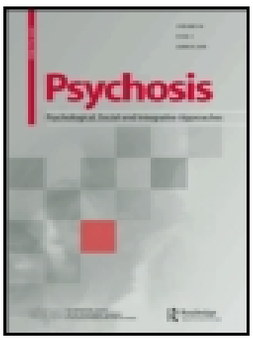

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Experiencing negative symptoms in psychosis: a systematic qualitative review

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ABSTRACT

Although negative symptoms of psychosis are frequently researched, the subjective experience of these symptoms is not often studied in detail. This paper addresses this shortcoming by reviewing qualitative research about first-person perspectives on negative symptoms. A systematic literature search using Web of Science, Scopus, PsychArticles, PubMed, CiNAHL and Embase revealed 12 relevant studies. Our review yields a model with five clusters: failing social interactions; experiences of disconnection; overwhelming psychotic experiences; an eroded self-image; and detrimental side effects of psychotropic medication. In the discussion, the authors conclude that disturbances underlying negative symptoms should be studied in greater detail, starting explicitly from theoretical frameworks like phenomenology or psychoanalysis.

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Psychosis; metasynthesis; subjective experience; negative syndrome; detachment; social difficulties

Introduction

Next to positive and cognitive symptoms, negative symptoms make up an important part of psychotic experiences, with a detrimental impact on patients' quality of life (Ventura et al., 2009). Negative symptoms imply a loss of normal functioning (Kirkpatrick et al., 2006), including diminished emotional expression, avolition, alogia, anhedonia and asociality (DSM-5; American Psychiatric Association [APA], 2013). Factor analytic studies demonstrated that these might be clustered in a motivational (avolition, anhedonia, asociality) and an expressive (diminished emotional expression, alogia) dimensions (Azorin et al., 2014).

Despite extensive scientific interest, research on the subjective experience of negative symptoms is limited. Negative symptoms are often mapped using structured interviews and self-rating instruments. Yet, these fail to grasp the full-lived experience by limiting scoring to predetermined categories and merely quantifying the results (Lincoln et al., 2017). Furthermore, observer-rated scales, like the Scale for the Assessment of Negative Symptoms (SANS; Andreasen, 1989) rely on the assumption that outward behavior adequately reflects inner experience, e.g., deducing flattened affect from diminished emotional expression (Lincoln et al., 2017). However, while emotional expression might decline in psychosis, emotional experience is often intact or even amplified (Kring et al., 1993; Trémeau, 2006). Instruments like the Brief Negative Symptom Scale (BNSS; Kirkpatrick et al., 2010) and the Clinical Assessment Interview for Negative Symptoms (CAINS; Kring et al., 2013) attempt to answer these difficulties by paying attention to underlying processes and assessing both behavioral engagement and reported experiences (Kring et al., 2013). However, what those experiences mean to individuals, how

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people make sense of them, and how these symptoms affect self-other experiences cannot be fully grasped using those approaches.

The method of qualitative research provides unique opportunities to foster insight into the lived experience of people suffering from negative symptoms. Yet, qualitative research is scarce within the psychosis-literature. Leader (2011) reported that only 0.17% of publications on psychosis addressed subjective experiences. For negative symptom-experience, the situation is probably even worse. For example, in a metasynthesis of qualitative evidence regarding the subjective experience of psychosis (McCarthy-Jones et al., 2013), negative symptoms are hardly discussed, presumably due to a lack of relevant publications. To address this limited knowledgebase, this paper reviews available published qualitative research on negative symptoms. To our knowledge, such a review has not yet been published. Moreover, relevant qualitative research is rather scattered, as patients often do not use the term "negative symptoms" when reporting feelings like emotional numbness, lack of motivation or loss of pleasure. Furthermore, research often only addresses one aspect of the negative syndrome, like emotion experience or lack of motivation. In this paper, we integrate these findings to engender an understanding of negative symptoms starting from first-person experiences.

Method

We conducted a systematic literature review with the aid of SUMARI software (2017), using the Web of Science, Scopus, PsychArticles, PubMed, CiNAHL and Embase databases in November 2018. Search terms were based on a preliminary literature search. As qualitative studies focusing on the negative syndrome as a whole were scarce, we included the most common manifestations of negative symptoms as search terms, next to the general denominator "negative symptoms". This yielded the following search query: "(Schizo* OR Psychosis OR Psychotic) AND ('Negative symptoms' OR 'Diminished expression' OR Emotion* OR Motivation OR Avolition OR Apathy OR Anhedonia OR Asociality OR Withdrawal) AND ('Lived experience' OR Qualitative* OR 'Thematic analysis' OR Hermeneuti* OR 'In-depth interview*' OR Interpretive* OR Transcrib* OR 'Focus group*' OR 'Grounded theory' OR Open-ended OR Narrative* OR First-person)". From this, we identified 3318 papers. Of all, 1567 were unique, English-written studies. Based on a screening of title and abstract by the first author (NM), only 34 appeared to be eligible. Studies were excluded when they did not meet the following criteria: qualitative research, psychotic disorder as primary diagnosis, patient-perspective, focus on negative symptoms, focus on illness experience (instead of treatment) and full-text articles or book chapters. After reading the full-text articles and a discussion between NM and SV (the second author), 24 more studies were excluded. Those had an insufficiently rich description of negative symptoms (especially studies focusing on the prodromal stage) or were rather purely descriptive instead of systematic qualitative research. Two studies, known by the authors, but not identified through the literature search, were also added to the final dataset. Quality of all studies was assessed using the critical appraisal instrument included in the SUMARI-software, which helps to determine whether studies adhere to the principles of good qualitative research (Lockwood et al., 2017). All studies proved to be of acceptable quality for inclusion in the review. Figure 1 gives an overview of the selection process.

Consequently, our review focused on 12 studies (Table 1). Results were integrated via qualitative metasynthesis, starting from the SUMARI guidelines, which aims at systematically aggregating data (Lockwood et al., 2017). However, we took the analysis a step further by integrating the resulting clusters in a comprehensive model. Analytic steps are outlined below. The analysis started from a constructivist approach of research (Ponterotto, 2005), aiming at enhancing the understanding of the negative symptom experience by integrating the original results in a model that highlights the dynamics of the experience. As both researchers have a Lacanian psychoanalytical background, this probably implicitly influenced how they categorized and interpreted the data, especially in the later phase of data analysis and the construction of the model.

Analysis started with listing all themes like they were reported in the results sections of the original articles. Themes that did not concern negative symptoms were discarded. Themes consisting

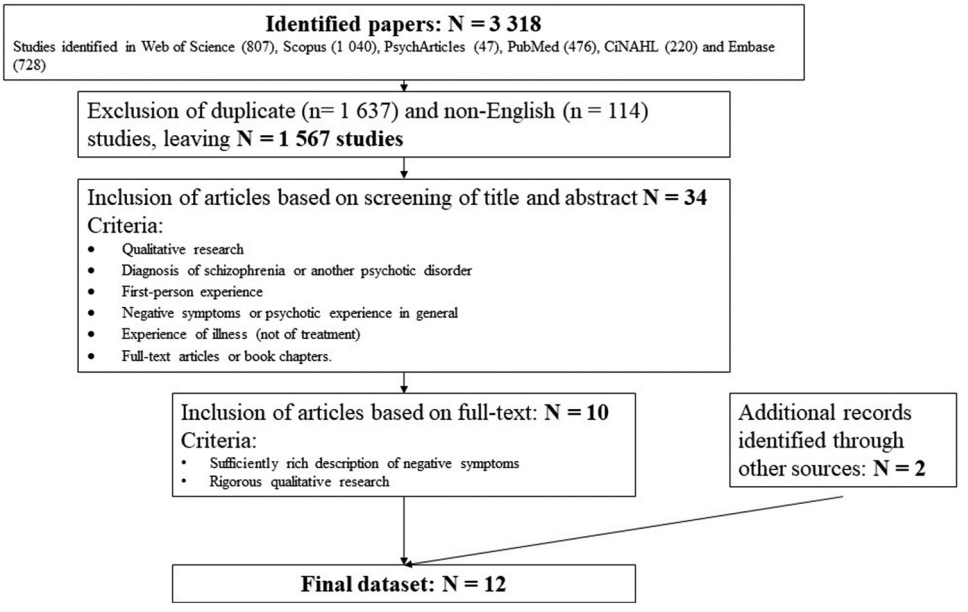

Figure 1. Overview of the selection process.

of several different ideas were split up in unequivocal themes. When original theme names were too vague to give a clear indication of a theme's meaning, we adjusted the names to enhance clarity. From studies describing results in a narrative way, without clearly demarcating themes (Bradfield & Knight, 2008; Corin, 1998; Corin, 1990), the authors derived the themes themselves based on discussion between both authors. This resulted in an overview of all the themes[1] from the original studies. Each theme was clarified with illustrative quotes.

Subsequently, the themes from the original studies were grouped in sub-clusters and clusters. A first organization in sub-clusters was based on returning descriptions across studies, e.g., all themes concerning medication side effects. During this analysis, five thematic clusters stood out: social interaction, detachment, intrusive experiences, self-image and medication side effects. These became the clusters in our final model.[2] Organizing the data in this model allowed for a richer data analysis than a pure aggregational approach, which carries the pitfall of abolishing the richness of qualitative data (Thorne, 2019).

Results

Our synthetic model (Figure 2) consists of three partly overlapping clusters, with at the intersection a fourth, central cluster concerning *Failing social interactions*. The clusters contributing to this, are *A double experience of disconnection, Being overwhelmed by psychotic experiences* and *An eroded self-image*. These elements are further influenced by *Detrimental side effects of psychotropic medication*.

Failing social interactions

Central in our model is the experience of failing human interactions, which is intrinsically related to the experiences discussed in the subsequent clusters. Participants reported profound difficulties in social interactions, indicating that many of their experiences are hard to verbalize, and that relating to others is confusing. Consequently, they tend to avoid social contact altogether.

Table 1. Characteristics of included studies.

Study	Methods for data collection and analysis	Country	Phenomena of interest	Number of participants	Participant characteristics	Description of main results
Boydell et al. (2003)	• Hermeneutical analysis • In-depth interviews	Canada	Subjective experience of motivation	6	**Diagnosis**: schizophrenia **Age**: early twenties to mid-forties **Male**: 66.66% **Ethnicity**: not specified	Main themes: • Experiencing schizophrenia • Being on "meds" • Spirit making/breaking • Experiencing stigma • Adopting a personal stance towards the world
Bradfield and Knight (2008)	• Phenomenological-informed case study • Unstructured interviews + written narrations provided by the participant	South-Africa	Intersubjective experience in schizophrenia	1	**Diagnosis**: schizophrenia, paranoid type **Age**: mid-twenties **Female** **Ethnicity**: white	Main themes: • Sense of isolation • Intolerance of ambiguity • Caution in dialogue • Diminished sense of self-worth • Experienced lack of reciprocity
Corin (1990)	• Mixed-methods analysis • Unstructured interviews	Canada	The meaning of being-in-the-world from the view of people who are repeatedly hospitalized	45	**Diagnosis**: schizophrenia **Age**: 25–50 **Male**: 100% **Ethnicity**: not specified	Main theme: positive withdrawal
Corin (1998)	• Mixed-methods analysis • Unstructured interviews	Canada	Pitfalls and limitations of deinstitutionalizing psychiatric patients	45	**Diagnosis**: schizophrenia **Age**: 25–50 **Male**: 100% **Ethnicity**: not specified	Main theme: positive withdrawal
Dintino (2002)	• Phenomenological qualitative analysis • Semi-structured interviews	United States	Subjective experience of negative symptoms	6	**Diagnosis**: schizophrenia (> 15y) with ≥2 negative symptoms **Age**: 45–58 **Male**: not specified **Ethnicity**: not specified	Main themes: • Affect • Alogia • Avolition • Self-disturbance • Ineffability
Flanagan et al. (2012)	• Interpretative Phenomenological Analysis • Structured interviews	United States	Relationship between the personal experiences of schizophrenia and its depiction in DSM-IV-TR	17	**Diagnosis**: schizophrenia or schizoaffective disorder **Average age**: 47.65 **Male**: 29% **Ethnicity**: 77% African American, 17% white, 6% Native American	Discussion of similarities, contradictions and additions of participants descriptions with respect to the DSM-descriptions of psychotic symptoms

(*Continued*)

Table 1. (Continued).

Study	Methods for data collection and analysis	Country	Phenomena of interest	Number of participants	Participant characteristics	Description of main results
Gee et al. (2019)	• Secondary, thematic analysis • In-depth interviews	United Kingdom	Negative symptoms	24	**Diagnosis**: psychosis (ICD-10 F20-F29) **Age**: 20–35 **Male**: 62.5% **Ethnicity**: 66.66% white, 8.33% Black-Caribbean, 12.5% Asian, 12.5% Mixed race	Main themes: • "Like a zombie" • Diminished internal experience • Medication side-effects • "A confidence thing" • Active avoidance
Le Lievre et al. (2011)	• Descriptive phenomenological analysis • Interviews	Australia	Emotional expression in relation to others.	7	**Diagnosis**: schizophrenia (≥2 episodes) **Age**: 30–55 **Male**: 57% **Ethnicity**: not specified	Main themes: • Transitioning into emotional shutdown • Recovery from emotional shutdown
Mauritz and van Meijel (2009)	• Grounded theory • In-depth interviews	The Netherlands	Lived experience of grief in schizophrenia	10	**Diagnosis**: schizophrenia **Age**: 21–38 **Male**: 90% **Ethnicity**: not specified	Main themes: • Internal loss: living in a different world • External loss: not belonging • Expressions of grief • Coming to terms
Sandhu et al. (2013)	• Framework analysis • Unstructured interviews with photo-elicitation	United Kingdom	Depression in the context of psychosis	8	**Diagnosis**: schizophrenia and post-schizophrenic depression **Age**: 18–35 **Male**: 62.5% **Ethnicity**: 50% white, 37,5% African-Caribbean, 12.5% Asian	Main themes: • Reflecting on psychosis • Becoming depressed • Being depressed • Wanting to get better
Stanghellini and Ballerini (2011)	• Qualitative analysis (not further specified) • Therapeutic interviews	Italy	Experience of social dysfunction in schizophrenia	46	**Diagnosis**: schizophrenia or schizotypal disorder **Age**: 21–63 **Male**: 35% **Ethnicity**: not specified	Main themes: • Disorders of embodied attunement • Algorithmic conception of sociality • Antithetic attitude toward sociality
Vodusek et al. (2014)	• Phenomenological, hermeneutic analysis • In-depth interviews	Slovenia	Emotion experience before, during and after psychosis	20	**Diagnosis**: first-episode, non-affective psychosis **Average age**: 22.1 **Male**: 60% **Ethnicity**: not specified	Main themes: • Emotional emptiness and the sense of loss and of being lost in the post-psychotic self • Emotional buffer, lack of flow and mourning for authenticity in the pre-psychotic self • Full contact, emotional overwhelming and fear of annihilation in the psychotic self

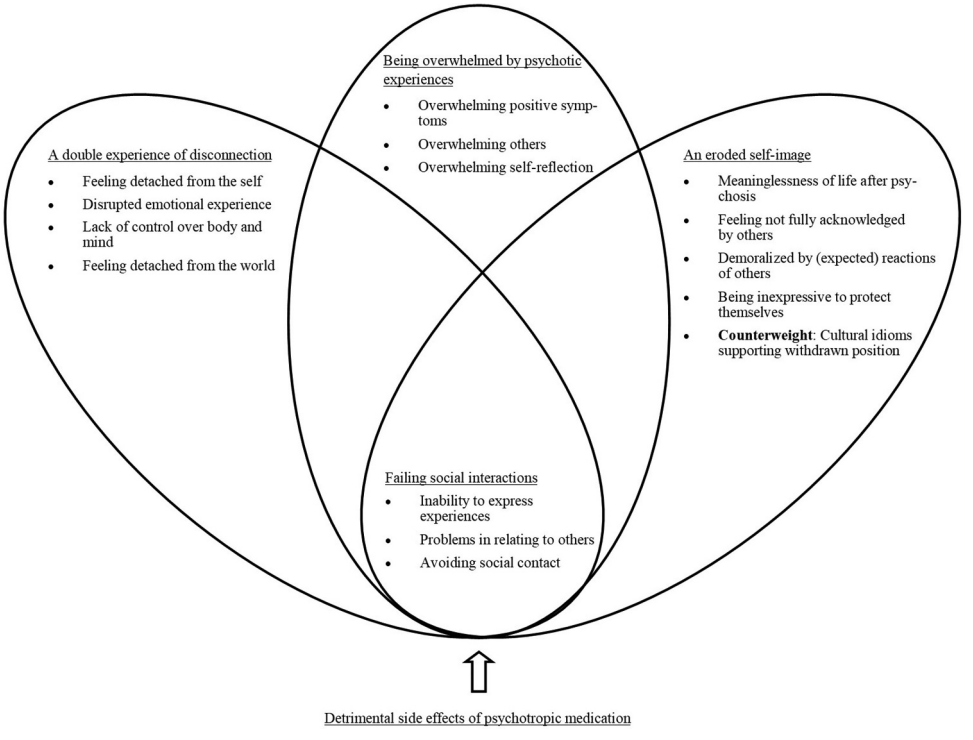

Figure 2. Synthetic model.

Inability to express experiences

Many participants do not talk much about their experiences, because they find it difficult to "communicate thoughts and emotions effectively" (Bradfield & Knight, 2008, p. 41). For some, their own body and mind inhibit successful expression of thoughts and emotions (Dintino, 2002), for others, it is "the voices, which won't let them express themselves" (Flanagan et al., 2012, p. 382). Some participants say that they need another person as a reference to access own feelings (Dintino, 2002), while for others their mind might go blank during conversations (Flanagan et al., 2012). Overall, participants struggle to verbalize their experiences, especially when they feel estranged from others (Dintino, 2002).

Problems in relating to others

Furthermore, relating to others might be troublesome as such. After a psychotic episode, some participants lack self-confidence, making them cautious in social situations (Bradfield & Knight, 2008; Gee et al., 2019). They are often confused by social interaction. Actions of others seem ambiguous, and they don't know how to interpret these (Bradfield & Knight, 2008; Le Lievre et al., 2011). To get a grip on confusing interactions, some participants try to gain background information about their communication partners (Bradfield & Knight, 2008). Others try to discover an algorithm in people's behavior – "People have a system. I try to understand it" (Stanghellini & Ballerini, 2011, p. 187) – or idealize humanity as a whole, but avoid actual interactions (Stanghellini & Ballerini, 2011). Another solution is to only retain superficial interactions, e.g., by visiting public places, while avoiding close relationships (Corin, 1998; Corin, 1990). Some even develop a different personality to be able to relate to friends and family. However, when this is challenged, it is experienced as "a self-destructive and disintegrative experience" (Bradfield & Knight, 2008, p. 44). Overall, it seems that "adopting a personal stance towards the world" (Boydell et al., 2003, p. 424) helps participants to facilitate social

interactions. However, when faced with social difficulties, they also might remain silent even when they want to express themselves (Le Lievre et al., 2011).

Avoiding social contact

Another option to limit social difficulties is to avoid social contact altogether, as expressed here: "I am not in the mood to talk to anyone and erm it really makes me feel like I just wanna be alone, I just wanna be by myself" (Sandhu et al., 2013, p. 170). Actively avoiding others is a way to avoid shameful interactions (Gee et al., 2019) or to cope with feeling different and unfit to be a productive member of society (Boydell et al., 2003). Others, however, have a positive attitude towards withdrawal (Corin, 1998; Corin, 1990), as it enables them to move at their own rhythm (Corin, 1998) and "to be yourself, because nobody influences you" (Stanghellini & Ballerini, 2011, p. 188). Overall, participants seem to prefer social withdrawal from time to time, as it helps them to prevent difficulties and confusion arising from interactions.

A double experience of disconnection

The second factor of our model concerns feelings of disconnection. Participants feel detached from themselves. They report both numbed and strong emotions, and a loss of control over their body and mind. Apart from these feelings of inner detachment, participants also feel disconnected from the outer world.

Feeling detached from the self

A first experience of disconnection concerns detachment from the self. A common description of such detachment is feeling like a zombie (Gee et al., 2019) or a ghost. "I don't feel present as a person, don't have a sensation of myself. I feel like a ghost – in the sense that I am not inside (myself). I am here physically but not psychically" (Vodusek et al., 2014, p. 256). Dintino (2002) describes this detachment as observing the self as from the outside and experiencing thoughts as concrete objects. Furthermore, participants doubt about who they are. After a psychotic episode, they no longer dare to trust their senses (Mauritz & van Meijel, 2009) and lack a stable reference frame about themselves (Vodusek et al., 2014). Detachment from the self thus entails both a feeling of not being fully present in the self as a detachment from a former stable self-concept.

Disrupted emotional experience

Additionally, participants are no longer in touch with their emotions, experiencing these as numbed and flattened (Dintino, 2002; Sandhu et al., 2013; Vodusek et al., 2014). Participants especially report to be only slightly affected by what happens around them: "Do you know that twin towers, when it crashed, I didn't care. I sat watching it, I was like, oh yeah boring" (Gee et al., 2019, p. 776).

However, other studies (Flanagan et al., 2012; Mauritz & van Meijel, 2009) indicate that some participants continue to experience strong emotions, but these are especially related to positive psychotic symptoms, for example: "I can be high and I can drop to very low, you know, in a matter of seconds. And that's what the voices do to me you know" (Flanagan et al., p. 382). Emotional experience has not entirely disappeared; even though it is numbed in many situations, strong reactions occur to events echoing psychotic experiences.

Lack of control over body and mind

Estrangement from own body and mind is another indication of a loss of connection. Participants speak about fading thoughts, odd bodily sensations, limbs that will not move when they are needed to and a general disconnection between the body and the mind. These experiences were only noted by Dintino (2002), but were prominently present in that study.

Feeling detached from the world

In strong relation with this disturbed relationship towards the self is "an estrangement from others" (Dintino, 2002) and the surrounding world. For some, this is a direct result of the disconnection from the self; as taking a detached stance towards the world is the only way to protect a fragile sense of self: "in distancing myself from friends and family, I could preserve myself better" (Le Lievre et al., 2011, p. 1340). For others, it is the experience of feeling different, which makes it hard to relate (Bradfield & Knight, 2008; Mauritz & Van Meijel, 2009). Overall, participants are confronted with difficulties to attune to others (Stanghellini & Ballerini, 2011; Vodusek et al., 2014). As a result of this aloneness and detachment, participants might "feel barren" (Bradfield & Knight, 2008).

Being overwhelmed by psychotic experiences

A third cluster of the negative symptom experience concerns the overwhelming effect of psychotic experiences. Participants point to the disabling effects of other psychotic symptoms and to the intrusiveness of social contacts. To get a grip on these experiences, participants might engage in excessive thinking.

Overwhelming positive symptoms

First, participants describe that positive symptoms, especially hearing voices, might prevent them from getting things done. Psychotic voice-hearing can be really engrossing and exhausting, which makes it difficult to concentrate (Flanagan et al., 2012). For some, even crossing the street becomes "a major accomplishment" (Boydell et al., 2003, p. 423). Furthermore, constant fear of relapse might be a hindrance, causing participants to avoid social situations (Sandhu et al., 2013).

Overwhelming others

Social contacts might also feel invasive. Some participants indicate that they are more sensitive than "normals". Others describe such sensitivity more explicitly, like as having "a hole, through which others enter them" (Stanghellini & Ballerini, 2011, p. 187). These experiences create feelings of nervousness, "emotional crisis" and "obscurity" when others get too close. In the end, some feel like "they can no more find themselves" when they are watching others or feeling others' mental states (Stanghellini & Ballerini, 2011, p. 187). Furthermore, others might also be experienced as disrespectful and invasive when they want to assess someone's mental state (Bradfield & Knight, 2008).

Overwhelming self-reflection

In order to get a grip on their strange experiences, participants report how they spend a good time reflecting. For some, this takes the form of spending an entire day thinking (Dintino, 2002), for others it is dwelling on the past, which makes it "virtually impossible to focus on anything else except that thought" (Le Lievre et al., 2011, p. 1340). Thinking can become so predominantly present that it hinders a person from living in the here and now.

An eroded self-image

A next cluster in our model concerns the undermining of one's self-image, which causes identity issues. After a psychotic crisis, one's former sense of self might be eroded, causing feelings of meaninglessness. Furthermore, it is hard to build a new and positive self-image, as others do not treat participants as equals. Stigma and shame reinforce negative self-images. In order to protect against such negative influences, participants might choose to be inexpressive. However, adhering to groups of likeminded people can help cultivating a positive self-image.

Meaninglessness of life after psychosis

After a psychotic crisis, people might lose former roles in life and the ability to perform daily activities. This may lead to experiences of meaninglessness and emptiness (Mauritz & van Meijel, 2009) or a profound feeling of uselessness: "It's a feeling of worthlessness, feeling of no hope, feeling of you're useless to anything, anyone" (Sandhu et al., 2013, p. 169). Some miss a clear direction in life and find daily activities dull, which makes them linger on past experiences instead of investing in their current life (Le Lievre et al., 2011). Overall, there seems to be a close connection between feelings of meaninglessness and (forced) passivity.

Feeling not fully acknowledged by others

In relationship to others, participants often have the experience of not being fully acknowledged. Others, like professionals, tend to talk over their heads, as such ignoring participants' needs (Le Lievre et al., 2011; Sandhu et al., 2013). Furthermore, participants often feel misunderstood, as others have a different focus or are unable to understand because they have not had similar experiences (Bradfield & Knight, 2008; Sandhu et al., 2013). Overall, participants report difficulties in relationships, as they are confronted with "a lack of reciprocity" (Bradfield & Knight, 2008, p. 42) or "the feeling of being 'kept out of things'" (Corin, 1998, p. 138). By contrast, acknowledgment by others helped participants to retake a more active position, which supported recovery (Le Lievre et al., 2011).

Demoralized by (expected) reactions of others

Participants are often confronted with, or expect, negative interactions, which is demoralizing. Stigma and low expectations from others drag people down, as such eliminating their motivation to undertake something (Boydell et al., 2003). Stigma can also be internalized, causing participants to "be so ashamed I wouldn't even come out of my house" (Flanagan et al., p. 383).

Being inexpressive to protect themselves

In order to protect from negative reactions, participants might choose to remain silent. They do not want others to know they have psychotic experiences, and they especially do not want others to think they are crazy (Dintino, 2002; Flanagan et al., 2012). For the same reason emotions are not expressed; for example: "I don't do it [express myself emotionally], even with my clinician I don't do it because I don't want people to think I'm crazy, you know. So a lot of things I harbor on the inside of me" (Flanagan et al., 2012, p. 382).

Cultural idioms supporting a withdrawn position

While negative interactions often impair a stable and positive self-image, certain cultural idioms might help participants to find a useful identification, which helps to remain connected with society, whilst avoiding all too intense social contacts. Corin (1990) describes how religious discourse can serve both to "associate a positive value to withdrawal" (p. 177) as to create involvement with a group likeminded others.

Detrimental side effects of psychotropic medication

Finally, negative side effects of psychotropic medication were often mentioned as contributing to negative symptoms. Anti-psychotic medication makes participants drowsy and unmotivated (Boydell et al., 2003), causing flattened mood and depression (Sandhu et al., 2013), thus decreasing their drive to engage in activities (Gee et al., 2019). Moreover, participants viewed weight gain, due to medication intake, as responsible for lack of motivation and depressed mood (Gee et al., 2019; Sandhu et al., 2013). Although participants understand the need for medication, they also blame it for their troubles: "It gets me down that I'm gonna have to take them [medications] for such a long time and then I attribute all the problems since to them" (Sandhu et al., 2013, p. 169).

Discussion

In order to respond to the limited and scattered knowledge regarding the subjective experience of negative symptoms, we conducted a metasynthesis based on 12 qualitative studies. From this we developed a model with five clusters, including failing social interactions; experiences of disconnection; overwhelming psychotic experiences; an eroded self-image; and detrimental side effects of psychotropic medication.

While our data do not allow for causal interference, we assume that these clusters represent overlapping experiences. For example, most probably experiences of disconnection fuel difficulties in social interaction. Indeed, participants who experience strong estrangement from what they personally feel and think, may precisely because of that, have difficulties to engage in dialogues that address thoughts and feelings. The other way around, difficulties in social interactions might also lead to estrangement with respect to own subjective experiences. As long as conversations remain neutral, they allow participants to remain in a neutral role. Yet, if others start addressing personal issues not only the interaction becomes difficult, also confusion about subjective experiences might thus arise. For all clusters of our model, such overlap might be described.

The interplay of dimensions, shown in our model, can be accounted for from different theoretical angles. Lacanian psychoanalysis, for example, assumes that experiences of reality take shape through the interplay of three registers: the Symbolic (i.e. the domain of language), the Imaginary (i.e. the domain of mental images) and the Real (i.e. the world – both intimate experiences as outside events – as escaping the control of language and mental images). In everyday life, the Real is captured with images and words, which enables sense-making and control. Moreover, language structures the self-experience, as it provides the means by which a speaker represents himself as a subject in relation to others. (Fink, 1995; Lacan et al., 2006; Vanheule, 2011; Verhaeghe, 2004). In a psychotic crisis, the coherence between these registers disperses and language loses its organizing role in mental life. Consequently, the Real is no longer structured by language and no longer contained in stable images. Specifically, this implies that common experiences, like feeling your own mind and body or participating in social interactions, might become very overwhelming. The symbolic framework to make sense of these is simply lacking. Next to that, as language loses its structuring role, the experience of subjectivity and of the other is destabilized as well. This might result in feelings of estrangement. In such state, a person no longer knows if he is, or what he is, and others are seen as too unpredictable to safely interact with. Apathy and withdrawal are then seen as answers to overwhelming experiences and estrangement (Vanheule, 2011).

From a phenomenological perspective, in its turn, psychotic experiences are the result of a qualitative shift in the experience of our normal, pre-reflexive being-in-the-world. In terms of such self-disturbance, negative symptoms are reactions to or expressions of an altered being-in-the-world, in which everything loses its self-evident character (Sass & Parnas, 2003). As such, experiences become, among others, characterized by hyperreflexivity, disengagement and bodily alienation (Sass, 2003; Sass, 2007; Sass & Parnas, 2003), leading to a diminishment of their perceived relevance and the tendency to react upon these experiences. Furthermore, as experiences lose their self-evident character, they are easily experienced as overwhelming.

More strongly than cognitive and metacognitive models of negative symptoms (e.g., Hamm et al., 2012: Rector et al., 2005), these psychoanalytic and phenomenological frameworks stress the tacit dimensions of detachment and invasiveness in the psychotic experience. Both clearly turned up in our model of negative symptom experience too.

Taking our model into account, we believe that both research and clinical practice should focus on all dimensions of the negative symptom experience. A possible pathway to this better understanding is questioning the typical positive-negative symptom dichotomy. Indeed, as Sass (2003), Sass (2007) argues, the absence of one thing implies the presence of something else (i.e. the loss of connection with the world implies the presence of feelings of detachment). In this sense, both positive and negative symptoms imply an unusual presence and absence of certain experiences.

A return to the classical division between primary disturbances (i.e. loss of coherence between the three registers in psychoanalysis; ipseity disturbance in phenomenology) and secondary mechanisms (i.e. symptoms like voice-hearing, specific delusions, inexpressiveness, lack of motivation …) might proof useful (Parnas, 2011).

Therefore, we believe that theory-driven empirical research focusing on new ways to conceptualize negative symptoms is needed. The way such symptoms are experienced in relation to other psychotic experiences and in relation to basic disturbances should be addressed. Such new conceptualizations, with attention for all dimensions involved, will foster our understanding and subsequent treatment of negative symptoms.

Limitations of our study include the primary selection of eligible studies by the first author only. As such, we might have missed possible relevant studies. This risk was minimized by using clear inclusion criteria and further scrutinizing of studies in the next phase by both authors when there was doubt about their relevance.

Second, our discussion focused especially on psychoanalytic and phenomenological accounts and payed minimal attention to other theoretical frameworks. However, as we argued, we chose these approaches as they are especially well suited to highlight the tacit dimensions of negative symptoms, which are often overlooked.

Third, we included the influence of medication in our model; however, we lacked the information to ascertain its specific influences on the different clusters. It would be interesting for further research to look into the interaction between antipsychotic medication and the different elements of the negative symptom experience, as also Kirschner et al. (2017) suggest.

At last, more qualitative research is warranted to further comprehend negative symptoms and related underlying disturbances. From the 12 studies, we examined, only three (Dintino, 2002; Flanagan et al., 2012; Gee et al., 2019) discuss the negative syndrome as a whole. Further research in this field might help to finetune the model we have developed.

Notes

1. List is available upon demand.
2. The final version of the model was established with the aid of the useful feedback from the reviewers.

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Disclosure statement

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