Original article

On the notion of psychosis: semantic and epistemic concerns

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Summary

In spite of its frequent and apparently unproblematic use, the meaning of the term "psychosis" remains largely unclear. Throughout this paper we will analyse some of the reasons underlying psychiatry's failure to define the notion of psychosis in a clear and unambiguous fashion, highlighting the inadequacy of a natural-scientific framework (inherited by psychiatry through its development as a medical discipline) when dealing with subjective experience. Following a longstanding trend in psychopathology, we will argue for the need to follow a hermeneutical approach, which is both perspectival and theory-laden. In order to prevent arbitrariness or a crude relativism, we will describe the notion of "hermeneutic objectivity" as an epistemic construct aimed at legitimising psychiatric judgement and its pretension of truth.

Key word

Psychosis • Psychopathology • Hermeneutics

Introduction

As psychiatrists, we are expected to identify individuals who are experiencing a psychosis and clearly differentiate them from those who are not. This is no trivial task, since identifying someone as psychotic might have extremely serious consequences:

- **a.** clinical: those who are included under the category "psychosis" will often be prescribed antipsychotic medication and will hence be at risk of experiencing significant side-effects, just like failing to identify a patient as psychotic might prevent him from receiving more adequate treatment. A clear and precise differentiation between psychosis *vs* no-psychosis has become particularly relevant in early intervention services working with individuals who are at high risk of transition to psychosis;
- **b.** legal: the identification of an individual as psychotic at the time that he committed an offence could act as an exculpatory circumstance. Also, labelling someone as psychotic can legitimise having him sectioned in an inpatient unit;
- **c.** social: the stigma and the risk of social exclusion and discrimination linked to the notion of psychosis demands that this diagnosis is not established arbitrarily. Moreover, labelling someone as psychotic might have a negative impact on self-image and lead to disempowerment [1].

In consequence, labelling a patient as psychotic should not be done arbitrarily but with a high degree of certainty. In the modern era, it is scientific knowledge that has achieved the status of *knowledge proper* and as such it represents the path towards truth and certainty. In fact, it is psychiatry's adoption of a natural-scientific methodology, inherited through its development as a medical discipline, that legitimises the practice of treating millions of kids with amphetamines worldwide, depriving patients from their freedom or deciding that an individual was unaware of what he was doing when he committed an offence. As such, psychiatry aims towards a pretension of truth that is characteristic of the natural sciences, a deterministic and law-abiding truth that is universally accepted.

So that the term "psychosis" is applied rigorously in clinical practice, two different though interrelated questions should be answered. There is a *semantic* question – *how can I define the term psychosis in clear and unambiguous terms?* and an *epistemic* question – *how can I rightly include a particular individual under the kind psychosis?* Throughout the next paragraphs we will attempt to understand how psychiatry has approached these questions from within the framework of medical semiology. We will then proceed to exemplify the failure of psychiatry's attempt to define one of its core notions, that of psychosis, in clear and unambiguous terms. In a next step we will argue for the reasons underlying this failure (namely the illegitimacy of some of psychiatry's epistemic assump-

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tions), and we will conclude by offering an alternative approach for psychiatry's quest for knowledge.

How does psychiatry traditionally address the semantic and epistemic questions?

Before addressing these questions, we must consider where psychiatry, taken as a medical/natural-scientific discipline, stands.

In the first place, psychiatry inherited a set of ontological assumptions and a specific epistemological framework through its development as a medical discipline [2 3]. In short, this framework (namely, medical semiology) states that a specific set of symptoms represents an unseen internal lesion (i.e. aetiology), whether structural or functional [a], with which it is linked through a causal and deterministic relation (this causal relation can be traced back through biochemical, anatomical, physiological, microbiological, or genetic processes [b]). Since this specific set of symptoms univocally represents (i.e. stands in the place of) its unseen internal lesion, they may both be equated. Hence, disease X may be defined either by the specific set of observable and objective symptoms (a descriptive definition) or by its aetiology (an essential definition).

By adopting this epistemological framework, psychiatry assumed that mental symptoms were causally linked to their unseen internal cause [4] (i.e. a putative neurological dysfunction, whether anatomical, physiological or functional) [c]. Since this relation was deemed to be causal and deterministic, an objective nature was necessarily assumed for mental symptoms, for deterministic relations exist only in the realm of space-time objectivity.

Further, it is commonly accepted that mental disorders have come to be defined according to descriptive criteria such as those found in the DSM and the ICD. These classificatory systems rely on the idea (borrowed from Logical Positivism) [5] that mental disorders should be described according to a purely descriptive and theory-free approach. This widely accepted idea reinforces the above-mentioned assumption that mental symptoms are objective entities, for if they are to be defined by means of atheoretical and purely descriptive terms they must be apprehended through observation (i.e. in an object-like fashion).

So, turning back to the semantic question, what is psychiatry's answer? As we have already mentioned, psychiatry's answer (taken as a medical discipline and hence deploying medical semiology as its epistemological framework) is that psychosis should be defined through the description of a set of objective features that are causally linked to a yet unknown internal lesion and that can be identified as being either present or absent. For over a hundred years the term "psychosis" has been linked to the notions of irrationality, incomprehensibility [6] or loss of touch with reality. Since these notions lack the kind of objectivity expected from descriptive definitions and are very likely to be either theory or value-laden, psychosis eventually came to be defined by those allegedly objective features that typically occurred in patients considered as irrational, as incomprehensible or as having lost touch with reality: delusions, hallucinations, disorganised speech, or catatonic behaviour [d] (i.e. psychotic symptoms). Following this line of argument, the term "psychosis" will refer to a yet unknown neurological dysfunction that is common to all psychotic symptoms.

Let's move on to the epistemic question (how can I rightly include a particular individual under the kind "psychosis"?). Clinical judgement has been argued to follow an abductive logic [10] (in short, it follows a "known-effect-to-putative-cause" reasoning direction, with different possibilities of interpretation of the empirical fact). In this sense, clinical judgement always implies a sign-token (any particular item that belongs to a specific type) and a sign-type (a universal or category, whether a symptom or a disease, which is synonymous with the descriptive definition of a sign) under which the token must be included. Following the principles of medical semiology, the descriptive definition for a sign-type includes all the necessary and sufficient features required for the complete characterisation of sign-token. Hence, the identification of the allegedly objective features that characterise psychosis (i.e. the descriptive criteria characterising delusions, hallucinations, disorganised speech, or cata-

[a] The multiple realisability of psychological kinds implies a one-to-many relation between psychological kinds and neural kinds. These different neural kinds would lead to a common functional or computational state common to all tokens of a particular kind [7].

[b] In the case of psychiatry, functional, cognitive, or computational processes have also been proposed, all of which retain an allegedly causal and deterministic character.

[c] The assumed existence of this putative internal lesion characteristic of psychosis is clearly exemplified by empirical research [8 9].

[d] The assumption of the allegedly objective nature of these phenomena is clearly instantiated by current empirical research (i.e. identification of neurobiological correlates that are causally related to delusions and hallucinations) and theoretical research (i.e. development of theoretical models that assume the existence of more or less opaque causal relations between symptoms and their unseen internal cause).

tonic behaviour) allows for the immediate inclusion of the individual under the kind "psychosis", which in turn refers to the existence of an underlying (yet unknown) neurological dysfunction that is common to all psychotic symptoms.

Some problems related to the concept of psychosis

Unfortunately, and in spite of psychiatry's natural-scientific aspirations, both the meaning of the term "psychosis" and the path for its indubitable application in clinical practice are far from clear. Let's have a quick look at some of the problems that the notion of psychosis faces:

a. the notion of psychosis is very often equated or reduced to schizophrenia. In this sense, a vast amount of papers that include the term "psychosis" in their title actually focus on schizophrenia. Whereas this condition represents a paradigmatic type of psychotic disorder, the term "psychosis" seems to be equally applicable to a wide range on non-schizophrenic disorders (e.g. chronic delusional disorder, acute psychotic episode, affective psychoses etc.);

b. a direct consequence of defining psychosis by the presence of delusions, hallucinations, disorganised speech, or catatonic behaviour is the fact that non-productive psychoses become highly problematic or even contradictory (in this sense, what is psychotic about Simple Schizophrenia?) [11 12]. In a similar fashion, the ascertainment of attenuated or transient delusions and hallucinations (as the Comprehensive Assessment of At-Risk Mental States does) often fails to identify the prodromal phases of schizophrenia, where such symptoms are most often not even present. Further, equating psychosis to the presence of delusions or hallucinations neglects a longstanding psychopathological tradition according to which these symptoms are secondary or even contingent [13-16];

c. a widely heterogeneous clinical sample might report phenomena that satisfy the commonly accepted descriptive criteria for delusions (i.e. high subjective evidence and incorrigibility). These could allegedly include paranoid delusions in schizophrenic patients, delusions in the context of affective disorders, overvalued ideas, fanatic religious beliefs, obsessive-like phenomena, rigid cognitive patterns found in autistic spectrum disorders or an exaggerated mistrust found in paranoid personality disorders. In spite of their complying with superficial descriptive criteria, their deep structure and the relation they hold with co-presenting phenomena varies to such a degree that assuming the existence of a common (anatomical, psychological, functional, computational, or neurocognitive) path or an identical psychological structure would lead to a rough conflation and a complete lack of specificity, eventually rendering the concept of psychosis meaningless. In a similar fashion, labelling as psychotic all patients who satisfy the descriptive criteria for auditory hallucinations (these have been described in a wide variety of disorders, ranging from schizophrenia to affective disorders, personality disorders [17], conversive disorders [18], sensory deprivation [19], or anxiety disorders [20]) would arguably render the extension of the term "psychosis" extremely heterogeneous and hence of little use for both research and clinical practice;

d. a descriptive definition of psychosis doesn't really say much about what psychosis actually is (all it offers are the descriptive features that an individual must allegedly satisfy in order to be identified under the kind "psychosis"). So, what is it that psychotic symptoms have in common? In short, most mental health professionals would answer to this question by saying that they all somehow imply losing touch with reality or, more technically speaking, a failure in reality testing or reality monitoring. However, no matter how often we talk about reality, little thought is actually given to what reality actually is or to how we get to know things about the world. In fact, a number of tacit and unacknowledged ontological and epistemological assumptions are held, most of which are still subject to vivid debates (e.g. ontological realism, a correspondence theory of truth, a representational theory of mind, an ontic independence between man and world, the existence of a clear and unambiguous matching between world and language etc.);

e. there is little agreement as to whether this term should be applied in certain cases (e.g. emotionally unstable patients who report hearing voices that encourage them to self-harm, anxiety-related overvalued paranoid thoughts, mood-congruent ideas in affective disorders, body-image distortion in anorexia nervosa etc.) and clinicians often disagree as to whether a particular token represents an instance of a specific kind of psychotic symptom. These facts point toward the idea that the allegedly descriptive features that characterise psychosis are not as objective as we wish they were. Probably the simplest illustration of this idea is the fact that a patient presenting with all the allegedly objective and descriptive features for any psychotic symptom might be after all malingering…

What's the reason underlying these problems?

In our view, the main reasons underlying psychiatry's failure to achieve the conceptual and epistemic consistency it aims for (clearly exemplified by the history of psychosis)

is the fact that psychopathological phenomena are not objective entities, they do not stand in causal relations with regards to co-existing objects, their eliciting requires the use of non-representational information and, most important, utterances and behaviour, understood as psychopathological phenomena, only acquire meaning when interpreted from within their horizon of meaning (i.e. the individual understood as a meaning-bestowing totality).

Psychopathological phenomena are not mere objects standing in the realm of space and time. They are not directly apprehended, but are the product of an interpretative endeavour: no one can actually see a delusion or a hallucination. An utterance only acquires meaning when analysed within its specific context, i.e. the individual understood as a horizon of meaning [21]. Only then, when we take into account the patient's biography, his personality traits, his hopes for the future, his fears, his traumas, his world etc., can we really understand the meaning of an utterance and hence label it as a delusion with a certain degree of certainty. Depending on this horizon, the interpretation of the utterance will have one meaning or another: he might be malingering, his paranoid traits might be due to past traumatic events, his high degree of conviction might be due to rigid cognitive patterns, the incorrigibility might be due to his reluctance to accept evidence that would shatter his world, etc. Similarly, no fragment of behaviour carries meaning in itself. It is only when we reach an understanding of the individual that we can ascribe meaning to his behaviour. Since psychotic symptoms are always identified as such through an interpretative process that requires taking into account the individual's idiosyncrasy, they may never be directly apprehended as physical *things* (i.e. in an object-like fashion). Furthermore, since the individual (understood as the horizon of meaning upon which interpretations take place) can never be fully or exhaustively apprehended, the result of the reconstructive process will remain inevitably open and unfinished (new information can always be obtained that might lead to an alternative reconstruction). Trying to establish a deterministic (fixed, causal and law-abiding) relation between psychotic symptoms (the reconstruction of which is always open, as the result of an interpretative process) and a specific internal lesion (anatomical, functional, physiological etc.), the meaning of which is closed or fixed, therefore seems rather illegitimate.

We will probably all agree that there are certain clinical cases where we all believe a patient to be psychotic (let's say, the very typical schizophrenic patient who experiences paranoid delusions, passivity phenomena and commenting auditory hallucinations, a severely depressed patient who assures that he's already dead, a jealous husband who *knows* that his wife is cheating on him without any evidence etc.). This intersubjective consensus might lead us into believing that there is something characteristic and specific about psychosis that we are all apprehending and that this feature could also be objectively identified in all other psychotic patients (after all, it might make sense to believe that we're apprehending an objective, descriptive and representational feature of psychosis if we're all agreeing on the conclusion). However, the fact remains (as the history of psychiatry has shown) that the meaning of psychosis cannot be codified in analytical terms and there is no set of specific features that are identified in all psychotic patients. One of the main reasons for this has been argued to lie in the role of present, although *non-representational* information that modulates the meaning of apprehended phenomena (following Rejon's example, the difference between schizophrenic and melancholic delusions may be observed and pointed out [e] – it may receive an ostensive definition – but it cannot be found in the descriptive definition of delusion [10]). This is clearly seen in clinical practice, where we continuously face atypical cases (that don't comply with commonly accepted descriptive features) in which diagnostic dissensus is the rule. It is in this sense that the role of non-representational information (how it is articulated, taken into account or simply neglected) helps in understanding some of the reasons why some psychiatrists might conclude that a particular patient is psychotic whereas others won't [f].

Introducing an alternative approach

According to the previous line of argument, we conclude that the natural-scientific pretension of truth that psychiatry aims for (i.e. based on certainty and law-abiding determinism) rests on illegitimate assumptions (based on the naturalisation or objectification of psychopathological phenomena). In spite of this, we are still committed to a pretension of truth that allows for valid and reliable

[e] This non-representational information plays a major role in the way we learn to identify psychosis through ostensive definitions during our training period [10].

[f] Though being non-representational, this information still holds semantic and interpretative value. It is arguably the role of non-representational information that led Minkowski to say that metaphors seemed more adequate than definitions when trying to grasp the meaning of the notion of "vital contact with reality" [26], whose distortion played a major role in his understanding of schizophrenia.

judgements that underpin and justify our clinical decisions. However, the pretension of truth we aim for is different from that of the natural sciences. Whereas these aim at establishing apodictic knowledge about the physical world by means of its subsumption under deterministic causal laws, psychopathology (taken as an alternative epistemic framework for psychiatry that aims at creating intelligibility) stabilises the meaning of clinical data through a hermeneutical procedure [22-24] that allows for the systematic and theory-guided articulation of raw data (including utterances, fragments of behaviour, non-representational information and contextual information). However, the open texture implied in all interpretative endeavours precludes reaching a "one and only" valid conclusion (after all, as Jaspers wrote, in the realm of hermeneutics "… a final 'terra firma' is never reached" [25]).
Hence, the pretension of truth that hermeneutics aims for has a different value than the one aimed at by the natural sciences. There is no Truth, just like there is no definitive diagnosis (according to the hermeneutical method, further information added to the global picture or a different guiding theoretical approach might allow for the different reconstruction of a particular case, leading to a different diagnostic conclusion), but only a multiplicity of perspectivistic truths. However, not all interpretations are equal.

Hermeneutic objectivity: psychopathology's quest for certainty

Hermeneutic reconstructions must respect certain constrains in order to avoid spurious interpretations and arbitrariness. In order for a community of psychiatrists to be able to make sense of the notion of psychosis (i.e. share a common understanding regarding its meaning and the way it is applied in clinical practice), they must be able to share a set of theoretical [g], pragmatic and common sense assumptions that might guide the reconstructive process through a common path, allowing for a common diagnostic conclusion (or at least for the establishment of a dialogical interaction focused on the interpretative process leading to a diagnostic rationale). In this sense, the result of an interpretative activity (such as psychiatric diagnosis) might achieve a varying degree of *hermeneutic objectivity*, the value of which will depend on features such as its plausibility, its global coherence, its capacity to articulate contextual and non-representational information, its capacity to justify the relation between symptoms present and absent, its acknowledgement of underlying theoretical implications, its predictive power or its capacity to offer effective paths for intervention.
As an oxymoron, the notion of "hermeneutic objectivity" must be understood in a metaphorical sense. As we already mentioned, hermeneutical endeavours never disclose natural objects that could ultimately be subsumed under universal laws (as a natural-scientific approach would pretend). This metaphorical notion of objectivity makes reference to *fallible constructs* that can *never* fully account for the totality of the reconstructed individual. Further, such constructs can never be directly grasped or intuited, but only apprehended through a narrative (reconstructive) and intellectual effort. However, the better a reconstruction complies with the abovementioned features (those that determine the value of "hermeneutic objectivity") the more it will *resemble* an ideal of objectivity (i.e. in the sense of achieving a greater level of intersubjective validity, global coherence and plausibility) [h].
In essence, the semantic and epistemic value of psychopathological terms (i.e. the way they are defined and how they are applied in clinical practice) does not rely on objective measures, nor does it abide by deterministic laws. On the contrary, this value relies on the strength of the context-dependent and theory-laden reconstructive consensus reached by the community of those who struggle to make sense of altered subjective experience through clinical practice.

How, then, can we define the term "psychosis" and apply it in clinical practice? [i]

The first point we need to make clear is that psychosis is not a thing, a definite and objective entity that can be fully defined in descriptive terms. We can argue that there is something that most patients who have been labelled as psychotic throughout the last century seem to share. In this sense, Heinimaa finds in the notion of "un-understandability" the core semantic trend followed by the notion of psychosis throughout the 20th century (following Bleuler, Jaspers, Schneider, Spitzer and eventually the DSM) [6]. In our opinion, un-under-

[g] Most important, these theoretical assumptions must include an understanding regarding the nature of subjectivity and reality (after all, psychosis is understood as a disorder of subjective experience or as a disturbance in the way in through which individuals apprehend reality).

[h] Consensual Qualitative Research, a methodological approach for subjective experience deployed in phenomenological investigations, represents a practical endeavour that is based on a very similar line of thought [27].

[i] It must be kept in mind that this paper has merely semantic and epistemic purposes. We are hence trying to understand the conditions of possibility for defining psychosis and not trying to achieve such a definition.

standability could be argued to represent a disadjustment between man and world [j] that is experienced by an observer as an irreducible estrangement. However, not all forms of un-understandability can be considered as abnormal, pathological, or psychotic (see for example the eccentric or the genius who is ahead of his time). In this sense, we must keep in mind that what we aim at understanding is a fellow human being in his relation towards the world (it is a person that we fail to understand, and hence a person who is psychotic – not a symptom). We therefore identify a need to articulate the relationship between man and world, between subjectivity and reality, so that we may determine which forms of incomprehensibility should count as psychotic (hence psychosis becomes a theoretical construct that tries to account for certain forms of incomprehensibility). Unfortunately, an understanding of the relationship between man and world is the very task that philosophy has struggled with for over 2500 years and no definitive answers have become available. Hence, a theoretical commitment with the most appealing theoretical assumption regarding the nature of the relationship between man and world (or subjectivity and reality) [k] seems to represent an indispensable requirement in order to reach a definition for the term "psychosis". Once the structure of this relationship has been disclosed, an account of how it might break down will come to define the deep structure of psychosis (or several accounts might come to define different possible ways of becoming psychotic).

In this sense, we identify a trend (focused mainly on schizophrenia) that expanded throughout the 20th century and that realised that reconstructing an individual for diagnostic purposes demands the previous articulation of the relationship between man and world [l] (Minkowski's loss of vital contact with reality [15], Binswanger's Transcendence [28], Blankenburg's loss of natural self-evidence [14], Stanghellini's loss of common sense [29], Sass and Parnas' ipseity disturbances [30] etc.). In fact, the notion of incomprehensibility as a core element pertaining to the notion of psychosis seems to have drawn back in the last decades [m], allowing for a growing focus on the ontological status of man and on the idea of a disadjustment between man and world [29-32].

However, these ideas imply a risk that should not be neglected. The underlying theoretical assumptions implied in the notion of psychosis cannot say in definitive terms what man or world are, for they only represent one approach among many (the history of philosophy is clear proof of this point). This should preclude descriptive definitions aimed at saying what psychosis *is,* for 1) they falsely imply *knowing* what man and world *are*, and 2) they neglect the fact that psychosis is a theoretical construct (whose meaning is also modulated by legal and social dimensions) and the product of a hermeneutic reconstruction. In spite of its perspectivistic flavour, a definition of the kind "taking into account this theory about man, world and reality, the term psychosis could be understood as…" would seem, in our opinion, more epistemologically sound.

As we already mentioned, not all definitions (understood as theoretical constructs) should be granted the same value. The better a definition complies with the values ascribed to hermeneutic objectivity (in the sense of plausibility, global coherence, appropriation of theoretical assumptions, articulation of contextual information etc.) the better it will be, the closer it will stand with regards to our aspired value of truth and the more it will resemble an ideal of objectivity.

According to the proposed view, the methodological framework that underlies the use of the term psychosis in clinical practice is a theory-guided hermeneutical process. The fact is then that a single patient might be interpreted or reconstructed according to different alternative theories or perspectives that offer different value to contextual and non-representational information. His utterances, his behaviour, other accompanying phenomena, his expression, his biography, his personality traits, his hopes and desires, his life-world as a meaning-bestowing totality, they all have semantic value, the relevance of which will be determined by different factors [33] (one of

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[j] This notion of world should not be understood as the totality of objects, as a world-in-itself, but as an intersubjectively constituted horizon of meaning that allows for the object's appearance.

[k] Ontological realism, nominalism, transcendental idealism, a representational theory of mind, a correspondence theory of truth, a coherence theory of truth etc.

[l] Interestingly, these accounts tend to consider delusions or hallucinations as contingent phenomena and, most important, allow for an understanding of the internal structure that interweaves the different clinical manifestations (namely what Minkowski called *trouble générateur* [15]).

[m] In fact, the notion of incomprehensibility as a core feature of psychosis has been repeatedly contested throughout the last decades: a) a lack of understanding might be due to my own incapacity to understand a patient, b) the act of understanding is context-dependent (someone might be considered as incomprehensible in a particular context and understandable in a different setting), c) a particular theory regarding a breakdown in the relationship between man and world might render certain phenomena (previously considered as incomprehensible) understandable…

which, as we have already mentioned, is the theoretical model in place). Hence, a patient can be considered both as psychotic and as non-psychotic at the same time (it is not at all strange that we find this happening in clinical practice). There is thus no certainty, at least not in the causal-deterministic terms implied by the pretension of truth of the natural sciences. Once again, however, not all interpretations should be granted the same value. The greater the value of hermeneutic objectivity, the better the individual reconstruction will be and hence the more the clinical judgement will approach a value of truth.
A final remark regarding psychotic symptoms. Although these can no longer be considered to bear the meaning of the term psychosis, they still play a central role in clinical practice. They represent the most frequent and characteristic forms through which an observer may conceptualise or categorise the experience of estrangement that interaction with a fellow human being might arouse. The fact that we might be able to reconstruct an utterance or a fragment of behaviour as a psychotic symptom does not allow for identifying the individual under the kind "psychosis". However, the initial identification of an utterance or a fragment of behaviour as an instance that satisfies the descriptive features of a specific type of psychotic symptom can be taken to represent an initial (and essential) step that catalyses the interpretative diagnostic process [33 34].

Conclusions

A pretension of truth based on causal relations and deterministic laws requires an epistemic framework that does not legitimately apply to psychiatry, for psychopathological symptoms are not directly apprehended as spatio-temporal physical objects nor do they stand in causal relations with surrounding objects. Given the nature of psychiatry's object of study (i.e. subjective experience), psychopathological raw data (i.e. uninterpreted utterances and behaviour) must be rendered meaningful through an interpretative process. The hermeneutic nature of this endeavour precludes both a single and universally accepted definition for psychosis and a uniquely valid diagnostic conclusion for any particular individual. It is hence due to the very nature of psychopathological phenomena as belonging to the realm of subjective experience that the semantic and epistemic questions defy an answer in the kind of terms expected by the natural sciences. However, neither all definitions nor all individual diagnostic reconstructions can be granted the same value. According to the above-mentioned view, the better they comply with certain features (such as global coherence, plausibility, acknowledgement of theoretical and philosophical assumptions, the capacity to articulate contextual information, predictive power or the capacity to open paths for intervention), the better the interpretation will be and the more it will resemble an ideal of objectivity.
Finally, we observe that the notion of incomprehensibility, a core element in the history of the notion of psychosis, seems to have drawn back in the last decades allowing for a growing focus on the ontological status of man and on the idea of a disadjustment between man and world [29-32]. In this sense, we believe that further theoretical and philosophical input on the relational structure between man and world will allow for better and more solid conceptualisations of psychosis.

Conflicts of Interest
None.

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