Section Two
NATURE AND CIVILIZATION

Cosmos-Containing Mental Disorders: Phenomenological Advancing for Psychopathology and Philosophy of Psychiatry

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The study explores the potential of phenomenological psychopathology to describe the experience of individuals with cosmos-containing mental disorders. These disorders are examined through the frameworks of psychiatric classifications such as the ICD-10 and DSM-5 while integrating insights from phenomenology, psychiatry, philosophy, and cultural psychiatry. The investigation employs interdisciplinary, comparative, phenomenological, and descriptive methodologies. These approaches integrate perspectives from phenomenological psychopathology, philosophy of psychiatry, and cultural psychiatry, using the frameworks of ICD-10 and DSM-5. The phenomenological method provides a nuanced description of the altered life dimensions of affected individuals, while the interdisciplinary approach synthesises insights from multiple disciplines to contextualise cosmos-containing mental disorders.

Through the analysis of clinical cases, the authors demonstrate the distinct manifestations of cosmological content in mental disorders. A notable challenge identified is patients' frequent dissimulation of symptoms, which complicates the diagnostic process and subsequently affects the efficacy of psychopharmacological and psychotherapeutic interventions. The findings underscore the value of incorporating phenomenological psychopathology into traditional diagnostic practices, enabling a more comprehensive understanding of these unique symptoms.

The findings highlight the necessity of incorporating phenomenological psychopathology into psychiatric practice to improve diagnostic accuracy and treatment outcomes for cosmos-containing mental disorders. Ethical concerns, including stigma, discrimination, and social exclusion, are underscored, emphasising the importance of raising awareness among non-mental health professionals. Enhanced understanding of the unique experiences of these individuals is crucial for early diagnosis and reducing societal stigma.

Keywords: cosmos-containing mental disorders, phenomenology, phenomenological psychopathology, philosophy of psychiatry, hallucinations, delusions, oneiroid syndrome, cultural psychiatry, cosmology

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Introduction

Cosmos-containing mental disorders are a unique phenomenon in psychiatry and psychopathology. These disorders often involve symptoms such as hallucinations and delusions related to concepts of the creation, development and structure of the universe. While this aspect of the disorders is not new, insight is being gained through phenomenological psychopathology, which allows researchers to gain a deeper understanding of the subjective experiences of individuals suffering from mental disorders.

The cosmological content of these mental disorders reflects a deep inner connection between a person's mental state and his or her perception of the macrocosm. Patients with these disorders may see themselves as part of a larger cosmic order or believe they have a special role in cosmic events. For example, some may believe they are a prophet or messenger from another world with special knowledge or abilities. These beliefs may manifest as complex hallucinations in which patients see or hear deities or other supernatural beings.

Delusions may include the belief that cosmic forces influence them or that their actions can affect the course of cosmic history.

Phenomenological psychopathology allows researchers to focus on the experience of mental disorders and their interpretation by patients with cosmos-containing mental disorders. This approach attaches importance not only to the external manifestations of symptoms but also to the inner world of patients and their subjective perception of reality. Phenomenological psychopathology examines how patients perceive and interpret their experiences, what cultural and personal factors influence their beliefs, and how these beliefs are reflected in their behaviour. This leads to a deeper understanding of mental disorders and allows for a more sensitive approach to diagnosis and treatment tailored to the individual needs of the patient.

A phenomenological approach also allows researchers and clinicians to better understand how patients integrate their cosmological beliefs into their daily lives. This may include examining how patients use these beliefs to explain or respond to their experiences. For example, patients may use cosmological beliefs to give meaning to their symptoms or to create a sense of control over their lives. This is particularly important when patients feel anxious or fearful about their symptoms and are looking for ways to cope.

In addition, a phenomenological approach can help to develop more effective therapeutic interventions for patients with cosmos-containing mental disorders. Therapists can use phenomenological methods to help patients understand and interpret their cosmological experiences and find ways to integrate these experiences into their lives. This may include methods such as narrative therapy or cognitive behavioural therapy to help patients understand their experiences and develop healthier ways of responding to them.

Disorders of the psyche and behaviour with cosmological content are a complex and multifaceted phenomenon that requires a careful and delicate approach by researchers and clinicians. Their in-depth study requires a combination of methods from phenomenological psychopathology, cultural psychiatry and philosophy of psychiatry, and an explanation of their origin through the dominant model in modern psychiatric practice.

A further problematic issue is the ethical challenges that may arise from stigmatisation, over-prescribing of medications and lack of public trust in people with mental disorders.

The Phenomenological Approach in Psychopathology and Psychiatric Practice: a Research Background

Phenomenology is a philosophical tradition initiated in the first half of the twentieth century by Edmund Husserl and further developed and improved by Martin Heidegger, Maurice Merleau-Ponty, Jean-Paul Sartre, and others. In the twentieth century, phenomenology became a central philosophical movement and field of research.

The methods and characteristics of phenomenology as a philosophical discipline were widely discussed by Husserl and his colleagues, and they are still a field for current and future research.

Phenomenology involves a careful, unbiased description of conscious, subjective experience, without imposing an external explanatory framework, whether from the natural or social sciences or ordinary language.

In modern philosophy of mind, psychiatric and psychological research, the use of the term "phenomenology" is limited to the description of sensations that occur in sensory analysers such as sight, hearing, smell, taste and touch. However, our experience usually has a much richer content than just sensations. On this basis, the phenomenological tradition provides a

much wider range of meanings that are reflected in our experience, in particular, the meaning of objects in the world around us, past, present, and future events, the flow of time, perception, thinking, memory, imagination, emotions, desires and will, bodily awareness, awareness of the self, its structure and stability, embodied action and social activity, including language activity.

The structure of these forms of experience, according to Husserl, includes "intentionality". That is the orientation of experience towards things in the world, the property of consciousness to be conscious of or about something. According to Husserl's classical phenomenology, our experience is directed to things and represents or "intends" them, only through certain concepts, thoughts, ideas, and images (Woodruff, 2018). They are the content of this experience and differ from the things they represent or signify.

The basic intentional structure of consciousness, which we find in reflection or analysis, includes further forms of experience. Thus, phenomenology develops a comprehensive description of temporal awareness, spatial awareness, attention, awareness of one's own experience, self-awareness, self in different roles, embodied action, purpose or intention of action, awareness of other people, language activity, social interaction of everyday activity in the world of life (Woodruff, 2018).

The continued attraction of the phenomenological approach to research in the social, behavioural, and medical sciences lies in the persistent advocacy of the importance and anti-reductionism of subjectivity and the detailed analysis of the structures of the lived world.

Contemporary phenomenology is not only characterised by research in its subject field. Today, it is a set of interdisciplinary projects. Phenomenology actively interacts with cognitive sciences, psychiatry, literary studies, gender studies, and theology. This openness to new interactions, the creation of new approaches, and convergence is the most significant and characteristic trend in contemporary phenomenology. These studies lead to the improvement and expansion of the boundaries of the phenomenological method in other fields of scientific research and the development and filling of phenomenology in general with new theoretical and practical perspectives.

Below are some examples of such interaction.

The cognitive sciences integrate the phenomenological methods and conceptual apparatus of phenomenology into their empirical research. One such project has become neurophenomenology or frontal phenomenology. They are designed to investigate and demonstrate the correlation of first-person data with third-person data obtained through neuroimaging. Another example is the objectification of first-person phenomenological description through mathematisation.

In general clinical medicine and bioethics, phenomenology is becoming a platform for integrating discourses about the body and bodily processes into clinical practice. Here, the phenomenological method is used to describe a patient's subjective experience of somatic disease and the changes in the physicality that it causes. This experience is expressed in interrelated dimensions, such as material, affective, functional and social. That is why the language and methods of the medical sciences cannot comprehensively capture the entire experience of disorders. The involvement of phenomenology can provide such an opportunity (Adamiak & Pokropski, 2018: 12).

Before we begin to review the use of phenomenology in psychopathology, a brief definition is necessary.

Psychopathology is a branch of general psychiatry and clinical psychology. It is a branch of scientific and clinical research that focuses on the observation, description and evaluation

of abnormal cognition, inappropriate behaviour and experiences that accompany mental and behavioural disorders and contrast sharply with generally accepted social norms. Based on the subject of its study, psychopathology is divided into general and special.

General psychopathology studies the main symptoms and syndromes common to many mental diseases, patterns of manifestation and development of mental pathology, general issues of aetiology and pathogenesis, and the nature of psychopathological processes, their causes, principles of classification, methods of research, and treatment.

In turn, specialised psychopathology studies changes in human mental activity in specific mental disorders (e.g. schizophrenia, generalised anxiety disorder), their aetiology, pathogenesis, clinical manifestations, developmental patterns, treatment and rehabilitation.

The main method of diagnosis within the framework of general psychopathology in psychiatric practice is a clinical (psychiatric) interview. During the interview, the psychiatrist, in a certain sequence, examines various areas of mental activity for the presence of pathologically altered processes. For example, they examine attention, memory, emotions, cognitive skills, imagination, and orientation in oneself and the surrounding area.

Karl Jaspers' seminal work *General Psychopathology* was the first to outline the connection between phenomenology and psychopathology. He argued that, unlike general psychopathology, which focuses only on the objective side of the information that a psychiatrist receives from a patient or their relatives, phenomenological psychopathology would provide clinicians with the tools to "intuitively imagine" a patient's experience of mental disorders (Dey et al., 2020: 915).

Phenomenological psychopathology is an interdisciplinary project that aims to assess and describe the abnormal subjective experiences of a mental disorders patient through changes in their basic existential structures, such as selfhood, spatiality, embodiment, temporality, affectivity, understanding, and intersubjectivity (Messas et al., 2018, p. 1).

Phenomenological psychopathology attempts to describe the diversity of empirical variations and differences and to set aside socio-political and scientific views of what is considered a mental and behavioural disorder. It attempts to find, identify and demonstrate what is 'human' about the irrational phenomena of mental disorders. If we take the position that the most important task of psychiatry is to understand mental suffering, then its project should be to articulate each person's life world and identify the conditions for the possibility of pathological phenomena in human existence. This can shed light on the structure, meaning, and significance of the phenomenon under study. Phenomenological psychopathology can help us rethink the meaning of psychopathological conditions.

Psychiatric and psychopathological research has had a close and fruitful relationship with philosophical phenomenology. Leading philosophers such as Husserl, Stein, Heidegger, Gadamer, Sartre, Merleau-Ponty, Ricoeur, and Levinas, and psychiatrists and psychologists such as Jaspers, Binswanger, Boss, Fanon, Laing, Minkowski, Strauss, Krachmer, Tellenbach, Blankenburg, Kimura, and Basaglia, have conducted research in phenomenological psychopathology.

The result of fundamental research in recent years in phenomenological psychopathology is *The Oxford Handbook of Phenomenological Psychopathology* by G. Stanghellini, M. Broome, A. Fernandez, P. Fusar-Poli, A. Raballo, and R. Rosfort. The manual consists of six sections that comprehensively cover the history of development, specificity of the phenomenological method in psychopathology, the main conceptual categories, the application of phenomenological psychopathology in direct clinical practice (for example, in describing the lived experience of schizophrenic spectrum disorders, verbal and auditory

hallucinations, and delusions) and describes the current state and prospects of research on phenomenological psychopathology in the fields of neurology, psychotherapy, general and special ethics, political and social regulation of mental health issues (2019: 34).

In the article *New Perspectives in Phenomenological Psychopathology: Its Use in Psychiatric Treatment*, G. Messas, M. Tamelini, M. Mancini and G. Stanghellini demonstrate how modern models based on the principles of phenomenological psychopathology can be used in direct clinical practice, using the example of the dialectical-proportional approach and the personality-oriented dialectical approach in the implementation of therapeutic measures.

The study *Phenomenology as a Resource for Translational Research in Mental Health: methodological trends, challenges and new directions* by R. Ritunnano, D. Papola, M.R. Broome, and B. Nelson emphasises the importance of understanding the experience of mental disorders using the methods of phenomenological psychopathology, pointing to the need for their integration into direct clinical practice, which will increase the emphasis on the subjective structure of the patient's experience when planning psychological and psychotherapeutic interventions.

H. R. Neto and A. Tomé's phenomenological analysis of post-traumatic stress disorder (PTSD) using phenomenological interviewing in the article *Phenomenological description of PTSD through a case* demonstrated the need for an interdisciplinary approach to the process of initial diagnosis and further classification of symptoms that correspond to the diagnosis of PTSD. Since existing diagnostic systems, such as the International Statistical Classification of Diseases and Related Health Problems-10 (ICD-10) and the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), do not take into consideration the specifics of a person's experience of mental disorders, this can lead to an inappropriate diagnosis.

In the article *The Phenomenological Model of Depression: From Methodological Challenges to Clinical Advances*, O.O. Frohn and K.M. Martiny proposed a phenomenological model of depressive disorder based on a semi-structured phenomenological interview. The authors emphasize the possibility of improving the provision of psychotherapeutic care for depression, including art therapy and complementing existing diagnostic scales and clinical guidelines.

In Ukrainian psychotherapeutic practice, the use of phenomenological psychopathology is represented in the practical application of existential-analytical psychotherapy in the Second Inpatient Department of the Lviv Regional Psychoneurological Dispensary (Zabor & Filts, 2018: 29).

The history of the interaction between philosophy and psychiatry begins in the late nineteenth century. This interaction can be divided into four stages: the initial stage (S. Freud, E. Bleuler), the syncretic stage (phenomenological psychiatry: K. Jaspers, E. Minkowski, E. Strauss, V. Emil von Gebsattel, L. Binswanger, and existential analysis: M. Heidegger, M. Boss), the practical or anti-psychiatry stage (R. Laing, D. Cooper, T. Saas) and the stage associated with the formation of an interdisciplinary project in the late twentieth century, which is positioned by its representatives as a philosophy of psychiatry (Dariienko, 2022: 60).

The first stage of this interaction was characterized by humanization in psychiatry. The development of phenomenology at that time meant the necessity of research in psychiatric practice that appealed to the experience of mental disorders. The second stage (syncretic) was characterized by the development of the phenomenological approach in psychiatry and the creation of new categories and concepts in the study of mental disorders. The phenomenological method was constituted as one of the main methods for describing the

experience of mental and behavioural disorders and abnormal experiences. The stage of anti-psychiatry was characterized by several objections and criticisms of the postulates of classical psychiatry. These included the questioning of the reliability of psychiatric diagnosis, the grounds for its determination, the analysis of the potential effectiveness and harm to the individual's life world associated with the use of psychopharmacology, the inability of biological psychiatry to explain the origin and development of mental disorders only in terms of, for example, molecular theory, and ethical and legal issues affecting patient autonomy and the restriction of their civil liberties. The last stage, the philosophy of psychiatry stage, is characterised by the study of psychiatry as a science, using the tools of the philosophy of science more broadly, involving the study of concepts used in the study of mental disorders, including the experience of mental disorders, its phenomenological analysis, normative issues that arise from the understanding of this experience and the study of the links between psychopathology and the philosophy of consciousness (Adamiak & Pokropski, 2018, p. 11; Dariienko, 2022: 61-62).

One of the main texts in the field of philosophy of psychiatry is *The Oxford Handbook of Philosophy and Psychiatry* by K. W. M. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler and G. Stanghellini. The handbook brings together a representative cross-section of the new field of research between philosophy and psychiatry. The authors note that the material presented is of immediate practical relevance and reflects several innovations that reflect the lively dynamic between theory and practice that is such a characteristic feature of the philosophy of psychiatry. The materials presented in the handbook are based on direct clinical cases, and the structure is built around the stages of the clinical encounter between patient and clinician to better reflect the problematic issues of diagnosis, classification, and treatment of mental disorders (Fulford et al., 2013: 6).

The next important work in recent years in the philosophy of psychiatry is *Philosophy of Psychiatry*, edited by Sam Wilkinson. According to the author, this is a textbook for undergraduate and graduate students studying philosophy and seeking to deepen their knowledge of the philosophy of psychiatry. An important note from the author indicates the growing demand for the study of the philosophy of psychiatry as a philosophical discipline in universities in the training of certified specialists in philosophy. Wilkinson examines in detail the definition of "mental disorders," the concept of "diagnosis," and the analysis of the criteria for its assessment, the role of cultural and religious background in the diagnosis of mental and behavioral disorders. The philosophical conceptualisation of schizophrenic spectrum disorders, depressive disorders, delusions and addictions is also provided.

The growing interest in the philosophy of psychiatry and its formation as an independent philosophical discipline is evidenced by the book *Continental Philosophy of Psychiatry* and the creation of scientific communities and associations around it, for example, The Association for the Advancement of Philosophy and Psychiatry, The International Network for Philosophy and Psychiatry, which organise joint research, conferences and educational programmes. It also launched scientific journals aimed at highlighting topical issues of philosophical understanding of psychopathology and building strong interdisciplinary links between philosophy and medicine, such as the journal *Philosophy, Psychiatry, & Psychology*, which has been covering various philosophical aspects of psychopathology and psychiatric methodology since 1993. Research on the philosophy of psychiatry is regularly published in interdisciplinary journals such as *The Journal of Medicine and Philosophy*, *Philosophy, Ethics, and Humanities in Medicine*, *Medicine, Health Care and Philosophy*, and *Phenomenology and the Cognitive Sciences*. Philosophical research in the field of mental

health also appears in psychiatric journals such as *General Psychiatry* and *World Psychiatry*. A separate achievement for the development of the philosophy of psychiatry was the creation of specialised courses and educational programmes. For example, the University of Warwick was the first to open a department of philosophy and mental health. The Royal College of Psychiatrists in the UK has included a philosophy course in its mental health training programme.

Some of the most recent research in the field of philosophy of psychiatry is devoted to the issue of patient autonomy, ethical challenges faced by psychiatrists in their practice, and discrimination against and/or stigmatisation of patients with mental disorders (e.g. epistemic and hermeneutical injustice, an overview of which is presented below).

The Biopsychosocial Model of Cosmos-Containing Mental Disorders

In 1977, the American psychiatrist and pathologist George Engel in his article *The need for a new medical model: A challenge for biomedicine* proposed a new model for understanding the causes of somatic and mental diseases called the biopsychosocial model. His research was based on cases of depression, ulcerative colitis and psychogenic pain. The study of these pathological conditions was a challenge for the biomedicine of the time and the dominant biomedical model of understanding the causes of somatic and mental diseases because they favoured somatic manifestations of diseases as more "real", more "reliable", and therefore the only thing worthy of a clinician's attention. What could not be verified or explained in terms of cellular and molecular processes was either ignored or devalued. In such a conceptual and methodological context, medicine neglected the subjective dimension of the human experience of disorders as a source of meaningful research and understanding (Borrell-Carrió et al., 2004).

The biopsychosocial model is both an updated philosophical approach to understanding healthcare service delivery and a practical guideline for healthcare practitioners. It aims to change the paradigm of research in medical practice from exclusively analytical, reductionist and specialised to more contextual and interdisciplinary.

Philosophically, it is a way of understanding how the causes of the development and progression of somatic and mental disorders and their experience are influenced by different levels of organisation of internal and external factors, from the molecular level of an individual to the level of social interaction between such individuals.

On the level of practice, it is a way of understanding how the subjective experience of a person suffering from a particular somatic or mental disorder can make a significant contribution to the accuracy and comprehensiveness of diagnostic processes, the results of selected pharmacological, psychotherapeutic and other types of therapeutic interventions, the expected outcome of treatment, and humane, ethical treatment during and after treatment and rehabilitation.

The direct application of the biopsychosocial model in clinical practice is called biopsychosocial-oriented clinical practice.

In psychiatric practice, the biomedical model describes mental disorders as defects or abnormalities in brain structures, dysregulation of neurotransmitters, or genetically determined defects. However, the common theory of chemical imbalance could not provide a diagnostic test that included an assessment of neurotransmitter levels that could be used in direct clinical practice. Neither of the primary nosological systems for classifying mental disorders, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or

the International Statistical Classification of Diseases and Related Health Problems (ICD), included biological tests for detecting, diagnosing or classifying mental disorders. No valid and reliable biological tests for the diagnosis of any psychiatric disorders exist yet.

The reductionist approach of the biomedical model, which conceptualised all behavioural manifestations as disorders of physico-chemical processes, was not sufficient to explain all aspects of mental disorders and ignored the individuality and uniqueness of the patient's experiences and feelings. The basic principles of the new biopsychosocial model include a combination of biological, psychological and social dimensions of human life. It postulates that a person suffers from a disease as a whole and not just as a specific disorder of the adequate physiological activity of isolated, separate organs. The doctor should use a holistic and integrated approach to the study and treatment of the disease and consider his relationship with the patient to be socially equal (Tripathi et al., 2019: 583).

In the aetiology of the onset and progression of mental and behavioural disorders in psychiatry, the biopsychosocial approach is implemented through the following components:

a) Biological: genetic predisposition to the development of diseases and pathological conditions, sex, gender, age, presence of concomitant diseases, state of the immune system, anatomical features of the brain structure, possible negative effects of medications, level of activity of neurochemical reactions.
b) Psychological: emotions, behaviour, state of development of coping strategies, temperament, character, beliefs, social interaction skills, self-esteem.
c) Social: socio-economic status, cultural characteristics, occupation, education, communication with colleagues, family background, level of social support from others.

Psychiatry, as a branch of medical knowledge, has certain features in everyday practice that are distinct from other medical disciplines due to the complexity and polymorphism of the expression of mental disorders and their close relationship with psychosocial factors, the lack of obvious pathognomonic elements and the stigma of mental disorders. For these reasons, the biopsychosocial model has been used to diagnose, classify and explain the causality of mental disorders (Papadimitriou, 2017: 210).

The biopsychosocial model stimulated the development of interdisciplinary research in the field of psychiatry. This allowed us to expand the subject field of study of mental disorders characterised by the presence of psychopathological symptoms of cosmological content using the methods and conceptual tools of philosophy of psychiatry, cultural psychiatry, phenomenological psychopathology, cultural studies and religious studies.

In formulating the biopsychosocial model, Engel recognised culture as an important factor in understanding disorders. He noted that the boundaries between health and disorders are far from being as clear as we have come to believe, as they are diffused through the lens of cultural, social and psychological assumptions. Engel defined culture as a set of institutional conditions, formal and informal practices, explicit and implicit rules, and ways of making meaning and representing experience in ways that will influence others. However, in practice, culture has been relegated to a social factor, which largely underestimates the fundamental role of culture in the experience and manifestation of mental and behavioural disorders, including those with cosmological implications (Babalola et al., 2017: 294).

The Cultural Psychiatry of Cosmos-Containing Mental Disorders

The objective of psychiatry is to solve clinical problems that arise between the patient and the doctor with the knowledge acquired within the discipline, using it to provide qualified medical care. In most cases, this task is not problematic, as the doctor and patient share a common cultural and linguistic background, and communication on relevant topics is relatively easy and accessible between them. For example, they have a common understanding of social reality, what mental disorders and mood disorders are, what a psychiatrist should ask during a psychiatric interview, and how to talk about and explain problematic, unexplained phenomena that a person faces in the process of experiencing a mental disorder.

The objective of cultural psychiatry is quite similar but at the same time different due to inconsistencies in the ontology and epistemology of psychiatric disorders in speakers of different cultures, and differences in speech acts, which can complicate communication between doctor and patient during the diagnostic and treatment processes.

Cultural psychiatry focuses on the development and improvement of data on how culture and language affect all aspects of a person's mental state. This includes, for example, the causes of disturbances, the characteristic manifestations of these disturbances, their interpretation by the patient and their relatives, and the behavioural consequences in the patient's personal and social world. All these factors form symbols, meanings and values. The basic principle of cultural psychiatry is a correspondence between, on the one hand, the meaningful elements of the mental state as they are represented cognitively in the patient, and on the other hand, the meaningful elements that shape the patient's social relationships, circumstances, situation, life problems, and the actual signs and symptoms of mental and behavioural disorders. The patient's social background, ethnicity, religious affiliation and level of religious involvement, view of self, and social situation are considered to understand how the mental state is constructed. What does it mean in the patient's world of thought and life space? How does it affect and fit into the patient's social world? What in this world needs to be addressed in treatment to improve the patient's social functioning? (Fabrega Jr, 2007: 547)

The relationship between religion and mental health depends on previous upbringing, education, gender, religious denomination, and other factors. The most accurate measure of religiosity is geography. For example, while religious identification is declining in Western Europe and North America, it is increasing in other regions. Until the early nineteenth century, the diagnosis and treatment of mental disorders were largely the domain of religious communities. A significant change occurred when Charcot and Freud linked religion to hysteria and neurosis. This created a gap between religion and psychiatry that has only begun to change in the last few decades.

One of the signs of change was that in 1994, the DSM-IV introduced a code called "religious or spiritual problems" to help professionals better understand their patients' beliefs and rituals. In the current version of the DSM-V, using this code is recommended when the focus of clinical attention is a problem of a religious or spiritual nature. Examples of this include experiences of anxiety related to conversion to a new faith and doubts about the individual's current spiritual values, which are not necessarily associated with a stable, organised religious institution. Moreover, manifestations of certain religious practices can serve as leading symptoms of mental disorders. For example, certain forms of hallucinations, including the creation of the universe, the cosmos, its origin and development, but at the same time being within the normative framework of a particular religious affiliation, are

considered socially and medically acceptable. This can directly affect the interpretation of psychiatric symptoms in the diagnostic process.

Religiosity and religious beliefs play a role in the diagnosis and treatment of mental and behavioural disorders, but to what extent remains a matter for further research. Information about affiliation with a particular religious denomination can provide clinicians with initial parameters for providing primary psychiatric care. In turn, spirituality is more subjective and has no clear indications of what a patient believes in or how they feel about mental health and treatment. Although these are separate areas of belief, they often go hand in hand when understanding the need for mental health care.

When planning diagnostic and treatment interventions for people with symptoms of mental and behavioural disorders, doctors should address the following questions: Should a potential patient's religiosity be considered a symptom of a mental disorder if the patient did not show interest and involvement in religious practices before the onset of the disease? Can religion negatively affect a person's mental health, or is it an auxiliary mechanism in the preparation and implementation of treatment and diagnostic measures? What list of specialists, other than mental health professionals, can identify signs of hyperreligiosity and its direct impact on all aspects of a patient's life? If the content of a culture is determined by the people who are part of it, then if a certain religious movement or spiritual beliefs no longer correspond to that culture, is this a manifestation of a mental disorder?

Reflecting on this list of problematic issues, cultural psychiatry becomes a unique example of a medical, philosophical, religious and cultural focus on psychiatric disorders. Cultural psychiatry does not only analyse specific, relevant aspects of the influence of religious beliefs, faiths, spirituality and other cultural practices to address clinical challenges from a modern perspective. After all, the multifaceted factors inherent in psychiatric phenomena, such as stigmatisation of people with mental disorders, equating symptoms of mental disorders with mystical practices, and determining the rank of psychiatric symptoms in comparison with somatic diseases, are historically conditioned. For example, the significance and role of altered mental states in ancient medical traditions (Ayurveda, traditional Chinese medicine, Central Asian medicine, Mediterranean medicine) contrast with the ideas and scientific paradigm of modern psychiatry. However, they should be seen as a necessary component of what psychiatric conditions mean in a comparative perspective. This comparison makes available for analysis the concepts of defining a person's identity, the conformity of his or her actions to a social situation based on dominant, stable models of cultural systems, and cosmological ideas that are passed down from generation to generation (Lim, 2006: 84).

Religious cosmology is a vivid example of the combination of religious beliefs of an individual who may potentially suffer from mental and behavioural disorders with cosmological ideas about the origin, evolution and further development of the universe and the cosmos. The experience of mental disorders in this case will reflect the following ideas: the myth of the creation of the world, beliefs about the further evolution of the world, its current form and nature, and the possible fate or purpose of the universe. The characteristic features of these experiences may vary and be supplemented according to different traditions in each particular religion or religious mythology. For example, religious mythologies may include descriptions of the act or process of creation by a creator God or a pantheon of deities, explanations of the transformation of chaos into order, or claims that human existence is a never-ending cycle of transformation. People with symptoms of mental disorders can testify and convince others that they hear the voice of God, talk directly to Him, and receive beliefs about the order of the universe in these conversations. Psychotic experiences of a

spiritual and religious nature with cosmos-containing narratives also include the themes of being persecuted by evil spirits from distant planets, control over the person's actions and thoughts by representatives of alien religions or cultures, and the person acquiring the status of a "prophet". Reflecting on such experiences of psychotic symptoms, a person tends to perceive them more plausibly and convincingly (Sweet & Paul, 2022:142).

Recently, a combination of religious and cultural practices with cosmos-containing narratives has occurred in popular culture. For example, among the most frequent theories are secret experiments of governments on artefacts of alien origin and their possible use to control human behaviour or theories suggesting that the origin of humanity is the result of alien genetic engineering, for example, that representatives of the Sumerian culture were a race of aliens. Another topic under discussion is the "reptilian conspiracy", according to which all processes on Earth are controlled by shape-shifting reptilian aliens; researchers do not exclude that this theory originates from earlier pseudo-historical legends that became known during the study of the culture of Indigenous tribes in Africa (Fountoulakis, 2022: 552).

These new explications of cosmological and religious-cosmological content can expand, supplement and qualitatively change the narrative of psychotic experience, which in turn requires improving the methods of its identification, description and conceptualisation.

The Phenomenological Psychopathology of Cosmos-Containing Mental Disorders

The description of the experience of changes in basic existential structures in modern phenomenological psychopathology involves a phenomenological interview, which is conducted using a semi-structured psychometric questionnaire. Examples of such interview instruments include the Examination of Anomalous Self-Experience (EASE), the Examination of Anomalous World Experience (EAWE), and the Examination of Anomalous Fantasy and Imagination (EAFI).

The EAFI is one of the most recently created semi-structured phenomenological interviews, developed in 2018 by A. Rasmussen, H. Stephensen, and J. Parnas. The EAFI is an instrument for semi-structured phenomenological research into the psychopathology of imagination and provides a conceptual and descriptive framework for the study of such experiences by describing them through 16 main items: 1) spatiotemporal constancy, 2) autonomy, 3) localisation and sense of experiential distance, 4) intense affects, 5) imagination as multimodal perceptualisation, 6) anomalous vivid imaginative experience, unspecified, 7) violent, macabre, or bizarre content, 8) ruminations-obsessions, 9) disturbance of control, 10) loss of ipseity, 11) image interference, 12) image pressure, 13) existential reorientation in fantasy, 14) preoccupation with fantasy life, 15) disturbances of irreality, 16) lack of insight. The researchers suggest that the imagination abnormalities studied by the EAFI reflect changes in the structure of consciousness and belong to the fundamental, generative layer of psychopathology, which should improve the differential diagnosis of mental and behavioural disorders (Rasmussen et al., 2018: 1).

The Ukrainian psychodiagnostic tradition has implemented the reception and adaptation of the EAFI. The potential of using the EAFI semi-structured phenomenological interview in the study of the heterogeneous nature of schizophrenic spectrum disorders (SSDs) is emphasised. No epistemological and heuristic basis exists for modelling imagination disorders in SSDs. In modern systems of classification of mental and behavioural disorders, the dimension of imagination is also ignored, which is an obstacle to further research and personalised psychotherapy (Pushko, 2023: 183).

To describe cosmos-containing mental disorders using a semi-structured phenomenological interview, we will provide examples of case reports for the nosological units of mental and behavioural disorders that are most characterised by manifestations of abnormal fantasy and imagination: paranoid schizophrenia (F20.0), delusional disorder (F22.0) and oneiroid syndrome. The codes are presented following ICD-10.

Paranoid schizophrenia is the most commonly diagnosed form of schizophrenic spectrum disorder. Its characteristic symptomatic features are auditory and visual hallucinations and delusions of persecution (Harrison et al., 2017: 256). The expression of cosmos-containing psychotic symptoms within paranoid schizophrenia has the following clinical picture: a middle-aged patient who graduated from high school and the law faculty of the university. In childhood, she was fond of astronomy and led a school club for its in-depth study. From time to time, she visited the planetarium. During one of her visits, she thought someone was following her. When she returned home after the show, she could not sleep at night because of the constant fear and anxiety that she was being watched from a neighbouring universe. The anxiety intensified in the morning because a part of the cosmos came down to her apartment to transform one of the planets into several smaller ones. For three days, the patient did not leave the apartment and watched the process unfold before her eyes. Later, she wanted to tell her family about this incredible astronomical miracle, but she was being watched from above, and an alien voice told her that it should remain a secret. After that, she became silent, as the forces from above took away her voice so that she would not talk about them while they were on Earth.

Analysing the patient's evidence from the perspective of the EAFI, activity in the following areas can be recorded: spatiotemporal constancy describes a stable quasi-spatial structure of the image as an object that persists in time. Hallucinatory images are experienced with a fixed arrangement and ratio of elements and are accompanied by a sense of depth. The duration of the experience of hallucinatory contemplation is described. Autonomy occurs when hallucinatory images acquire their own course, sequence or development, regardless of the subject's will. A feeling of passive perception of such images is described, including localisation and a sense of experiential distance, where psychotic images and experiences are described as having mutual spatial relations and being in motion with each other. Intense affects: anxiety, anxiety, and fear during the experience of abnormal imagination are strong. Concerning disturbance of control, the case describes the inability to distract attention or otherwise stop unwanted imaginary or intrusive experiences by willpower. The person experiences a violation of their ability to exercise control over their object of attention.

Also, persons with paranoid schizophrenia describe delusional experiences as consisting of "souls", "gods" and "rays" that span the cosmos, connect them to God, and often monitor or control their thoughts and actions (Sass & Pienkos, 2013: 646).

The next mental disorder that can manifest itself with cosmological narratives is delusional disorder. This pathology of the psyche and behaviour is characterised by the development of a single delusion or a set of interrelated delusions, which are usually persistent and sometimes lifelong; their content is highly variable. The presence of hallucinations does not support this diagnosis (Boland & Verduin, 2022: 1055-1059). For example, a patient went to church every Sunday, but for the last four months he has not been attending because he has had "enlightenment". Waking up in the moonlight, he saw that the constellation of the Big Dipper was moving and changing its configuration. The moon moved closer to the bright stars and placed itself in the centre, with a figure that looked like a hand pointing to the right. Turning his head in the direction of the hand, he saw a shooting star. The man interpreted this as a sign

from God that he should spread the word of God and that this would help save all sinners. He was firmly convinced of this and told everyone he met what his mission was in this world. He would become anxious and then angry if people around him did not share his views.

Examining this case through the diagnostic prism of EAFI, we can emphasise the presence of the changes in spatiotemporal constancy, autonomy, intense affects, and disturbance of control already described in the previous case. The following parameters are new to the description here: Ruminations-obsessions are manifested in the disturbing persistence of repetition of certain obsessive content of the mind. These repetitions are usually religious, as noted in the case study. Existential reorientation in fantasy means that the experience of an abnormal experience of imagination and fantasy causes a fundamental change in the metaphysical worldview and redefinition and restructuring of the hierarchy of human values and interests. In our case, this change was the acquisition of the qualities of a "prophet", and a preoccupation with fantasy life, where the patient spent an excessive amount of time and energy analysing, processing, and comprehending fantasy experiences. We consider this parameter to be relevant to this case, since in an attempt to convey to others his or her purpose in the world, the patient reactualises and rethinks his or her situation, spending a certain amount of time on this. Lack of insight means the patient does not consider his or her abnormal imaginary experience absurd or inappropriate and does not critically define the content of his or her experience as indicative of mental disorders.

Oneiroid syndrome is a rare form of confusion that is poorly described in the psychiatric literature and is not represented as a separate nosological unit in the ICD-10 and DSM-5 classification systems. The symptom complex of the oneiroid syndrome is represented by the kaleidoscopic nature of psychopathological experiences, in which reality, illusions and hallucinations merge into one. They are filled with modified fragments of what has already been seen, heard, experienced, and read, which are intricately intertwined with distorted perceived details of the environment. The scenes and dreams that emerge are distinguished by their scene-like nature, similar to dreams. The patient is their protagonist, actively participating in delusional events, for example, getting into a spaceship and landing on Mars, meeting and talking to the inhabitants of the planet (Chamelee et al., 2019: 3938). Clinically, the oneiroid syndrome manifested itself as follows: The man lay with his eyes open for several hours, did not respond to the treatment, periodically made floating movements and was completely immersed in his own world. The patient noted that during this time he managed to travel into space, visit several planets, become friends with aliens and save the Earth from collision with Venus and Mars. His inner gaze saw the formation of stars from gas and dust clouds in the Milky Way, and he felt shock waves caused by collisions of different galaxies. At the beginning of his delusional experiences, he felt anxious, but then he felt happy to have become a direct participant in such incredibly exciting adventures.

The development and reduction of the oneiroid syndrome can occur quickly, so a phenomenological interview should be conducted directly during the development of psychotic symptoms if the patient's condition allows it. After active psychopathological symptoms, the data obtained may not be representative of a particular individual case since oneiroid syndrome ends with partial amnesia of delusional events.

The above example captures the following EAFI parameters: spatiotemporal constancy, autonomy, localisation and sense of experiential distance, intense affects, and disturbance of control. Their characteristic features have been discussed above. However, in contrast to a protracted, chronic delusional process, in a phenomenological study of oneiroid syndrome, the parameters responsible for profound changes in worldview, values, and interests do

not change. The relationship between the person's inner self and the outside world is not disturbed, and a minimal critical assessment of abnormal experiences is not lost.

To summarise, cosmos-containing mental disorders are characterised by three phenomenological dimensions (Pushko, 2023: 193):

a) perceptualisation of images: the experience of psychotic symptoms acquires certain quasi-perceptual qualities, such as spatiality and spatiotemporal constancy, and becomes a researchable experience;
b) autonomy of images with a quasi-spontaneous flow and a sense of empirical distance between the conscious image and the sense of will;
c) blurring of unreality: usually, the functioning of the imagination is accompanied by the character of unreality. Individuals suffering from schizophrenia spectrum disorders and other psychotic disorders perceive delusional images without a clear separation from the real world.

Ethical Challenges

The above cases of using the semi-structured phenomenological interview EAFI in the process of diagnosing cosmos-containing mental disorders indicate the limited use of phenomenological tools to describe the subjective characteristics of the experience of mental disorders. Such limitations are associated with the situational use of phenomenological psychopathology in the process of diagnosing mental disorders due to the need for additional training of specialists, additional material resources, increased time for diagnostic procedures, and the use of methods only within the framework of scientific research or educational process.

For people who need qualified psychiatric care, this may mean a lack of concentration or complete neglect by clinicians of the subjective features of mental disorders. This, in turn, can lead to insufficient diagnosis and inaccurate diagnosis, polypharmacy, and stigmatisation of a person suffering from a mental and behavioural disorder.

These ethical challenges are discussed below.

Disregard for the testimonies of patients with mental disorders about their experiences of mental disorders is most often associated with epistemic and hermeneutical injustices. Epistemic injustice is a form of discrimination related to the ability to produce knowledge and provide testimony about one's condition. It is manifested in the exclusion of epistemic agents belonging to marginalised groups from the process of creating and disseminating knowledge and testimonies. The role of interpreters of the experience of excluded epistemic agents is assumed by agents who do not share their social position, which in turn distorts and devalues the knowledge gained. Hermeneutical injustice is associated with the lack of tools for the social interpretation of experience in society.

Thus, in the system of mental health care, the evidence of epistemic agents with mental and behavioural disorders is rejected in favour of clinical, academic, and professional knowledge. This is due to the peculiarities of training future mental health professionals. During the educational process, emphasis is placed on the positivist-oriented notion of the "gold standard" of research based on randomised trials, meta-analyses and systematic reviews, i.e. on the generalised scientific and academic achievements of medical science. In turn, empirical patient data may be of less diagnostic value to clinicians (Okoroji et al., 2023, p. 2).

The consequence is a growing lack of trust between people with mental and behavioural disorders and healthcare professionals and between clinicians and these people. The mere

possibility or indirect evidence of a mental disorder can provoke a lack of trust. In some situations, certain religious practices with a different cosmology from the dominant religious one in a particular social landscape are considered to be a manifestation of mental disorders, which can lead to false hospitalisation and prescription of psychiatric drugs. Alternatively, a person with a confirmed diagnosis of a mental disorder may deliberately dissimulate and conceal cosmos-containing psychotic symptoms because they fear forced hospitalisation in a psychiatric hospital and the prescription of an excessive amount of psychopharmacological drugs (polypharmacy).

People with mental disorders are often stigmatised. In everyday language, they are often described as "crazy", "not from this planet", "strange", or "defective". Stigmatisation generates social rejection of people with mental disorders. It extends to all areas of human functioning: work, housing, financial security, and relationships with others. As a result, they are constantly trying to adjust their social identity. This increases their cognitive and social burden, which can lead to a worsening of the disease. People suffering from mental disorders describe stigma as a much worse and more destructive phenomenon for the individual than the symptoms of mental disorders they experience (Crichton et al., 2017: 67).

Conclusions

The article discusses the phenomenological approach to the psychopathology of cosmos-containing mental disorders, which allows for a deeper understanding of the subjective experience of persons suffering from mental disorders. Cosmological ideas related to hallucinations and delusions about the universe, creation and divine forces are important aspects in the diagnosis and treatment of such disorders.

Cosmos-containing mental disorders should not be considered only from the point of view of the biological model in psychiatry. The biopsychosocial model, proposed by George Engel, allows us to consider biological, psychological and social aspects that influence the development and course of these disorders. This approach contributes to more accurate diagnosis, adequate treatment and more ethical and humane treatment of patients.

Phenomenological psychopathology emphasises the importance of patients' subjective experience, their inner feelings and personal interpretations of the symptoms of mental disorders. The use of semi-structured interviews, such as the EAFI, allows for a detailed examination of changes in imagination, fantasies, and perception of reality as a result of experiencing psychotic symptoms. This allows a better understanding of the specifics of mental disorders such as paranoid schizophrenia, delusional disorders, and oneiroid syndrome.

Cultural psychiatry also plays a major role in the research of cosmos-containing mental disorders. Patients' religious and cultural beliefs can have a profound impact on their mental state and interpretation of symptoms of mental disorders. This emphasises the need to consider the cultural context in the process of diagnosis and treatment.

The ethical challenges associated with stigmatisation and discrimination against people with mental disorders are serious problems. Stigma can lead to social isolation, negatively affect self-esteem and worsen the course of disorders. Healthcare professionals and members of the public must avoid prejudice and treat people with mental disorders with due respect.

The authors emphasise the need to disseminate knowledge about cosmos-containing mental disorders among mental health professionals and medical professionals of other specialities, social workers, and psychologists, since premorbid changes in personality, against

the background of expressing cosmological ideas did not correspond to the characteristic features of the person concerned before, may indicate the initial stage of a mental disorder.

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