult task. Then, Phase I and Phase III of the study may be replicated in other groups of patients in order to provide elements for a prompt and accurate diagnostic differentiation.

Finally, the future challenge in the field of phenomenological psychopathology would be to develop coherent methodologies for empirical research, since this is the closest we can get to the patients' self-experience. Conceptualisations, if established in isolation from direct experience, would be only theoretical and not necessarily

relevant for the clinical practice (to help patients). An embodied science of intersubjectivity seems a promising framework to consider in this direction.

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