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Eric Morris *Editors*

Psychological Interventions for Psychosis

Towards a Paradigm Shift

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Foreword: From Pathologizing to Meeting with Full Human Beings

In psychiatry, during the last decade, more openness has appeared towards psychotherapeutic orientation concerning the recommendations of care in psychotic crises. During the previous two decades, the neurobiological paradigm has prevailed and psychotherapeutic interventions have been neglected. For people in psychotic crises, this period was unfortunate because it meant that they only were introduced to neuroleptic medication as the standard of care. Psychotherapy was abandoned by the belief seeing psychosis as a neurotoxic condition, and neurobiological intervention became the only relevant care recommended. Emphasizing the medication as the principal care, the experiences of the persons with psychotic experience were disacknowledged as non-relevant because they were seen to be speaking from the ill brain position. Unfortunately, psychotherapists seemed to adopt the neurobiological explanations and on a large scale ceased to introduce psychotherapy in psychotic crises. This happened in individual psychotherapy but also in family therapy, which is my special interest.

People with psychotic experiences in a way were abandoned by the system of care and by psychotherapists as well. Their voices were not taken seriously, because the experts knew better what actually the problem is. This may seem like an overly critical definition of the situation, but it is actually what people with psychotic experiences say. I receive emails every day from patients and from family members all over the world and they repeat the message: "No one listens to me". No one takes it seriously. People tell stories, in which I can read that they have been put as targets of terror and bullying from professionals who deny the valour of their experiences. In many instances, professionals who used to have psychotherapeutic interest stopped working psychotherapeutically. In practice, this meant that they were no longer interested in listening to and taking seriously the accounts of the person who had psychotic experiences, because in the clinical practice professionals started to adopt the "truth" that psychotic experiences illustrating schizophrenia really would be a neurobiological illness.

All that happened for two decades was unfortunate also because professionals in clinical practice adopted the new neurobiological explanation and stopped to rely on meeting their clients with empathy. Thus, psychotherapists also became a part of the

movement of abandoning the clients and their families. The sad part of the story is that the new explanation of the background of psychotic experiences was not based on reliable scientific evidence. Claims of the deterministic neurobiological quality of psychosis were based mainly on myths and studies that mostly did not clarify the issue that they were told to explain. If some study would show that a group of psychotic patients using neuroleptics during the very first weeks would recover faster from their symptoms compared to the one who did not use them, it is not a confirmation that schizophrenia is caused by structural changes in the brain and thus the medication is needed immediately. But this was the story. Poor scientific evidence was repeated in the treatment of excellence guidelines overemphasizing the importance of neuroleptic medication as the treatment of choice and disacknowledging the importance of psychosocial approaches.

Although this has been the main story, this book is an illustration that all the way through there have been clinicians who have continued the psychotherapeutic work with their psychotic clients. They have kept the flame of psychotherapy alive until the climate has become more plausible for humanistic practice in psychotic problems. Climate change started to happen in the studies, in which it was found that the use of neuroleptic medication can be related to shrinkage of the brain, they can cause structural changes in the brain and they can increase mortality especially if using multiplicity of drugs. These results encouraged to look for more human practice. While in the medication the emphasize is on removing the symptoms, the psychotherapeutic approaches have the interest to meet the full human beings, not only their symptoms.

This shift is groundbreaking, moving the focus on all the voices respecting the unique individual experience. This type of humanistic perspective is the basis of any psychotherapeutic method. But it is not a new one. In psychotic crises, psychotherapy used to have an essential role a long time ago since the 1930s. First in psychodynamic psychotherapy and in family therapy and later in several different methods of cognitive and cognitive behavioural therapies. During the last decades, we have seen the enormous growth of different psychotherapy methods including the variations of therapies emphasizing the importance of embodiment. The new arising paradigm has also been supported by new research showing the effects of psychotherapies producing more permanent results in life in comparison to only using medication.

I have been involved in developing Open Dialogues in most serious crises including psychotic problems. The special element of open dialogues is to mobilize the resources of the families and other parts of social network of the clients in crises, and the outcomes have been promising. In one study of 19 years of follow-up after the first psychotic crisis, it was found an enormous difference in comparison to treatment as usual in Finland. In the case of those who had been in open dialogue care 19 years ago during their first crises, 28% needed contact to care, 33% were using neuroleptic medication and 33% were living on disability and the rest of the patients working actively. All these mean that about two-thirds of the ones having psychotic crisis 19 years ago were doing well with having a full responsibility of their lives. What happened to the patients in medication-oriented care? Out of them, 49% were in contact with psychiatry, 81% were using neuroleptics and 63% were

living on disability. The reader may remember that in the 1980s it was told a story that one-third of schizophrenia patients will recover, another one-third would become better but are in need of support and the rest one-third would be chronic. Now, more than 30 years thereafter, the outcomes are the same in medication-based care. Decades of the neurobiological hegemony the outcomes have not improved, perhaps the opposite. The results of care have become worse.

It really is the time to start to invest in psychotherapeutic approaches. What makes me glad while reading this book is the variety and beauty of the different methods. If you have an interest of starting psychotherapy with people suffering from psychotic problems, you really have a variety of approaches and thus the possibility to find the style of work that fit your interest.

What is the basis of psychotic experience? To understand psychotic behaviour as a response to what has happened in one's life seems to be the most important starting point. Usually, psychotic experiences emerge in an extreme stress situation, which may be obvious, but it also may be hidden in many small hints of life. The multiplicity of the stressors in a way put the person in a dead-end situation, in which hallucinations may be found as a solution, as an outcome of the impasse. In these hallucinations or delusions, people speak about real issues in his/her life and he/she should be taken seriously because this may be the first time ever when words are shared about the most important memories without any other words than psychotic ones.

Psychotic experiences many times include a sense of terror, which may be related to relationships with those nearest to the key person. This may lead to a sensation that others become too close and thus individual space is needed to protect oneself. This often leads to the unfortunate conclusion to isolate oneself from human relations. In isolation, people easily start to generate non-constructive strategies to survive the extreme situation. These type of non-constructive survival strategies are often visible in the behaviour of the protagonist, and we often think that they are the core of his/her illness. But instead of thinking of the behaviour style as a sign of illness or psychopathology for me, it is more fruitful to think of them as being responses of the embodied mind. Therefore, an appropriate professional response to psychotic crisis should include two important elements: Firstly, to introduce help immediately by organizing crisis intervention services; secondly, to include the family and other relevant parts of the social relationship immediately to stop the isolation and to help to see the human relationships potentially helpful.

In meetings with a person having psychotic experiences and with his/her family what is needed is to respect everyone's point of view without conditions. In different approaches, this is done in a unique way to each approach but is essential to mobilize everyone's own resources to meet with the challenging experience that perhaps never has been spoken about openly. The dialogical practice focuses on seeing things in the relational context in the life of the one having psychotic experiences. It seems to be important to have space for speaking about the emotional part of everyone's experience instead of having argument about whose observations are more real. In the end, what seems to be important is to be awake in the conversation, because while someone starts to speak about incidents of life in a psychotic way,

this may be the moment to open the window more to the part of his/her experiences that never has been spoken before.

Shortly said, for me, these are the main guidelines to meet with the person and the family. In different approaches, I can easily see most of these elements. For the therapists this is challenging, and new skills are needed. I hope that with the help of the chapters in this book, we all will have more skills to be present and to be available for those who really need help more than ever in their lives.

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Preface: Towards a Paradigm Shift in Psychosis – Models of Change

We are honoured as the editorial team to present a range of models and approaches that we believe reflect a broader change in how people with psychosis can be supported in their personal recovery. The chapters in this book reflect shifts in understandings: about recovery from psychosis, in how people make sense of their worlds, and increasing recognition that our efforts to help people should be guided by recognising common human needs for connection, purpose and autonomy and working collaboratively and creatively to help people meet these needs. We believe these shifts reflect important changes in how care and support for people with psychosis are considered and offered.

The chapters in this book provide the reader with a diversity of viewpoints on how psychological and social interventions may help people with psychosis. The chapter collection provides a sense of contemporary intervention models, with reflections, strategies and practical guidelines demonstrating how these models can inform practice.

Across the models presented in the chapters, we hope the reader will see the common purpose reflecting the shift in paradigm we believe is happening in psychosis care. The chapters present person-centred models that lead to a way of seeing, understanding and accompanying psychosis that is very different from the traditional biomedical model. Current authors and approaches are revolutionising an outdated model trapped in purely pharmacological actions and tautological explanations of a biological nature, where symptom control is the basic and fundamental form of approach, and in which psychotherapeutic actions take second place as a subsidiary to the former.

Approaches such as Acceptance and Commitment Therapy, Acceptance and Recovery Therapy by Levels, Open Dialogue, Compassion-Centred Therapy or the Hearing Voices movement, to name but a few of those presented in this book, represent a journey of self-knowledge and learning for those recovering from psychosis and have an intense transformative potential for the therapeutic team.

The reader can also see that working from the perspectives shared by the contributors implies abandoning the position of expert and being open to learning alongside the person recovering from psychosis through shared discoveries and

finding common humanity. The approaches presented in this book have the potential to transform the professionals who participate whether through processes such as mindfulness and acceptance, the cultivation of self-compassion, new relationships with unusual experiences, or finding ways to communicate in open dialogue. This is why we feel the need to bring this collection of models and interventions in the book, and learn from contributors, to improve and guide the lives of all, professionals and people who experience psychosis, towards meaningful goals.

The fundamental principle that guides this book is to share models belonging to psychology that aim at personal development while respecting the needs, values and goals of each person, and that are capable of integrating any professional or student of clinical psychology, psychiatry, nursing, social work or any other discipline who is motivated by finding the pool of common humanity and wants to dive in and drink from these waters.

As experienced therapists, we see every day how difficult it is to intervene with people affected by psychotic spectrum disorders (PSD). These serious problems affect people globally, in each of their vital spheres (self, family, context, etc.) that make their definition a highly complex challenge. Throughout the history of psychiatry (whose object of study has always been traversed by the social context), there have been many attempts to conceptualize schizophrenia, with efforts to reach consensus around nosological criteria set out in diagnostic manuals such as the ICD and DSM. The efforts at definition have not necessarily led to greater precision and effectiveness in interventions, and there is as much disagreement as ever about the nature of psychosis. It can be argued that at worst the diagnostic conceptualizations of psychosis imply a disease model and stigmatising labels that are supported by biased pathognomonic interpretations far removed from scientific rigour. In the meantime, people recovering from psychosis may continue to have many needs under-served by mental health systems built on the assumptions of the disease model.

In these systems, it is unfortunately common for professionals to forget to "listen" to what people with psychosis tell us about what matters, to disassociate their life history from their symptoms, to disregard their most pressing needs, and to fail to take their needs into account when defining what is most important to them. This may not be deliberate but rather an outcome of these systems reducing complex lived experiences of psychosis occurring in the social and personal contexts to disorders to be treated. These systems can also result in professionals acting in paternalistic ways or from an expert position, rather than adopting a genuine "helping" position.

At present, transdiagnostic models, or new developments such as "The Power Threat Meaning Framework", together with new ways of understanding PSD are making their way from different origins and very distant theoretical-practical perspectives. With their new approaches, they show how diagnostic manuals, commonly used in the Western mental health system, do not take into account what happens to people, their suffering or their particular needs, and how they are associated with a standardized treatment that does not respond to the demand for accompaniment, respect, empathy, listening and dedication of time that people need in order to recover.

Positioning ourselves on the theoretical bases and principles of these psychological models, we have decided to write this book. The contributions in this book provide a sense of contemporary thinking and practice on psychological and social approaches to support the recovery of people with psychosis, including those models built from empirically validated knowledge and those yet to be validated. The reader will also see how these models can be demonstrated in practice with case material presented that has been elaborated by authors who intervene with PSD in its different manifestations and stages.

In addition, we delve into the importance of a paradigm shift that gives priority to the person's decisions, takes into account the traumatic history that accompanies their suffering, their personal circumstances, gives importance to psychotherapy and presents critiques of biologically reductionist approaches, which are currently widely questioned by authors who also contribute to this work. With all this, in the different chapters, we will have the opportunity to work with the social, family and individual contexts of people in an integral and holistic way.

Based on this working hypothesis, and throughout the different approaches presented in the book, we will try to bring our psychotherapeutic models to the applied environment, both public and private. We will take an interdisciplinary approach drawing on lessons from different parts of the world, with a perspective based on the individual, imbued in values and principles, committed to warm and humanistic care.

Melbourne, VIC, Australia — Eric Morris
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Chapter 1
Toward a Change of Paradigm in Psychosis: A Contextual Phenomenological Approach

Marino Pérez-Álvarez and José Manuel García-Montes

1.1 Introduction

In times that clamor for evidence, few things are more evident than the need for a change in paradigm in psychosis. On one hand, unsustainability of the dominant paradigm, presided by the biomedical model in which psychosis would be a brain disease and medication the treatment to be selected, is becoming more and more obvious. However, so-called mental diseases are not brain diseases (Borsboom et al., 2019; Ioannidis, 2019), nor is antipsychotic medication really a treatment that could correct etiological conditions. In fact, what medication really does is produce the same neurochemical and structural alterations (Whitaker, 2015; Yang et al., 2021) with psychotropic effects that can alleviate symptoms (Moncrieff, 2013; Pérez-Álvarez, 2021, Chap. 11), but not innocuously. As a symptomatic treatment, medication may be a useful resource, but it would not properly be a curative treatment. This is not to say that psychosis is not a disease, but perhaps more than a disease: a way of being-in-the-world.

On the other hand, the sustainability of an alternative paradigm, such as the phenomenological approach to schizophrenia in this case, is also more and more obvious (Sass & Parnas, 2003, 2007). Thus, the way is opening to a variety of aids in a contextual perspective (Díaz Garrido et al., 2021). Perhaps it is time to propose a contextual phenomenological approach beyond, in fact, cognitive behavioral therapy (Fuchs, 2019; Nelson et al., 2021; Pérez-Álvarez et al., 2011; Sass, 2019). A contextual phenomenological approach represents an alternative to the biomedical

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model. At least a contextual phenomenological approach concentrates on the person and his circumstances. Nothing about psychosis can be understood without referring to the person. The person, and in this case, the self or the subject, is the level of analysis, the "thing itself" (remember the phenomenology slogan "back to the things themselves") that clinicians find themselves with. While a statistical focus dilutes individuals in supraindividual structures (averages), a neurobiological focus reduces them to subpersonal mechanisms.

A radical change in global mental health focused on the person is demanded by the World Health Organization (WHO), not without recriminating promotion of the biomedical model. The WHO follows in the steps of the United Nations Convention on the Rights of Persons with Disabilities. Not in vain, the WHO document is entitled *Guidance on community mental health services: Promoting person-centered and rights-based approaches* (World Health Organization, 2021).

The term psychosis has recently become generalized as the most appropriate denomination for a variety of disorders with their own name, such as schizophrenia, manic depressive psychosis, psychotic depression, melancholia, and mania. Manic depressive psychosis has experienced its own transformation into bipolar disorder. Bipolar disorder includes depression, melancholia, and mania now seen as a manic-depression tandem. The brilliant idea of the bipolar spectrum ends up extending bipolar disorder not only horizontally (including several categories) but also vertically, including subclinical and clinical aspects in the same dimension with no apparent solution of normal-pathological continuity (Haslam, 2016; Paris, 2021).

The notion of spectrum also came to schizophrenic psychosis, leading to the psychotic spectrum. Psychotic spectrum similarly extends horizontally and vertically. Now the psychotic spectrum and the bipolar spectrum partly overlap and each extends on its own. The remaining disorders, autistic spectrum, anxiety, addiction, etc., would be separate. The "clinical spectrum" is projected over the general population. The notion of spectrum, which has solved the problem of lack of definition of diagnostic categories, certainly without precise edges, in favor of a dimensional, less stigmatizing conception, ends up, however, overdimensioning clinical categorization and thus extending the territory of pathologization. The clinical spectrum looms over normality, converting ordinary misfortunes into "spectrum disorders" of something.

Another problem with the handy notion of spectrum that fully affects any psychopathology that values its name is that it dilutes possible differences between what happens to people, now liquified and liquidated in the abovementioned spectrum as if, for example, the world as lived in schizophrenia, melancholia, and mania were the same or eccentricities and changes in mood were already enough for a psychotic spectrum or bipolar spectrum diagnosis. In the end, psychotic spectrum or bipolar disorder is a "false friend" serving the biomedical model more than understanding of individuals according to their circumstances.

The change in paradigm in psychosis requires going beyond the mainstream established around the biomedical model, including the psychotic spectrum disorder. It also requires going beyond the standard science that sustains the biomedical model.

Standard science is no other than a positivist, statistical science "based-on-evidence", practically, randomized controlled trials and meta-analysis. It is not a matter of leaving science, but seeing which science best corresponds to the nature of clinical psychological and psychiatric problems. Progress could be made based on the discussion above that a holistic-contextual science would be more appropriate than the statistical-mechanistic science in use, not discarding it, but putting it in its place (Pérez-Álvarez, 2021; Pérez-Álvarez & García-Montes, 2019). Thus, for example, it is not proposed to avoid statistical analyzes when they are pertinent, but to direct their object towards the meaning that phenomena may have for people, who are always in a lived situation. Statistics could be, in its case, a way of extracting structures in which people's experience is organized just as, for example, it is, from a qualitative strategy, the "grounded theory". However, in practical terms, this holistic-contextual science, focused on individuals and their circumstances, becomes a qualitative methodology and clinical method. The clinical method, consisting of research in psychological phenomena in case studies, at one time was the scientific method of psychology by antonomasia. Some authors of important innovations in psychology may be recalled, who, although not clinicians, used the clinical method as their research method: Mary Ainsworth and attachment theory, Lawrence Kohlberg moral development, Jean Piaget and cognitive development and Burrhus Skinner and behavior analysis, and so many others.

In view of the above, the change in paradigm in psychosis would therefore involve going beyond the mainstream (biomedical model, positivist science) in the direction of a person-centered approach based on a holistic-contextual science shaped by the clinical method and qualitative methodology. This book of case studies is a true example of this change in paradigm, and this chapter theorizes and reasons about such a change. After all, the most practical, decisive, and hardest change is probably paradigmatic: a change in theory, viewpoint, worldview, and way of thinking. The change in paradigm is not merely a cognitive change, but one of inhabiting, thinking, and doing, a *habitus*.

The argument is developed under three headings. The first shows the need for a change in paradigm based on exhaustion of the biomedical paradigm, even though now very much currently in use. Second, a possible new paradigm for rethinking schizophrenia in a person-centered context is shown. Finally, some implications of the contextual phenomenological "turn" are highlighted as the new paradigm is identified.

1.2 Need for a Change in Paradigm: How Schizophrenia Exposes Mainstream Psychiatry

Psychiatry, like psychology, is an unstable science, in permanent crisis, always in tension due to the two souls or cultures that it is made up of, whether as positivist-naturalist sciences or human sciences (holistic-contextual). This tension is particularly evident between the biological (biomedical, neuroscientific) orientation, which

is the mainstream psychiatry and hermeneutic psychiatry (phenomenological, interpersonal, contextual), which in turn, criticizes the mainstream. Critical psychiatry – criticism precisely of neurobiological psychiatry – epitomizes this tension. The same tension that also occurs in psychology between the positivist-natural psychology adhering to the biomedical model (typically second wave cognitive-behavioral therapy, Cougle et al., 2017) and phenomenological contextual, person-centered psychology, also criticizes the biomedical model (Pérez-Álvarez, 2021).

1.2.1 Intellectual Crisis in Psychiatry

The fact is that, in spite of the buoyant neuroscientific research, the main current of psychiatry is going through as much of an intellectual crisis as ever (Fava, 2020; Pérez-Álvarez, 2021, Chap. 10) and faces growing strong criticism by eminent scholars, published in the high-impact journals (van Os & Kohne, 2021). Table 1.1, taken from Jim van Os and Annemarie Kohne, presents some citations of these criticisms.

Schizophrenia and psychosis in general are like the sacred cow and the battle field of neurobiological psychiatry, as supposed brain diseases, charged to future discoveries for over a century. The so-called precision psychiatry criticized by Os and Kohne (Table 1.1) would really be a thing of the future. As their believers say, with more faith than evidence, "Precision psychiatry will eventually provide results because there is no doubt, in our opinion, that mental disorders are brain disorders, and as such, can be traced through biological clues, which may be complex, but are still there, waiting to be discovered" (Salagre & Vieta, 2021, p. 1413). About as much could be said of the Research Domain Criteria Project (RDoC). The litany that disorders are multifactorial and complex, while still true, in the neurobiological context, could mean that nothing of what they are looking for has ever really been found.

Meanwhile, schizophrenia is the abandoned illness of our time (The Schizophrenia Commission, 2012). It seems that the more is known about the brain and genome (neurotransmitters and polymorphisms included), less real flesh and blood people, reduced to a bunch of symptoms that qualify for a diagnosis and the "corresponding" antipsychotic medication, are understood. Ironically, it could be said that nothing is better than not to talk to the patients, except to confirm symptoms, if one wants to anchor schizophrenia as a brain disease. Experiences undoubtedly strange, bizarre, apparent nonsense, that seem to suddenly spring up as hallucinations, delusions, disorganized thought, duly decontextualized from the life of the person who suffers from them, will seem to be symptoms of a damaged brain to clinicians trained on the biomedical model. The consequential antipsychotic medication easily turns into an antipsychotic race, some would say, "against psychotic", insofar as what antipsychotics do is produce sedation, indifference, weakness, and thereby alleviate the symptoms. Thus, antipsychotics would better continue to be called neuroleptics or major tranquilizers.

Table 1.1 Examples of criticisms of psychiatry in high-impact journals

"There is enormous investment in basic neuroscience research and intensive searches for informative biomarkers of treatment response and toxicity. The yield is close to nil. Much of the mental-health-related burden of disease may be induced or prevented by decisions in areas that have nothing to do with the brain. Our societies may need to consider more seriously the potential impact on mental health outcomes when making labor, education, financial and other social/political decisions at the workplace, state, country, and global levels."	Ioannidis (2019)
"Ironically, although these limitations [of "biologic treatments"] are widely recognized by experts in the field, the prevailing message to the public and the rest of medicine remains that the solution to psychological problems involves matching the "right" diagnosis with the "right" medication. Consequently, psychiatric diagnoses and medications proliferate under the banner of scientific medicine, though there is no comprehensive biologic understanding of either the causes or the treatments of psychiatric disorders."	Gardner and Kleinman (2019)
"We suggest that clinical psychiatry's taken-for-granted, everyday beliefs, and practices about psychiatric disease and treatment have narrowed clinical vision, leaving clinicians unable to apprehend fundamental aspects of patients' experiences."	Braslow et al. (2021)
"The main message delivered to lay people, however, is that mental disorders are brain diseases cured by scientifically designed medications. Here we describe how this misleading message is generated. Biomedical observations are often misrepresented in the scientific literature through various forms of data embellishment, publication biases favoring initial and positive studies, improper interpretations, and exaggerated conclusions. These misrepresentations are spread through mass media documents. Exacerbated competition, hyperspecialization, and the need to obtain funding for research projects might drive scientists to misrepresent their findings. These misrepresentations affect the care of patients."	Dumas-Mallet and Gonon (2020)
"Mental disorders are not brain disorders. To the extent that mental disorders arise from the causal interplay between symptoms, as represented in network models, it is highly unlikely that the symptomatology associated with psychopathology can ever be conclusively explained in terms of neurobiology. Therefore, sticking to the idea that mental disorders are brain disorders may be counterproductive and can lead to a myopic research program, because it assumes the implausible position of explanatory reductionism a priori. As we have purported to show in the present paper, this position does not stand up to empirical and theoretical scrutiny."	Borsboom et al. (2019)
"The implicit premise of precision psychiatry is that phenomena of the mind are physically represented and that these representations are relevant to our understanding of mental suffering. This belief is so strong that it does not require explicit reflection, let alone further examination. To belong to the traditional academic psychiatric community is to reiterate the self-evident nature of the belief. To seriously entertain the hypothesis that, for example, schizophrenia may not be a self-evident disorder of the brain is dismissed as 'antipsychiatry'".	van Os and Kohne (2021)

1.2.2 How the Biomedical Model Is Not Up to Schizophrenia

Nobody goes crazy for no reason: without motivation and without method. Perhaps the worst part of the biomedical model is that it closes off exploration of possible reasons or motives for the psychotic crisis and excuses understanding of psychotic experiences ("symptoms") as if they lacked reasons, sense, or method. Recalling

Chesterton's famous saying: "A madman is not someone who has lost his reason, but someone who has lost everything but his reason." "Losing everything" may mean somehow *ontological insecurity* (mentioned by Laing in the *Divided Self*) such as traumatic childhood experiences, adolescent existential crisis, social defeat, or migration, conditions often found among the antecedents of psychosis. Also recalling what Polonius says about Hamlet's mad ideas, "Though this be madness, yet there is method in't." "Method" refers here to sense and function. Hallucinations and delusions make sense in the person's context, and disorganized thought also has its internal logic, far from being random products of a broken brain or something like that. The biomedical model cancels out the person and their circumstances with those of someone who is going mad.

Beyond the biomedical model (symptoms of a malfunctioning brain), schizophrenia assumes a peculiar alteration of the way of being-in-the-world. The lived world of people with schizophrenia is a break with the common conventional world and with themselves (Kusters, 2014). Even when a psychotic crisis does not spring suddenly from nothing, but has its history, probably counting on a certain way of being with its eccentricities and oddness (schizoid or schizotypy type), the truth is that the psychotic crisis is both an interpersonal rupture with others, and intrapersonal with oneself. While, for example, the voices mean strangeness of one's own thoughts or internal language experienced as voices from outside, delusion is an ontological transformation of reality in which everything now seems different, strange, altered, without any of its usual familiarity. No matter how much delusion may be a defensive "arrangement", avoiding, explaining, and protecting from anomalous experiences (such as threatening voices), it is still a "psychotic" arrangement, deranged, illusory, and delusional. Although a psychotic crisis may remain just a passing crisis, it may also lead to a "mystic psychotic path" (Kusters, 2014) and a whole existential crisis of nihilism (Klar & Northoff, 2021).

A person, typically adolescent or young adult, experiences an existential crisis and loses contact with reality, and the world taken for granted is shaken. In such a crisis, evolution is not necessarily heading toward a worsening course (*dementia* praecox as Kraepelin thought, full schizophrenia, chronification), but open to recovery, although not discarding either a certain way of being "vulnerable", eccentric, unconventional, creative, and paranoic-critical in the Dalian sense. A particular way of being "psychotic" (conventionally, "schizoid", eccentric, odd) could already be involved in the crisis itself, although it could still survive it.

In the end, schizophrenia does not stick to the person from outside, nor spring from nothing, as suggested by the expression "person *with* schizophrenia", but somehow, person(ality) may be involved. A "schizoid" style or personality has often been mentioned, perhaps due to experiences, situations, circumstances, models, to which this style would be adaptive. Although its use is understandable by reason of its stigma, the expression, "person with schizophrenia", does not remove a certain quality of being a "schizophrenic person". According to Louis Sass, "we should listen to the person's specifically schizophrenic qualities more closely and as sympathetically as possible. It may be precisely in their schizophrenia that such an

individual – in a certain sense, a schizophrenic person – could embody viewpoints that challenge and profoundly enrich our own points of view" (Sass, 2007, p. 415).

The more colloquial notion of "madness" is also used as an alternative to "schizophrenia", as is "normalized madness" in Lacanian contexts.

It is not a matter of romanticizing schizophrenia at all; after all, it is an alteration of the lived world that involves great suffering, alienation, and incomprehension.

1.3 Possibility of a New Paradigm: Rethinking Schizophrenia in the Context of the Person and the Person's Circumstances

Given the need, the possibility for a new paradigm of schizophrenia beyond the biomedical model that thinks of it as a brain disease also exists. The problem with a new paradigm is that it has to open the way in a terrain colonized by the biomedical model already the default way of thinking, without having to think. When you do not think, the biomedical model thinks for you. That is why we talk about rethinking, because we have to go back and think again – weigh and weight – the preconceptions another way, somehow upstream, against the current.

Human science may even be more appropriate than natural science (often scientism more than really science) for understanding human subjects, including schizophrenia (Pérez-Álvarez, 2021, Chap. 2 and 10). The change in paradigm is beyond the mainstream, but not outside of science, but within a conception of contextual holistic human science.

In particular, the phenomenological tradition offers today a whole new way of conceiving schizophrenia (Sass & Parnas, 2003, 2007). The phenomenological paradigm opens a new field common to psychiatry and psychology (Irarrázaval, 2020; García-Montes & Pérez-Álvarez, 2010).

1.3.1 The Phenomenological Paradigm, Beyond Symptoms

The term phenomenology is common in clinical practice with regard to the description of signs and symptoms by which a nosological category of the type of the DSM (Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association) or ICD (International Statistical Classification of Diseases and Related Health Problems by the World Health Organization) is defined.

However, phenomenology as a psychopathological approach is different. It refers to exploration, description, and conceptualization of the content and structures of the subjective life: the particular lived world, for instance, what it is to be a person with schizophrenia (Stanghellini & Mancini, 2017; Parnas & Zandersen, 2021). Psychopathological phenomenology is not limited to a mere description of the

subjective experience, but attempts to capture and define the core, configuration, structure, or center of gravity on which they gravitate and organize and disorganize the symptoms observed. Beyond the symptoms are individuals with their particular altered lifeworld. The patients do not have bunches of symptoms, but *disturbed* (backwards, confused) ways of being-in-the-world, which the symptoms reveal without themselves being the whole problem. The best help would not be, then, to eliminate the symptoms, but understand their meaning and change the relationship with them when a useless effort is involved, as is usually the case, such as struggling against the voices (Pérez-Álvarez et al., 2008).

Even though phenomenology uses a psychopathological language, it is far from the biomedical model, beginning with the notion of "symptom" sensibly, the meaning of which should be interpreted in the biographical context and circumstances of life. It would not be the first time that the symptoms understood as such open another way of having them without being *had* and dominated by them. By making them understandable in the context of life, the symptoms take on a new sense and enter in another narrative different from the biomedical one. In the end, the biomedical explanation is still a narrative, not *the* narrative, which because of its scientific foundation – which in fact it does not have – cancels out others. However, the biomedical narrative in terms of brain disease is more stigmatizing than any other and probably iatrogenic insofar as the medication it leads to is often worse than the disease. On the contrary, the hermeneutic phenomenological narrative reduces the stigma and opens other possibilities such as empathic comprehension and psychotherapy.

The phenomenological approach is different scientific conception from the natural positivist (statistical, cerebrocentric), based on qualitative methodology (without detriment to mixed methods), beginning with the phenomenologically informed semi-structured interview (Pérez-Álvarez & García-Montes, 2018). It also assumes another clinical procedure other than the nosological (in third person) based on the therapeutic relationship in which the interview (empathetic, understanding, exploratory, hermeneutic) continues to be the clinical method by antonomasia (Pérez-Álvarez, 2021, Chaps. 3 and 13).

For a phenomenological or for a psychodynamic approach (or one based on functional behavior or systemic analysis), the symptoms of schizophrenia are not aberrations, mere manifestations of breakdowns, or neurocognitive dysfunctions. The so-called "positive symptoms" of schizophrenia: Disorganized thinking, hallucinations, and delusions are not merely thinking without feeling, perceptions without object, and erroneous beliefs, as they are often dismissed. It is important to rethink positive symptoms.

1.3.2 Starting Out by Rethinking "Positive Symptoms"

Disorganized thinking still has its own internal organization and associative lines, even though they challenge common sense. Within its idiosyncrasy and strangeness, the thinking of people with schizophrenia can sometimes entail higher, more logical

cognitive or perceptive functioning than the conventional thinking of "normal" people, although not necessarily in the general intelligence tests (Sass & Parnas, 2017). In particular, the way people with schizophrenia reason may be more logical than how "sane" people do, in tasks that require different types of reasoning (Cardella, 2020). The "paranoic-critical method" coined by Dalí enables links to be perceived between objects that are rationally or apparently unconnected. The unconventional attitude may often take precedence over conventionality. As one patient said, "My aversion to common sense is stronger than my instinct for survival" and thus the values of people with schizophrenia, including divergent forms of thought, could be beyond the banalities and common places of daily life (Stanghellini & Ballerini, 2007). Cases could always be put forward where their logic is impossible to grasp, but neither should the rationality of madness be minimized.

Hallucinations, far from being perceptions without object, have an object, more felt and experienced than "perceived" or heard sensorially, consisting of normal "objectivation" of processes and functionally tacit, silent like thought. It is interesting to recall that patients used to refer to "thoughts", and these were often subclinical, until the term "voices" was established and became prominent for clinicians – diagnosis, medication, and research (Katschnig, 2018; Yttri et al., 2020).

However, this may be that the experience of thoughts or voices is lived as inescapable interference: present-there and at the same time external. The truth is also that the experience occurs in an ontological space different from perceptive space. As strange as they may be for the patients and incomprehensible for the clinicians, the voices make sense in the biographical context, are related to real life situations, and often go on to form part of the person's life (McCarthy-Jones, 2012). Thus, the emergence of the voices has to do with real life situations, particularly, when one's position is threatened in matters that have to do with their very existence (Who am I?) and the intentions of others (Who are they?). They are very real experiences (*the real*, a Lacanian would say), which escape our understanding. It is not surprising that these vital questions are expressed in themes related with kinship and authority, sexuality, relations, gender identity, the meaning of life in the light of death and what the other wants, all existential themes (Moernaut et al., 2018).

Neither are delusions "erroneous beliefs" about the "outside world" according to the conceptions in use. Some delusions have the propositional structure of beliefs and are therefore disputable and are empirically tested. Unlike these empirical, epistemological, belief-type delusions, there are the ontological delusions that involve a whole transformation of awareness of the characteristic reality of schizophrenia. It is the distinction already established by Jaspers between primary or true delusions and secondary delusions arising from other factors, such as guilt in melancholia or a paranoid personality. Ontological delusions have an affective, experiential, immediate nature, revealed to the patient and imposed, not derived from reflection or inferential reasoning. The content of delusions in schizophrenia usually has a metaphysical, scatological, or charismatic sense, beyond worldly, empirical, ontic concerns. Thus, they are ontological delusions more than ontic, practical-worldly, empirical, paradoxically lived in a "double reality" with a subjective quality disconnected from the intersubjective world (Sass, 2014).

This double reality refers to the phenomenon described by Bleuler as "double bookkeeping", according to which two disjoint ways of being in the world, one delusional psychotic and the other worldly practical, coexist in patients with schizophrenia as kings, emperors, and popes, carrying out their daily tasks in the hospital without trying to exert their imaginary condition. Phillippe Pinel knew about this phenomenon well a century before when he recognized reasonability in madness which enabled dialogue with fools and moral treatment (Swain, 2009). Double bookkeeping is a paradoxical and enigmatic phenomenon. Patients refer to ontological convictions that seem mysterious to us, but are not problematic for them. They function like a sort of evidence from which we, as observers, are isolated. This aspect, which to clinicians seems enigmatic, is not a symptom like "pressure of thought" or "depressed affect". Rather it expresses a fundamental change in the structure of subjectivity which confers a particular quality to the many symptoms. An experienced clinician might notice an atmosphere (vital, experiential) of something paradoxical and strange in the patient's expression and the way he is. However, to go beyond this atmospheric stage, we need to conceptualize more clearly what is paradoxical and enigmatic about this impression (Parnas et al., 2021; Sass, 2014).

Schizophrenic delusions would not be, then, beliefs about mundane matters. Rather they refer to a different realm that transcends the shared social world. The "evidence" of the delusion does not refer to evidence in the shared world. The delusion is evident in itself, in a vital, experiential manner. The two attitudes or realities (delusional, practical), even in the case of an explicit contradiction, may coexist peacefully one next to the other (Parnas et al., 2021, p. 1516). More than a matter of erroneous beliefs about the world, delusions involve a qualitative change in how reality is experienced, including feelings of derealization and subjectivation combined with the intuition of a different type of transcendent reality (Feyaerts et al., 2021a, p. 243). Table 1.2 summarizes a qualitative study of delusional experience in schizophrenia showing the ontological transformation involved in delusions, beyond beliefs and the abovementioned double bookkeeping (Feyaerts et al., 2021b).

Beyond the symptoms, structural phenomenology finds that the structure or center of gravity of psychotic experiences would be in a certain alteration of the basic-self or minimal-self. The basic-self, minimal-self, or ipseity (from the Latin *ipse* = self or itself) refers to the tacit experience of one-self, implicit, pre-reflexive: the basic sense of existing as a vital subject of the experience and agent of action. It deals with, in any case, a sense of oneself anchored in one's own lived-body and in the implicit temporality (sense of permanence). This fundamental sense of self constitutes an organizing, and disorganizing, principle of experience, thoughts, and action. It is like a sort of infrastructure or "operating system" of tacit or implicit self-awareness of oneself, point of reference of the activity, and directionality toward the world and unthought of *doorway* to first-person experience. As such an "operating system", it functions even better to the extent that it is not noticed, as if it did not exist. Due to its own tacit functionality (implicit, prereflexive), the basic-self or ipseity consists of an experience hard to capture and realize, as intangible and ineffable as fundamental. Its strength is not in its patency. In fact, when it becomes patent, experience of the self and of the world is altered, which is what happens in schizophrenia. If we noted the presence of the eye, vision would be altered.

Table 1.2 Themes of delusional experience (Feyaerts et al., 2021b)

Psychosis as an ontological transformation
"In one single instance, everything was totally different. I found myself in an entirely different world."
The limits of language
"I am simply unable to formulate it. No, really, it's something I cannot formulate."
The detached observer of life
"I think that's the best description. You're on automatic pilot and you're an observer. You're doing all kinds of stuff, but it's like you're not really present, as if you're observing everything from your own perspective. When you're observing, you participate less."
Psychosis as a state of hyperreality
"I had a sort of heightened perception – I saw connections everywhere, connections which I alone saw, for example, on the doors of the psychiatric ward. The semantics of words revealed a hidden meaning."
Mystical unity
"I gained a new form of consciousness, discovered a new world which others couldn't follow."
The self in hyperreality
"I was convinced that others would consider me a figure of Jesus, that I had discovered heaven, and that I had proven the existence of the supernatural."
Double bookkeeping
I lived between two realities. Much of our time we are here on earth taking care of our daily business. But on the other hand, there is this question of the purpose of life, of god and the angles. I just couldn't get a grip on the situation."
Aftermath: The enduring impact and value of delusional experience
"Perhaps it's a dangerous thing to say that other people are more superficial and less profound. But still, there's something more fleeting or cursory in other people. They're more prone to pass over things more easily."
In search for a meaningful therapy
"I must admit I prefer rational thinking and philosophy over following therapy. I would be more inclined to read philosophical rather than psychological literature."

1.3.3 The Ipseity Disturbance Model

In their seminal article of 2003, the American psychologist Louis Sass and the Danish psychiatrist Josef Parnas proposed the ipseity disturbance model for conceptualizing schizophrenia based on a renewed long philosophical and clinical tradition (Sass & Parnas, 2003). The model now has growing research and semi-structured interviews for evaluating anomalous self-experience (EASE: Examination of Anomalous Self-Experience; Nordgaard et al., 2021) and anomalous world experience (EAWE: Examination of Anomalous World Experience; Sass et al., 2017). A phenomenological evaluation referring to these interviews may be found in Pérez-Álvarez and García-Montes (2018). The model is briefly described below.

The ipseity disturbance is described around three mutually interdependent points: hyperreflexivity, diminished sense of self, and hold or grip on the world. Hyperreflexivity refers to a heightened self-awareness (involuntary, nonintellectual) of normally and functionally unnoticed aspects (tacit, prereflexive) that form part of

the infrastructure of the self ("operating system") as if the eye saw itself. Diminished sense of self refers to a decline in experience (passive and automatic), the self-identical subject of experience and action: the sense of belonging, that the experiences I am having are mine, and of the sense of agency as I am the one who performs the action. Diminished sense of self is understood to be a complementary aspect of hyperreflexivity as a compensatory effect. But hyperreflexivity could also be seen as a compensatory effect of the diminished sense of self (Sass & Parnas, 2007).

Loss of hold or grip on the world, on the other hand, refers to disturbance of the spatiotemporal structure of the experiential field, such that *familiar things* are decontextualized and become merely *strange objects.* The model assumes that distortion of the world experience involves previous anomalies of the basic self. However, since the self-and-the-world are mutually constructed (I am I and my circumstances), their disturbance may be conceived as mutual as well, without being able to say which came first. The model could begin with disturbed sense of the world, instead of the self (hyperreflexivity, diminished sense of self), as is usually done. In his day, Eugène Minkowski proposed "loss of *vital* contact with reality" as the "generative disturbance" of schizophrenia (Minkowski, 2001), renewed by Wolfgang Blankenburg as "loss of natural self-evidence" as expressed by a patient (Blankenburg, 2014) and by Giovanni Stanghellini as "common sense psychopathology" (Stanghellini, 2004). Table 1.3 presents the ipseity disturbance model with examples taken from patients.

The theory of ipseity disturbance provides an alternative to the problem of the diversity of symptoms characterizing schizophreni. The variety of aspects involved in schizophrenia, certainly disconcerting, is a problem for the biomedical conception, but not for a phenomenological conception. According to the ipseity theory, the apparent diversity of symptoms (positive, negative, affective withdrawal) would share a self-disturbance that involves the sense of self-identical subject of experience and action. The theory of ipseity disturbance relocates and reconceives schizophrenia in the perspective of self, of the subject, or the person. Thus, the ipseity theory and the phenomenological approach in general offer a new paradigm for understanding and treating schizophrenia. In reality, it is not new, but an old-new paradigm, renewed, from when psychopathology was done. Perhaps new for the new generations of clinicians trained on the biomedical model.

All in all, the phenomenological approach, including the ipseity theory, has its limitations, notably, negligence in the explanation: How is the ipseity disturbance, and in short, the psychotic disorder, generated. The strength of phenomenology is the description of the lived world – the psychotic experience, not so much the explanation of how it arose or where it is heading. According to the phenomenological approach, the psychotic experience (with its double bookkeeping) arises and comes from intersubjectivity in agreement with the self and the world, the person, and their circumstances, mutually constituting each other. In this sense, disorders are situated in the person's context and circumstances, derived from the vicissitudes of life, such as biographic events (Pérez-Álvarez et al., 2016). With respect to how culture and familiar circumstances can cause a person to go mad, the study by Louis Sass of the "Schreber case" (Sass, 1994) is exemplary. However, the explanation is not the strong point of phenomenology (as description is), so its alliance with clearly

Table 1.3 Components of ipseity disturbance model

Ipseity	Ipseity disturbance	Examples
Sense of oneself as existing as a vital and self-identical subject of experience and action.	Disturbance of sense of self: Global crisis of common sense or world taken-for-granted; loss of the natural self-evidence of things.	Elyn Sacks in *The Centre Cannot Hold*: "Consciousness gradually loses its coherence. The center cannot hold. The "me" becomes a haze, and the solid center from which one experiences reality breaks up like a bad radio signal. There is no longer a vantage point from which to look out, take things in, assess. No core holds things together, providing the lens through which we see the world"." (Sacks, 2007, p. 12). "[M]y sense of self is totally crushed when the "bubble" surrounding my self-consciousness is destroyed by this unstable permeability. […] until the entire self-experience disintegrates" (Kean, 2009).
	Hyper-reflexivity: Heightened self-awareness of normally unspoken aspects involving alienation.	One patient realized that he was someone "watching" his own receptivity to music, his own mind receiving or registering musical tones. He periodically experienced his own movements that he reflected upon and de-automated. His thought acquired acoustic qualities. (Sass & Parnas, 2003, p. 438).
	Diminished sense of self: Decline of one as a subject of experience and action.	Elyn Sacks: "Random moments of time follow one another. Sights, sounds, thoughts, and feelings don't go together. No organization principle takes successive moments in time and puts them together in a coherent way from which sense can be made. And it's all taking place in slow motion." (Sacks, 2007, p. 12).
	Loss of grip on the world of contact with the world: Loss of vital contact with reality, of natural self-evidence, or of common sense.	René in his *Diary of a schizophrenic*: "I looked at, for example, a chair or a jug, I no longer thought about its usefulness, about its function: for me it was no longer a jug for holding water or milk, or a chair made to sit down on. No! They had lost their names, their function, their meaning and had become 'things!' (p. 138). "People seemed to me as seen in a dream: I did not distinguish their particular character; they were 'human' and nothing else "(Sechehaye, 1947/2003, p. 156).

dialogic and contextual approaches is appreciated (Galbusera et al., 2021; Galbusera & Kyselo, 2019; Pérez-Álvarez et al., 2016; Seikkula, 2019), which in turn should appreciate a phenomenological "touch."

1.3.4 What About Biology and Medication?

The phenomenological approach does not exclude biology or medication. But neither does it put them in first place like the biomedical model. The biomedical model does not exclude the phenomenological approach either, in principle, but in the practice, it is marginalized as being secondary.

The phenomenological focus includes the biology forming part of the biography as lived-body and organism changed by the vicissitudes of life. The biography and lived-body are another (more pertinent) way of considering the body, not organic – cerebrocentric, mechanist – like the neurobiological approach. After all, genetic and neural mechanisms are not to be found anywhere, no matter how hard they are searched for. The more that is known about the genome and the brain, the more impoverished is the understanding of schizophrenia. In the end, schizophrenia is not a brain disease (*dementia praecox*) like Parkinson's or Alzheimer's. If it is still psychiatric, it is because of what it has of psyche. The abysm (vital, epistemological, and ontological) between the molecular levels (genetic, neurochemical, neural), and for example, "receive a mandate from God for a better way of life", will be acknowledged.

Medication is recognized as not properly a treatment correcting the supposed neurochemical imbalances causing the symptoms. Nor are they explained by chemistry, nor was antipsychotic medication developed based on knowledge of the cause of what is being treated.

This does not mean that medication is not useful as a *resource* in the context of psychotherapeutic and community benefits (alternatives to medication) such as Open Dialogue, Soteria Houses, and medication-free hospitalization by preference of patients (Pérez-Álvarez, 2021, Chap. 10; Standal et al., 2021; Stupak & Dobroczyński, 2021). What happens is that the way assistance services are "set up", medication becomes inevitable, not only because that is how it is established, but because, and for the same reason, there is no alternative, such as Open Dialogue for crisis help, psychotherapy, family, and community support, and not discarding medication as a resource for continued help. However, medication as the (last) resource that it should be is placed from the beginning as a first-line treatment, and that often begins a race toward chronification.

1.4 Implications of the Contextual Phenomenological "Turn"

Phenomenology restores lost psychopathological knowledge. Thus, psychopathology is reestablished beyond symptoms, and schizophrenia is relocated in the context of the person and their circumstances. This contextual phenomenological "turn" has five implications that should be highlighted here.

1.4.1 Qualitative Differences Between Psychotic Spectrum Disorders

Within sharing symptoms and forming part of the same spectrum, psychotic disorders – schizophrenias, melancholia, mania – have their own "centers of gravity" which make them basically different. The differences are revealed in a variety of

Table 1.4 Qualitative differences between psychotic spectrum disorders

	Schizophrenia	Melancholia	Mania
Qualitative differences	Loss of common sense and of conventionality. Need and fear of interpersonal contact. *Ontological* paranoia of centrality. Dissociation of the meaning of "words" converted into perceptive objects. *All* experience seems ineffable.	Conformism, "normopathy", and perfectionism. Hypersyntony with others. Paranoia *contingent* on feelings of guilt or shame. Language *only* seems limited for capturing their sorrow, sadness, or emptiness.	Hypersociability. Need for approval. "Sense of communion" with others. Paranoia *contingent* on feeling envied. Language as a torrent of associations changing from context to context.

ways. Thus, for example, while schizophrenia is characterized by loss of common sense ("natural self-evidence") and conventionality, melancholia is characterized by conformism and "normopathy" (conventionality), and mania by sociability and "sense of communion" with others. Table 1.4 presents some of these differences (Sass & Pienkos, 2013, 2015, 2016).

1.4.2 New Life for Psychotherapy in Psychosis

The biomedical model with medication in the fore does not exclude psychological help, but it does limit it. The phenomenological approach returns dialogue to psychosis and opens it to psychotherapy, without excluding medication as a resource. Medication-free treatment, beginning with personal treatment, listening to the person, not the drug, should be an option. As the psychotic disorder basically consists of disturbance of the experience of selfhood, of the world, and of others, psychotherapy would be the most logical help. To begin with, psychotherapy would be the help most in agreement with the nature of the problem and the person's needs, including listening, understanding, and open dialogue; all of this, in the context of an interpersonal, person-centered relationship, which psychotherapy provides like no other relationship (Fuchs, 2019; Galbusera et al., 2021; Nelson et al., 2021; Pérez-Álvarez, 2021, Chap. 13; Pérez-Álvarez et al., 2011; Škodlar & Henriksen, 2019; Stanghellini & Lysaker, 2007). Chemistry is much discussed, but as one patient said, "the "chemistry" with my psychotherapist was what helped me the most" (Pérez-Álvarez & García-Montes, 2012).

Psychotherapy in psychosis should not have the biomedical stamp of a treatment or intervention in order to repair mechanisms that have supposedly broken down and eliminate or reduce symptoms. More than reducing symptoms, it would be important to change the relationship with them (Pérez-Álvarez et al., 2008, 2011; Stanghellini & Rosfort, 2015). In this respect, a phenomenological approach would