New Life for Schizophrenia
Psychotherapy in the Light
of Phenomenology

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Recent contributions to the theoretical conception and empirical evaluation of schizophrenia in the light of phenomenology are opening the way to new perspectives in psychotherapy. The phenomenological conception understands schizophrenia as a disturbance of the basic sense of selfhood (ipseity) characterized by hyper-reflexivity and diminished sense of self. Evaluation consists of examining the anomalous self-experience in a series of domains, which makes the conception presented operable. On this basis, a phenomenologically informed psychotherapy is introduced. Its characteristics are pointed out and early intervention is reviewed (the last frontier in psychosis) from this perspective. Finally, a series of psychotherapies which, although they do not have a phenomenological origin, may be seen from that perspective, are re-examined. These are the narrative, mindfulness and acceptance and commitment therapies. Copyright © 2010 John Wiley & Sons, Ltd.

Key Practitioner Messages:
• The phenomenological conception can contribute to a new understanding of schizophrenia.
• The phenomenological conception can contribute to evaluation of the subjective experience.
• The phenomenological conception opens a new perspective for psychotherapy of schizophrenia.

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PHENOMENOLOGICAL CONCEPTION
AND EVALUATION OF SCHIZOPHRENIA

The general purpose of this article is to show how the emergence of a new life for psychotherapy of schizophrenia is opening up in the light of phenomenology. For the last few years, phenomenology has offered a renewed understanding of schizophrenia (Bürgy, 2008; Nelson, Sass, Thompson et al., 2009; Parnas, Sass, & Zahavi, 2008; Sass, 1992; Sass & Parnas, 2003, 2007). Its wide variety of contributions could be reduced to two (which it is important to mention here with a view to psychotherapy): a new conception of schizophrenia and an empirically developed evaluation procedure. The evaluation procedure makes
the theoretical conception operable and serves empirical research and clinical practice, including psychotherapy. This introduction briefly describes, first, the phenomenological conception of schizophrenia, and then, its evaluation, with a view to contextualizing a variety of psychotherapies so they can be seen from this perspective. Both the phenomenological conception and its evaluation concentrate on early schizophrenia, a focus rooted in the current tendency to early intervention in psychosis (McGorry, Killackey, & Yung, 2008). Although the early intervention approach targets the broad category of psychosis, this work concentrates on the schizophrenia spectrum, which to date has been the focus of most research.

Phenomenological Conception

Phenomenology today offers a renewed conception of schizophrenia, in terms of a disturbance of the basic sense of self (Parnas, 2003; Sass, 1992; Sass & Parnas, 2003, 2007). The idea of a disturbance of the self is not new. Thus, Kraepelin conceived the ‘dementia praecox’ as an ‘orchestra without a conductor’ to refer to the characteristic disunity of conscience. Bleuler introduced the term ‘schizophrenia’ precisely as a disorder of the self (Ich-Spaltung = ‘divided ego’). Among other authors, Minkowski argued that the ‘trouble générateur’ of schizophrenia was the self’s loss of vital contact with reality (Minkowski, 1927, 1997). More recently, Blankenburg (1969, 2001) pointed out that the central alteration in schizophrenia is a ‘loss of natural self-evidence’, that is, loss of the usual common-sense orientation to reality that normally enables a person to take for granted so many aspects of the social and practical world.

What is new in this formulation is a combination of novel phenomenological descriptions of experience with systematic empirical data collections, finally leading to a construction of a descriptive psychometric instrument (Moller & Husby, 2000; Parnas, Jansson, Sass, & Handest, 1998; Parnas et al., 2005). More specifically, schizophrenia would be a disorder of ipseity (from the Latin, ipse = self), a term from the phenomenological tradition (Gallagher & Zahavi, 2008) referring to the basic constitutive aspect of the self or selfness, in the sense of pre-reflexive self-experience.

The different aspects or levels, which according to phenomenology make up the self or personal identity, should be kept in mind here: the pre-reflexive, reflexive and narrative self (Gallagher & Zahavi, 2008; Parnas, 2003; Parnas & Handest, 2003; Zahavi, 2005). While the reflexive and narrative self assume an explicit consciousness of self, where one is his own object or subject of attention and reflection (self as object), the pre-reflexive self is characterized by an implicit, tacit, non-thematic awareness, and as the name implies, pre-reflexive self.

Pre-reflexive self-consciousness is the basis for reflexive self-consciousness and of the narrative self. Pre-reflexive self-consciousness is characterized by going unnoticed, not being focused on, and thus functions as the means of contact with the world without becoming an end in itself or a subject of attention. This is the normal and natural self-consciousness in first person of the self-as-subject, ipseity or selfness. Pre-reflexive self-consciousness is a dynamic structure that establishes one’s essential constitutive relationship with the world. This dynamic structuring was defined by classic phenomenology as a system of ‘operative intentionality’ or ‘intentional arc’. As Maurice Merleau-Ponty (2002) says, ‘Life of consciousness—cognitive life, the life of desire or perceptual life—is subtended by an “intentional arc” which projects round about us our past, our future, our human setting, our physical, ideological and moral situation, or rather which results in our being situated in all these respects. It is this intentional arc which brings about the unity of the senses, of intelligence, of sensibility and motility. And it is this which “goes limp” in illness’ (p. 157).

Ipseity disturbance refers to loss of presence or inhabiting the self, of the ‘mineness’ or first-person ownership of experience (Nelson, Sass, & Skodlar, 2009, p. 285). Ipseity disturbance, therefore, affects the basic sense of self, sometimes referred to as ‘basic’ or ‘minimal core’ self (Zahavi, 2005), different from reflective or narrative selfhood, and, therefore, also affects the whole structure of the self, including reflexive and narrative processes. Ipseity disturbance consists of two complementary processes: hyper-reflexivity and diminished sense of self. Hyper-reflexivity refers to intensified self-consciousness of aspects of the normal, functionally implicit, tacit or pre-reflexive self. Pre-reflexive aspects are objectivized, presented as if they were outside objects (e.g., synesthesic experiences or hallucinatory voices). First-person experience becomes an experience of the self in third person, as one is altered by self-experiences which were implicit before, turning him into an observer of himself. Here, hyper-reflexivity does not share a process or an intellectual attitude, but presents
implicit aspects to consciousness, interrupting the thematic field and making it the subject and object of occupation and concern. It is a type of hyper-reflexivity in which, in a manner of speaking, the pre-reflexive ‘operating system’ becomes aware of itself (Sass & Parnas, 2007, p. 69).

Furthermore, the diminished sense of self refers to weakening of the intensity or vitality of one’s own subjective self-presence or awareness of oneself as the subject of experience. Self-presence itself and the feeling of being oneself is altered (‘I don’t feel like myself anymore’; ‘I was just there, without being present’). This diminished sense of self is not merely an alteration of self-image or of personal identity, although it also involves them, but in fact affects the basic sense of being oneself as the subject of experience.

Hyper-reflexivity and diminished sense of self may seem self-contradictory phenomena, but their relationship is probably complementary. Objectivation of pre-reflexive, ‘operating’ aspects is understood as breaking up and interrupting the experience of self (hyper-reflexivity), thereby weakening and losing the sense and control of own personal identity (diminished sense of self). At the same time, this weakening may contribute to hyper-reflexivity, as an attempt to understand, control and compensate for the weakening itself. As if that were not enough, hyper-reflexivity consists of pre-reflexive aspects that can be added to a reflexive, introspective, intellectual or metacognitive hyper-reflexivity, also known to be present in schizophrenia (García-Montes, Pérez-Álvarez, Soto-Balbueba et al., 2006). As Sass and Parnas (2007) say, ‘what can result is a veritable “centrifuging” of the self—a process whereby phenomena that normally are “inner” or tacit are progressively spun and away, thereby depriving the individual of the very medium of normal forms of ipseity or self-experience’ (p. 85).

**Phenomenological Evaluation**

Although interest in self-experience in schizophrenia forms part of the clinical tradition, including early psychiatry, existential psychiatry, psychoanalysis, psychosocial rehabilitation, phenomenology and dialogical psychology (Lysaker & Lysaker, 2010), systematic evaluation instruments have only been available recently. Systematic evaluation of self-experience in schizophrenia has mainly been introduced through the concept of basic subjective symptoms in the German tradition (Schultze-Lutter, 2009) along which line a series of procedures consisting of semi-structured interviews have been developed. In this series of procedures, the reference taken here is the Examination of Anomalous Self-Experience (EASE), developed by Parnas, Moller, Kircher et al. (2005).

The EASE was developed from a combination of empirical research, clinical experience and phenomenological approach (Parnas et al., 2005), and therefore has a solid empirical and clinical basis, including previous scales in the line of self-disorders and ‘basic symptoms’ (Moller & Husby, 2000; Parnas & Handest, 2003; Parnas, Handest, Jansson, & Saebye, 2005; Parnas, Handest, Saebye, & Jansson, 2003; Parnas et al., 1998). As for the rest, the EASE continues the phenomenological conception summarized above, and Parnas himself was an important contributor to its conception (Parnas, 2003; Sass & Parnas, 2003, 2007). In fact, Bürgy (2008) gives the EASE as an example of the new focus of phenomenology. The EASE explores the various types of alteration of self-experience characteristic of incipient schizophrenia. It consists of five domains: cognition and stream of consciousness, diminished sense of basic self, bodily experiences, demarcation/transitivism, and existential re-orientation.

**Cognition and Stream of Consciousness**

Alterations in this domain consist of a sort of fissure between the self and its content, interrupting the normal and natural course of thought, of consciousness and of subjective life. One frequent alteration is characterized by spatialization of subjective experience, in which private events take on physical perceptive qualities, as e.g., hearing one’s own thoughts (Stanghellini & Cutting, 2003).

**Self-awareness and Presence**

This is an alteration of the usual and natural presentation of the world, resulting in a whole crisis of common sense (Stanghellini, 2001). The sense of self no longer ‘saturates experience’, but is instead alienated from itself (Parnas & Handest, 2003). Items from this domain are a diminished sense of basic self (e.g., a pervasive sense of inner void, lack of identity, feeling of being anonymous), distorted first-person perspective (e.g., feeling as if it is not me who is experiencing the world), and hyper-reflexivity: tendency to take oneself or parts of oneself or aspects of the environment as objects of intense reflection (e.g., monitoring inner life, while at the same time interacting in the world).
Bodily Experiences

Refers to a lack of harmony between one’s subjectivity and bodily experiences, consisting basically in experiencing one’s own body as an object (Cutting, 1999). Several items define this domain, including morphological change, such as feeling ‘as-if’ some part of the body grew or shrank, mirror-related phenomena, e.g., patients either perceive changes in their own face or they look for such changes, and de-automatization of movement, in which normal actions such as dressing or washing now require an effort and conscious attention.

Demarcation/Transitivism

Although these disorders are closely related to self-consciousness and presence, Parnas et al. (2005, p. 254) list them separately here due to their more articulate symptomatic nature. Items of this type include confusion with the other, e.g., experiencing oneself and the interlocutor as being mixed up or interpenetrated, threatening bodily contact, feeling autonomy and existence threatened, and passivity, a feeling of being exposed, at the mercy of the world.

Existential Re-orientation

Solipsist experiences and existential and interpersonal change are also frequent at the beginning of schizophrenia. Among solipsist experience, the most outstanding is self-centrality, in which one feels he is the centre of the universe (Raballo & Maggini, 2005). This existential and intellectual change means fundamental re-orientation with respect to the metaphysical view of the world, involving the hierarchy of values (Stanghellini & Ballerini, 2007).

In spite of all of the above alterations, ipseity still holds onto a ‘centre of experiential gravity’, according to the magnificent expression of Nelson et al. (2008, p. 386). According to these authors, ‘when this central organizing dynamic is disturbed, the various modalities of consciousness are thrown off-kilter, resulting in the aberrations of experience we see in psychotic symptoms’ (p. 386).

Reasons for a Phenomenologically Informed Psychotherapy

The phenomenological conception demands a specific treatment method, which approaches the types of alteration mentioned directly. Neither anti-psychotic medication nor cognitive behaviour therapy (CBT), as the best established psychological treatments, address restoration of the ‘center of experiential gravity’ identified by phenomenological research. While medication is limited to damping the salience of abnormal experiences (Kapur, 2003), CBT also tries to reduce and manage the symptoms as quasi-neuroleptic (Birchwood & Trower, 2006) by restructuring supposedly underlying dysfunctional cognitions (Beck, Rector, Stolar, & Grant 2009). Once more, the CBT procedure could be counterproductive, to the extent that it stimulates the hyper-reflectivity already exacerbated in schizophrenia, according to the phenomenological conception. As shown by Nelson et al. (2009), CBT ‘may in fact ‘feed into’ the hyper-reflective processes that are already exaggerated in the person with psychotic vulnerability and which in fact constitute an important aspect of the pathological process at play. That is, with the outward migration from tacit to focal already exaggerated, the cognitive therapist’s attempts to assist the patient in identifying, challenging, and restructuring normally tacit cognitive processes may encourage hyper-reflective processes and thereby further undermine an already fragile self-structure (the vulnerability factor). This therapeutic strategy may also encourage an inner vigilance and anxious monitoring of the self by the self (see Sass, 1992, Chap. 8). It is conceivable that these effects of CBT could actually promote psychotic symptoms in high-risk individuals’ (Nelson et al., 2009, p. 285).

Patients, for their part, reveal that the process of recovery from schizophrenia involves strengthening the sense of self (Davidson, 2003; Davidson & Strauss, 1992). The patients’ experience of recovery backs the specific method of treatment claimed by the phenomenological conception, which is not found in the more often applied treatments, pointedly, anti-psychotic medication and CBT.

The following explanation consists of four sections. In the first place, the principles of a phenomenologically informed psychotherapy are presented. Then, early intervention from the phenomenological perspective is reviewed. Third, several psychotherapies which, even though not directly based on the research discussed, have a distinct affinity to the phenomenological conception. In any case, they are included here in the interest of promoting psychotherapeutic integration. Phenomenology can also inform these other psychotherapies, as well as benefit from them. We refer in particular to the narrative, mindfulness, and acceptance and commitment psychotherapies. Finally, in conclusion, we emphasize the new life
that the phenomenological perspective opens for psychotherapy of schizophrenia.

PRINCIPLES OF PHENOMENOLOGICALLY INFORMED PSYCHOTHERAPY

It is important to start out by acknowledging something that, while valid for psychotherapy of practically any type of disorder, is a *sine qua non* condition for psychotherapy of schizophrenia: the therapeutic relationship. This is not only a good therapeutic alliance or cooperative relationship, but a whole interpersonal meeting. The interpersonal meeting is more interested in understanding the altered being-in-the-world experience than in repairing the supposedly malfunctioning of a mechanical system (Nelson et al., 2008, p. 283). There is much discussion of a chemical imbalance, but the important thing in psychotherapy of schizophrenia is the ‘chemistry’ of the therapeutic relationship.

The empathetic bridge allowing the patient’s situation to be appreciated and his person accepted in spite of his disorder is the bottom line of recovery from schizophrenia (Davidson, 2003). The space necessary for a person to come out of the illness is opened up through others’ perception of the person as being more than just his illness (Davidson, 2003, p. 173). Stanghellini and Lysaker (2007) have shown that this occurs during the psychotherapy session, when the therapist repeatedly offers a second-person viewpoint, when one ‘you’ addresses another ‘you’, which is different from a third-person viewpoint, talking, e.g., about ‘the illness’ or some supposed mechanism outside of it, such as an underlying conflict or a cognitive process. Thus, the therapist continuously offers a second-person viewpoint (‘You are feeling bad’) to the more tenuous first-person perspective (‘I’ve had too many bad thoughts’). It is not a matter of analyzing the content of the experience or arguing about it, but acknowledging and validating it and offering the perspective of another you.

Stanghellini and Lysaker (2007) identify four principles of phenomenologically informed psychotherapy.

**Relevance of Intersubjective Disturbances**

Let us begin by emphasizing that intersubjective difficulties are the core of schizophrenia and not derived epiphenomena, whether from supposed neurobiological anomalies, psychodynamic conflicts or idiosyncratic cognitions (Nelson et al., 2009). Greater intersubjective participation in the world is understood to facilitate the management of ‘symptoms’ such as delusions and hallucinations. Thus, e.g., to the extent that hallucinations are really ‘human’ voices substituting for a world that has become uninhabitable (Rojcewick & Rojcewick, 1997), the therapeutic relationship can provide a context from which the relationship with the voices can be changed (Pérez-Álvarez, García-Montes, Perona-Garcelán, & Vallina-Fernández, 2008).

**Establishing a Shared Relationship**

This means establishing mutual recognition as persons, a necessary condition for the reestablishment of the first-person perspective and thus of the reappropriation of own experiences. As pointed out by Stanghellini and Lysaker (2007), phenomenologically informed psychotherapy takes place, not ‘internally’, but out in the open, in public, *between* the therapist and the patient. As shown by Nelson and Sass (2009), a therapeutic relationship presided by an attitude of understanding and gentle curiosity and concern by the therapist provides a space where the patient can evolve a more robust pre-reflective self-awareness (first-person perspective), second-person perspective, and experience of trustworthy relationships when encountering others.

**Concentrating on the Here-and-Now, on the You-and-I Relationship**

The purpose is to re-establish the ‘intentional arc’ which, as mentioned above, articulates the person with the present context and, according to the phenomenological approach, would be altered in schizophrenia. As Stanghellini and Lysaker (2007) say, ‘Psychotherapy may serve as a “dialogical prosthesis” to help re-establish the lost connection between bodily feelings (emotions) and interpersonal situations’ (p. 174). Although the consideration of emotions as bodily feelings is not universally accepted, it can be argued here on the basis of the importance that bodiliness (Merleau-Ponty, 2002) and inter-subjectivity (Zahavi, 2005) have in phenomenology. It is understood that the you-and-I relationship in psychotherapy involves the feeling of being there, a bodily presence for the other, felt mutually.
Building Up Shared Meanings

The second-person approach as a therapeutic method proposes constructing stories that assist in reconstructing the sense of self, stories that require both internal and external coherence. While internal coherence is necessary for the patient to develop any significant understanding, the external concerns the interpersonal restrictions that make the narrative significant to others. The therapist acts as the referee, catalyst and reference for common sense in significant narratives. Needless to say, both constructing dialogical prostheses and building of shared vocabulary require a detailed descriptive exploration of the structure of the patient’s experience. This skill does just assume familiarity with the phenomenological concept, but specific training in its practical application by the therapist.

Phenomenological psychotherapy does not consist merely of listening to the patient and understanding him sympathetically, but above all, capturing essential experiences and offering a personally significant hermeneutic (Sass, 1988).

Using vignettes from therapeutic sessions, Stanghellini and Lysaker (2007) show that the ‘intersubjective method’ can help persons with schizophrenia to develop the first-person perspective for themselves and second-person when they are with others and thus open the way to recovery.

PHENOMENOLOGICALLY INFORMED EARLY INTERVENTION

Early intervention is one of the most significant innovations in psychosis in recent years (McGorry et al., 2008). These authors say that early intervention takes place at the point where pessimism changes to optimism in the development of psychosis, and represents the maturity of the therapeutic approach in psychiatry. Early intervention involves detecting persons who are at risk of developing psychosis, identification of those who have already developed it but have not received adequate treatment, and application of specific treatment in each stage, directed at impeding continuation of the course of the disorder and, if applicable, promoting rapid recovery (McGorry et al., 2008).

At Risk Mental States

The problem is that there is no etiopathological basis on which to establish the prediction of a psychotic disorder. Instead, early intervention proposes the concept of the At Risk Mental State (ARMS). When the ARMS is combined with other factors of recognized influence on the development of psychosis, such as deterioration of social functioning, family background or schizotypal personality, they become Ultra-High Risk (UHR) profiles. The UHR concept includes three groups: ‘attenuated psychotic symptoms’, ‘transitory psychotic symptoms’ and ‘trait or state risk factors’, which consist of schizotypal personality or family history of psychotic disorders and unspecified states of anxiety and depression (Yung, Phillips, Yuen, & McGorry, 2004).

The ARMS evaluation instrument, called the Comprehensive Assessment of At-Risk Mental States (CAARMS; Yung, Yuen, McGorry et al., 2005), is a semi-structured interview with the following subscales: disorder of thought content (e.g., delusions), perceptual abnormalities (e.g. hallucinations), conceptual disorganization (e.g., formal thought disorder), motor changes (e.g., difficulties with movement), concentration and affect, impaired energy, and impaired tolerance to normal stress. CAARMS has been demonstrated to have sufficient sensitivity and specificity to predict the transition to psychosis (Yung, Stanford, Cosgrave et al., 2006). In general, around 40% of the UHR criteria predict positive transition to psychosis in one year (Phillips, McGorry, Yung et al., 2005).

Although early detection along the line of the ARMS has meant a significant advance, it does have some limitations and, what would be more important from a phenomenological consideration, has space for possible supplementation. Thus, the ARMSs would omit essential basic features related to self-experience and the world. A symptomatic definition such as the CAARMS is still superficial and perhaps less useful than what it might be if it also included the ‘basic psychotic symptoms’ or essential features, such as those included in the EASE. After all, according to Nelson et al. (2008), predicting psychosis by attenuated or transitory psychotic symptoms the way the CAARMS does, would be like predicting extreme heat by an increase in temperature, without identifying the fire that could be causing the change (p. 384).

Integration of Anomalous Self-experience and at Risk Mental States

The ‘basic symptoms’ that reflect disturbance of self-experience mentioned as the centre of gravity of
schizophrenia (Nelson et al., 2008, p. 285), have
been found to be highly predictive of later de-
velopment of the disorder. Specifically, the absence
of ‘basic symptoms’ excluded schizophrenia with a
96% probability and their presence predicted it
with a 91% probability during monitoring over 10
years (Klosterkötter, Hellmich, Steinmeyer, &

It would thus be a matter of integrating ‘basic
symptoms’ and UHR, assuming that they are com-
plementary approaches (Phillips et al., 2005). In
fact, the discussion of a UHR study applying the
CAARMS suggests including ‘basic symptoms’ to
improve its short-term predictive validity (Yung
et al., 2006). On the other hand, a European study
on predicting psychosis integrating both aspects
(Klosterkötter, Ruhrmann, Schultz-Lutter et al.,
2005) has still to show its incremental value. For
the moment, ‘the inclusion of basic symptoms into
the assessment algorithm defines a more homoge-
neous sample of clinically and cognitively impaired
individuals’ (Simon, Dvorsky, Boesch et al., 2006).

Considering that the ‘basic symptoms’ are not
only more specific and predictive than the UHR,
but also that today a more complete test of subjec-
tive experience like the EASE (Parnas et al., 2005)
is available for them, it might be suggested that
such integration be done from the perspective of
anomalous ‘self-experience’ rather than ‘at risk
mental states.’ In any case, future research could
study whether the same complaints are observed
as for attenuated psychotic symptoms by following
the ‘ultra-high-risk’ criteria, or, as basic symptoms,
in this case following the criteria of the subjective
experience examination (Nelson et al., 2008,
p. 385).

**Phenomenologically Informed Psychotherapy
in Early Intervention**

From the phenomenological perspective, early
intervention on the basis of CBT may not be the
most suitable, according to Nelson et al. (Nelson,
Yung, Bechdolf & McGorry, 2008; Nelson et al.,
2009). This would not only be because CBT does
not address the centre of gravity that would be
self-experience, but perhaps also because it is
directed precisely at reflection and cognitive chal-
lenge, which, as specified above (at the end of the
Introduction), could stimulate hyper-reflexivity
already exaggerated in persons with psychotic vul-
nerability. For lack of studies that could settle
whether phenomenologically oriented early inter-
vention is better than the usual cognitive one, it
should be recalled that within its efficacy, CBT
does not seem to go beyond the efficacy of non-
specific interventions such as ‘supporting advice’
or ‘befriending’. Thus, early intervention con-
sisting of a CBT ‘concentrating on generating
alternative hypotheses for abnormal beliefs and
hallucinations, identifying, precipitating or allevi-
ating factors and reducing associated stress and
teaching strategies for facing them’, was no better
in the long-term than ‘supporting advice’ used as
a non-specific control treatment (Tarrier, Lewis,
Haddock et al., 2004). On the other hand, during
monitoring, befriending turned out to be practi-
cally the same as cognitive–behavioural interven-
tion (Jackson, McGorry, Killacky, et al., 2008).

In any case, whether CBT surpasses non-specific
interventions such as befriending or supporting
advice is still a debated issue. The point is that, as
imposing as it is, CBT is unimpressive in reducing
positive symptoms in the long term compared to
befriending (Turkington, Sensky, Scott, et al., 2008).
On the contrary, befriending and supporting
advice, used as non-specific control treatment,
have a more powerful effect than anticipated. The
fact that these non-specific treatments are also
effective to the extent that they may be due to the
importance of the interpersonal relationship in
the improvement of the schizophrenic condition,
where the participants feel involved in a you-and-I
relationship and not ‘objectivized’ like patients of
an organic disease. Thus, befriending consisted of
talking about neutral topics that interested the par-
ticipant, as well as the participant and therapist
engaged in activities (Jackson et al., 2008). The
more powerful effect than expected of non-specific
treatments suggests that the efficacy of CBT may
be due more to ‘non-specific factors’ than to pro-
cesses hypothesized to underlie the specific symp-
toms of schizophrenia. In fact, as Tai and Turkington
(2009) state, it ‘is not clear whom CBT works for or
when, raising further questions as to how therapeu-
tic change occurs’ (p. 827).

In this context, phenomenologically informed
psychotherapy emerges as an alternative, the prin-
ciples of which, following Stanghellini and Lysaker
(2007), have already been introduced. Here, only
two aspects are discussed, in the line of the above.
One is that the formulation of schizophrenia in
terms of ipseity disturbance may improve the ther-
aputic alliance and provide insight which is of
therapeutic value itself. The emphasis on the spe-
cific qualities of the modes of experience, more
than on the defects or deficits with regard to a
The supposed condition of normality, may make the patient feel understood and recognized. This may, in turn, form the basis for dialogue with the therapist as well as provide a guide and justification for the following therapeutic work, as was seen in a case reported by Nelson and Sass (2009). The phenomenological conception of schizophrenia, with its focus on subjectivity, provides an alternative 'narrative' to the prevailing 'narrative' of medical disease, with the focus on the brain. The narrative concentrating on the subjective experience may be more positive for recovery and probably also less iatrogenic than one concentrated on cerebral disease. In this line, the use of the expression 'schizophrenic person' is claimed rather than, or in addition to, 'person with schizophrenia', according to the clarifying approach of Sass (2007). As Sass shows, to 'the extent that the “person with schizophrenia” formula excludes the implications of “schizophrenic person”, and invokes a standard, deficit-oriented conception of all that is “schizophrenic” in a patient’s being, it is likely to blunt our clinical acuity, and also to foster oversimplified models in scientific research on pathogenesis as well as treatment.' (Sass, 2007, p. 411). On the contrary, Sass continues, ‘we must also listen, as carefully and sympathetically as possible, to the specifically schizophrenic qualities of the person. It may be precisely in his or her schizophrenic-ness that such an individual—in some sense, a schizophrenic person—may embody points of view that can most deeply challenge as well as enrich our own’ (p. 415).

The second point refers to stimulation for immersion and absorption in activities as a means of minimizing hyper-reflexive processes and highlighting a sense of being ‘present’ in activities. As Nelson and Sass (2009) point out, the phenomenological conception recognizes the (paradoxically-sounding) fact that normal ipseity or self-experience is in fact dependent on a certain ‘forgetting’ of the self, or at least a forgetting of the self as an objective focus of awareness, so that the more foundational sense of oneself as a subjective perspective on the world can be grounded.’ (p. 499). Case studies show the efficacy of involvement in activities in recovery from schizophrenic processes (Nelson & Sass, 2009; Veiga-Martínez, Pérez-Álvarez, & García-Montes, 2008).

The evolution of schizophrenia observed in CBT from challenging the negative content of thoughts and schemas to stimulating a mindfulness type of acceptance of experiences and immersion in the present activity (Tai & Turkington, 2009), show that the phenomenological alternative is right. Some of these therapeutic trends are reviewed in the following section.

**PSYCHOTHERAPIES WITH PHENOMENOLOGICAL AFFINITY**

Three narrative psychotherapeutic models are referred to (dialogical, cognitive–behavioural and interpersonal–cognitive) and psychotherapies based on mindfulness and acceptance and commitment. As mentioned above, although they are psychotherapies with different origins and influences, they can be viewed from the phenomenological perspective in the interest of promoting psychotherapeutic integration. Inclusion of these psychotherapies here may suggest greater phenomenological fertility than advisable. In turn, the procedure of these therapies may suggest procedures for implementing phenomenological psychotherapy itself.

**Narrative Psychotherapy**

This group includes relatively different models that all have recovery of self-experience, sense of self and personal identity through the narrative in common. The narrative can provide an account repairing the life story that disturbed the client or did not allow him develop to the utmost (Howard, 1991). Thus, e.g., a story about recovery may arrange things differently from one about a chronic illness and lifelong treatment. The narrative is not fictitious, but is based on the linguistic structure of experience and the narrative sense of personal identity, according to phenomenology in its convergence with hermeneutics (Sass, 1988).

The therapeutic role of the narrative can be seen in recovery stories. Recovery involves a new sense of self (Davidson and Strauss, 1992; Thornhill, Clare, & May, 2004) and a perspective of ‘life outside of schizophrenia’ (Davidson, 2003). According to Roe and Davidson (2005), reconstructing a sense of social agency and re-authoring one’s life story, rather than simply being a by-product of recovery should be considered key dimensions of recovering which interact with other important domains in a meaningful way (p. 89). Three recent models are presented here: a dialogical model (Lysaker & Lysaker, 2008), a cognitive–behavioural narrative model (Rhodes & Jakes, 2009) and a cognitive–interpersonal model (Gumley & Schwannauer, 2006).
**Dialogical Model**

This model, developed by Lysaker and Lysaker (2002, 2008), emphasizes interpersonal and intrapersonal dialogue. The model offers a psychology of self-positions and a taxonomy of disturbed self-experience in schizophrenia. The psychology of self-positions is like the grammar of the self’s ensemble (Lysaker & Lysaker, 2008, Chap. 3). In the dialogical model, the self would be, more than anything else, a composition of ongoing dialogues among different voices whose interaction would not be presided by an overarching ego, according to the dialogical tradition of Bakhtin (Hermans, 1996). Thus, we would have to talk about whether the self-as-X is, e.g., I-as-brother, I-as-woman, I-as threatened, I-as-patient, I-as-reflexive etc. Even so, Lysaker and Lysaker distinguish three self-positions: organism-position, to refer to the basic experiential-self (e.g., self-as-threatened, self-as-hungry, self-as-engaged etc.), character-position, concerning action-orientations revived from social roles (e.g., self-as-brother, self-as-citizen, self-as-heterosexual etc.), and meta-positions, when one reflects on the different positions or life in general (e.g., self-as-success, self-as-patient, self-as-fortunate etc.) (Lysaker & Lysaker, 2008, p. 54).

The taxonomy of disturbed self-experience is described by three self-organization models resulting from compromises in the inter-animating flow of self-positions that lead to experiences of self-diminishment, namely, the barren self, monological self and cacophonous self. The barren self describes undeveloped, mostly discontinuous self-positions, which lead to a fragmented life-story populated by few meta-positions and limited description of the world (e.g., the sense of drifting in a fog, unable to change anything). A monological self is inflexible dominance by one or two meta-positions, which lead to implausible interpretations of self and world, and a repetitive life-story (e.g., fear that everything one experiences is part of a plot to kill him). A cacophonous self is an often rapid and chaotic succession of self-positions, which lead to an incoherent life-story filled with abstract generalizations (e.g., critical and often tangled self-presentations (Lysaker & Lysaker, 2008, p. 90).

On the basis of the self-positions and taxonomy of the disturbed self-experience, the dialogical model develops an integrated psychotherapy, in the double sense of psychotherapy integration that calls for interventions interlaced into an internally consistent theoretical network and seeks psychological integration within the person by bringing together previously fragmented aspects of the self (Lysaker, Buck, & Roe, 2007, p. 28).

As Lysaker and Lysaker (2008) summarize, ‘Psychotherapy for schizophrenia should be understood in part as an effort to reignite intra- and interpersonal dialogue. The hope is that by empowering dialogical capacities, clients will cease to experience themselves as bits of diminishment and regain the sense that they are dynamic centers of insight and action’ (p. 158). Case studies done on dialogical integrative psychotherapy (e.g., Lysaker & Hermans, 2007; Lysaker & Lysaker, 2006, 2008) show psychological integration concomitant with the course of the therapy and the consequent improvement in social functioning and relief of symptoms from the supposedly mutual effect of narrative and symptom (Lysaker & Lysaker, 2004).

**Cognitive–Behavioural Narrative Model**

This model developed by Rhodes and Jakes (2009) emphasizes the integration of experience in the biographic context. It is also an example of integrative psychotherapy and integrative psychology. As integrative psychotherapy, the model is based on solution-focused therapy, on narrative therapy, on cognitive–behavioural therapy and on phenomenology (Rhodes & Jakes, 2009). Above all, solution-focused therapy contributes re-orientation of the problem towards the solution. The therapist helps the client to describe situations in which the problem does not occur and to clarify goals and values that could be an alternative. The goal is specified from both subjective experience (How would you know that a goal is being achieved?) and from the observation of others (What would others have to notice to realize that you are moving towards your goal?)

Narrative therapy attempts to articulate the negative story and its effects on the person and construct an alternative, preferred narrative with the client.

Cognitive–behavioural therapy (CBT) here involves working rather to strengthen a person’s capacity to recover positive representations that correct erroneous thoughts and false beliefs. It also emphasizes the person’s activation so that change in habits, aspects of the self, ways of life and outside environment can lead to more positive events occurring in his life. This constructivist accent of the CBT also leads to a more explicit use of the narrative than traditional CBT, which is why it is called narrative CBT (NCBT). For example, while traditional CBT focuses on specific cognitions and behaviours and does not explicitly emphasize the language (although it uses it), the NCBT assumes a network of influences and the
relevance of context and story and considers language, metaphor, narrative and discourse highly significant (Rhodes and Jakes, 2009, p. 19).

Phenomenology integrated in the NCBT is not reduced to considering the torrent of subjective experiences, but attempts ‘a sort of basic phenomenological grasp of the client’s “lived-world”, how the client experiences other people’s daily world, actions, relationships, and so forth’ (Rhodes & Jakes, 2009, p. 42). To capture the client’s lived world, the therapist needs to understand how ‘symptoms’ and experiences are connected, how both are inserted in daily life, how this situation has a story related to past circumstances and events etc. The story allows life-long meanings to be captured. Thus the therapist offers the customer interpretations and stories that allow him to understand the psychotic experience and behaviour.

As psychological integration, the NCBT positions current problems in the biographic context and opens possible solutions. Thus, the voices begin to make sense. To do this, the therapist must take them into consideration, explore their role (What do the voices do to you? How do they make you feel powerless?), and link them to the client’s past and current events. Delusions may be understood as part of the person’s more general stories of life and world. The NCBT sees delusions as conceptions, visions of the world and stories whose contents reflect themes derived from open domains of human experience (Rhodes, Jakes, & Robinson, 2005). In any case, the therapist’s position concentrates less on change and more on providing a context in which the change can take place, e.g., by exploring feelings about past and present relationships (Rhodes & Jakes, 2009, p. 145).

**Interpersonal–cognitive Model**

This model was developed by Gumley and Schwannauer (2006) who, insofar as we are concerned here, emphasize the reorganization of the identity during recovery from the psychotic disorder. The model is conceived for a return to normality after a psychotic disorder (staying well after psychosis). ‘Staying well’ means, above all, emotional recovery from the trauma of the psychotic disorder itself and prevention of relapse by reducing the psychological vulnerability to any new psychotic experience. The primary goal is to reach and create a sense of comprehension of the psychotic experience, more than change the symptoms per se, which would be a secondary goal.

Its interpersonal–cognitive nature suggests the integration of Bowlby’s attachment theory within the framework of a CBT. According to the attachment theory, experience during psychosis and the negative relational nature of psychotic experience (e.g., hallucinations that give orders or delusions of persecution) constitute the reflection of underlying negative relational schemata learned in the earliest relationships of attachment and loss, including separation, anger, anxiety, sadness and depression, so psychosis is lived as an event that confirms previous early experiences. Gumley and Schwannauer (2006) propose CBT as a model for explaining first signs and relapse. In this respect, they emphasize the role of catastrophic interpretations and interpersonal threat from subtle signs (e.g., cognitive–perceptive changes) and isolated symptoms (e.g., interpersonal susceptibility as evidence of the imminent reappearance of psychosis). In any case, in the phenomenological perspective, the CBT model must be taken with the precautions warned above (at the end of the general introduction), relative to its possible contribution in the exaggeration of hyper-reflexivity. In reality, the interpersonal-cognitive model is included here more for the interpersonal and narrative aspects than the cognitive.

A central component of the therapy is formulation of the problem in a narrative that includes the client’s perspective and the significant experiences in his life and that serves both him and the therapist for finding other alternative relational perspectives and strategies. According to this therapy, a normalizing, accepting and compassionate framework of psychotic experiences is basic to reorganization of identity during recovery. Cognitive interpersonal therapy is carried out in 25–30 sessions over 9–12 months. It is divided into three phases, therapeutic engagement and formulation of the problem (narrative), transforming beliefs and problematic interpersonal strategies (acceptance and self-compassion) and end phase and closure (preparation for ending and prevention of relapse).

Cognitive interpersonal therapy (Gumley & Schwannauer, 2006) may improve previous interventions that showed the association between psychotic relapse and appraisals of psychosis and self-esteem (Gumley, Karatzias, Power et al., 2006) to the extent that the therapy is more individualized and self-compassionate strategies are also implemented more (Gumley et al., 2006).

**Mindfulness and Acceptance and Commitment Psychotherapies**

Both these approaches, often integrated in one, change the relationship with the distressing experi-
ences, in this case psychotic experiences, in the sense of no longer reacting to them, and experiencing them instead as they appear (mindfulness) or accepting them with an open attitude (acceptance). They are based on the fact that the problem is not in the experience per se but in certain reactions to it, in particular, attempted control or avoidance. The fact is that patients often see themselves, above all in the first psychotic experiences, as lost in cycles of struggle, trying in vain to get rid of the voices, thoughts, images or feelings. In the end, they feel tyrannized by the psychosis and with little or no sense of agency. While mindfulness remains in experiencing, acceptance leads to the commitment to move towards values, constituting Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999). Although ACT usually incorporates mindfulness as a component of acceptance, mindfulness can be a procedure in and of itself (Chadwick, Newman-Taylor, & Abba, 2005).

**Mindfulness**

Although it originated in Buddhism, mindfulness today holds its own in psychological therapy, making a place for itself in the world of psychosis, especially due to the work of Chadwick et al. (Abba et al., 2008; Chadwick, 2006; Chadwick et al., 2005). The step from feeling overcome to reaching a certain peaceful release passes through changing the relationship with psychosis. ‘This is a key shift from trying to get rid of or defeat psychosis to learning to live with it without a struggle’ (Abba et al., 2008, p. 81). This change occurs in a three-stage process: (1) learning to center on awareness of psychosis (voices, thoughts, images) at the present moment; (2) allowing psychosis to come and go without reacting or struggle; and (3) reclaiming power by acceptance of psychosis and the self.

Stage 1 is a fundamental change from decentralizing psychotic experiences and focusing on the ‘knower’, on the person in his awareness of the voices, thoughts etc. This can be achieved by anchoring the experience on respiration and body, concentrating gently on what is present. Participants say that they are able to notice the fleetingness of their experiences, without having to be at their mercy. Their breathing and their body begin to be a secure place, a haven of peace (Abba et al., 2008, p. 82). Stage 2 is the liberation from the habitual cycles of struggling with the psychotic experience. The person learns to separate sensations and reactions and can see the fleetingness of the former without necessarily having to respond to them. As one participant says, ‘Let things come and go and not let them sort of linger and not work on them. If they come, you just let them go and they’re not there and you’re not fighting with them and you’re not struggling with them’ (Abba et al., 2008, p. 83).

Stage 3 is reclaiming power over psychosis itself through acceptance. Acceptance is not so much a technique as an attitude and even an entire philosophy about the problem. Acceptance involves willingness to experience something unpleasant and inevitable and open, experiential, not reflective, analytical or judgmental awareness. As another participant says, ‘Accepting it instead of fighting against it nonstop, worrying about it, thinking’ is ‘a completely new way of looking at it’ (Abba et al., 2008, p. 84).

To the extent that one accepts psychosis as a part of experience, of the self, psychosis does not define the self. One has the experiences, but is not held by them. The self recovers power over psychosis. The symptoms may continue to be present, as measured by descriptive phenomenology, in terms of how and how often, but phenomenology of subjective experience and of what the symptoms mean and involve for one is probably rather different.

**ACT**

This therapy with behaviourist roots is presented as a new generation of behavioural therapy. It is backed by solid research on the language and its clinical, psychopathological and therapeutic implications. Among its innovations are definition of experiential avoidance as a functional dimension common to various disorders, acceptance as a therapeutic principle often incorporating mindfulness and the explicit inclusion of values such as orientation in life, and an alternative to focusing on the problem (Hayes et al., 1999). ACT considers that experiential avoidance (avoidance, attempts at control etc.) of psychosis is more a part of the problem than the solution, and adopts acceptance and mindfulness, incorporating values as the horizon on which life is oriented. Values are ideals which one would like to achieve, and which it is unnecessary to define operatively as targets or goals (e.g. have a job or a relationship), but that serve to evaluate whether one is going in that direction or not, e.g., by staying stuck on the problem. Thus, one could undertake actions and make commitments to do something in spite of certain experiences (voices, thoughts etc.). The term ‘commitment’ which is part of the name of this therapy and its acronym, ACT, which is pronounced ‘act’ suggest this orientation towards action and activation of the person towards values.
With respect to mindfulness, it could be said that ACT adds commitment of acting on values, but it also could be said that ACT incorporates mindfulness in a wider and more solid theoretical and procedural body. In any case, acceptance and when applicable, mindfulness, are supplemented by action, that is needless to say, meaningful action, not doing for the sake of doing.

Mindfulness and ACT are not offered as a cure for psychosis because the presence of psychotic symptoms may continue. Its goals are rather to teach participants to respond to their psychotic experiences differently and to help them to get on with their lives (in ACT in particular). Studies show that participants learn to respond mindfully to the voices, thoughts and images and that this is associated with improvement in general clinical functioning (Chadwick, 2006; Chadwick et al., 2005). Controlled studies applying ACT show its efficacies in reducing relapse in people with psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, 2006). A case study has shown the combination of acceptance and commitment in the reorganization of the life of a patient (Veiga-Martínez et al., 2008).

The relevance of phenomenology to all of these psychotherapies is that it can orient their direction and optimize their methods, according to the specific phenomenological conception of self-disturbance in schizophrenia in terms of hyper-reflexivity and diminished sense of self. The phenomenological conception, although it warns against hyper-reflexive processes being promoted by traditional CBT, nevertheless includes the possibility of both heightened awareness of subjectivity itself, when it is of interest in exploring meanings and providing experiences with sense, and their attenuation, when immersion and absorption in activities is of interest, ‘forgetting oneself’ as a way of feeling present in activities (Nelson & Sass, 2009). In this sense, the phenomenological conception provides a conceptual basis for therapies such as ACT and mindfulness, at least in their application to schizophrenia. Otherwise, these therapies would be ‘abandoned’ to their own idea, as they were conceived for problems other than the one represented by schizophrenia. The phenomenological conception is interested in improving the diminished sense of self by establishing understanding therapeutic relationships and building up shared meanings. In this sense, the phenomenological conception provides the conceptual base for various narrative psychotherapeutic models. Thus, the hermeneutics involved in each of them could be seen and organized from the same phenomenological perspective concerning self-disturbance.

Moreover, these psychotherapies can be relevant to implementation of the principles of a phenomenological psychotherapy. In this light, the narrative seems to be well suited to the reconstruction of the sense of self as the centre of experience and as the agent of action. Mindfulness and ACT offer strategies for changing the way own experiences are undergone, in a direction of opening towards them and their acceptance—instead of fighting them—which can improve the sense of self. In particular, ACT has shown that improved involvement in activities involves commitment to values tending to a life with sense and not merely occupied or entertained by something (Veiga-Martínez et al., 2008).

**NEW LIFE FOR PSYCHOTHERAPY IN SCHIZOPHRENIA**

You might ask what significance psychotherapy has in the age of neuroscience (Brenner, Roder, & Tschacher, 2006). The truth is that after the decade of the brain and of the strong advances in neuroscience, the main thing with regard to the treatment of schizophrenia is still unresolved, although there is agreement that the sense of self and of being the key actor in one’s own life must be recovered. Recent proliferation of psychotherapies focusing on self-experience and recovery of personal identity reveal that no solution to the problem has yet been found and that the best way is not necessarily neuroscientific or neuroleptic.

In particular, the conception of schizophrenia as self-disturbance offers a perspective based on empirical research, clinical experience and phenomenological theory on which to ground and re-launch psychotherapy in schizophrenia. Although self-disturbance has been shown to be highly specific to the schizophrenia spectrum, it may also be a general psychopathological marker of psychotic vulnerability, as suggested, e.g., in the work of Nelson et al. (2009) and Parnas et al. (2003). Future research will determine how self-disturbance is profiled in each psychotic condition.

In any case, a revival of psychotherapy of schizophrenia is observed (Silverstein & Lysaker, 2009), in particular, phenomenologically informed psychotherapy, the subject of this paper. A variety of models has been presented in a review, which is not intended to be exhaustive, and more with a view to seeing the emergence of a new field than establishing different positions within it. In fact, the different models (narrative, mindfulness, ACT) are not...
offered to compete with each other, but seeking integration in the double sense of integrative psychotherapy and integrative psychology, as mentioned above. Naturally, it is not a matter of just any integration, but of one well founded empirically, theoretically and philosophically, which involves critical and reconstructive analysis. It is out of the scope here to go into whether these matters are, e.g., about the self as dialogical or single, whether the best framework is psychodynamic, cognitive, behaviourist, or interpersonal, or which combination of them the narrative develops in, or the limits of the narrative about self-experience, the combination of mindfulness/value acceptance etc.

All in all, perhaps integrative psychotherapy should not be imagined as a single model, finished and unanimous, given its interactive nature, more than natural, of psychological problems, susceptible to being reconstructed in relatively different ways (Pérez-Alvarez & García-Montes, 2007; Pérez-Alvarez, Sass & García-Montes, 2008). Psychological integration would not have to follow the same narrative pattern, as life-stories are varied. What psychotherapy cannot be free of is empirical testing, but in this respect it might be necessary to pass over the practice based on evidence to evidence based on practice or, at least, build a bridge between them (Barkham & Mellor-Clark, 2003). What should be taken advantage of is to get out of the neuroleptic metaphor according to which psychological therapy in schizophrenia is measured by the efficacy of anti-psychotic medication, when its contributions are different (Birchwood & Tower, 2006), among them the focus by the therapies presented here (reconstruction of self etc.).

What this new life of psychotherapy already has ensured is its welcome by users (patient, clients, participants), as it is well known that patients request psychotherapy (Coursey, Keller, & Farrel, 1995), want to talk and have much to say about what is the matter with them (McCabe, Health, Buns, & Priebé, 2002).

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