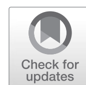
Chapter 11
The Phenomenological Perspective and Metacognitive Psychotherapy in Addressing Psychosis



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11.1 Introduction

Psychotic experiences are part of human diversity and, because they are unique individual experiences, they cannot be understood in isolation from life circumstances or subjective experience (Cooke, 2017; Fonseca-Pedrero, 2019). Similarly, psychosis as a phenomenon of study is intrinsic to disciplines such as clinical psychology and psychiatry and is today one of the most widely studied phenomena in the field of mental health. From the beginning and even nowadays, psychosis—schizophrenia being the most representative—has been conceptualized as an illness that is biological in origin, the product of the expression of certain genes, dysregulation of neurotransmitters, or abnormal functional connectivity in brain regions. Despite the enormous amount of research over the last 50 years, there is yet to be found evidence of these supposed genetic or cerebral causes of psychosis and related disorders and some authors have indicated that we have still not managed to understand its causes or how it functions (Keshavan et al., 2011; Tandon et al., 2008). In this regard, it would perhaps be wiser to think about reasons not causes,

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and at the same time understand psychosis as a response to the vicissitudes of life within the complex variety of human nature (Cooke, 2017; Fonseca-Pedrero, 2019). Psychosis, like any other psychological phenomenon, operates on a personal, phenomenistic, operant, linguistic, and contextual scale (Pérez-Álvarez & García-Montes, 2019).

Psychotherapy has been shown to be effective in addressing psychotic disorders (Leichsenring et al., 2022). Psychological treatments have been found to be beneficial to quality of life and personal development as well as to the reduction of "symptoms" and improved functioning. The treatments which are supported by the greatest amount of evidence and have been the most highly recommended are cognitive behavioural therapy (CBT) for psychosis and family interventions. It is worth mentioning that the NICE clinical guidelines (National Collaborating Centre for Mental Health, 2014) for managing psychosis recommend CBT as one of the main intervention options, even independently of medication. In recent years, new approaches to address psychotic "symptoms" have appeared, or old approaches have been recovered, including open dialogue, metacognitive therapy, and the phenomenological approach. These new and promising methods of intervention are still being analysed and evaluated, although they open the door to new ways of understanding psychosis and intervening in its "symptoms". This means there must be an approach focused on the person, on interpersonal relationships, on understanding experiences in the biographical context, on recovering the sense of *self*, and on giving a person back the scope of their life and thus escaping the trap of schizophrenia, without promising "a bed of roses" (Fonseca-Pedrero, 2019, 2021).

Within this context, this chapter explains the understanding of psychosis from a phenomenological perspective and the implications of that, outlining it in relation to the concept of metacognition. It presents the principles of phenomenologically oriented psychotherapy and introduces the characteristics of Metacognitive Reflection and Insight Therapy (MERIT), a psychotherapy that brings those aspects together. The chapter finishes with a summary and a description of a clinical case.

11.2 First-Person: Patient J.M

I am a 19-year-old male. I was born in a city in the north of Spain and grew up there in a middle-class family. Ever since I can remember, my childhood has been marked by my parents' work in the family restaurant. They expected me and my two siblings to help them in the kitchen and during service. If I had to describe my parents in two words, I would say that they were quiet and hard-working. I don't have any memories of them talking openly with me or my siblings about their feelings or thoughts, nor of me talking with them. I could also say that they are very strict, the kind of people it's better not to annoy. My two siblings are good students and have always been socially popular. They haven't had any physical or psychological problems as far as I know. In contrast, I suffered from ear infections and hearing problems from when I was little, and I had to spend a lot of time in hospital. Because of

that, my school attendance was spotty and I never had close relationships with classmates. Socially, I've always felt unconnected. Despite my long absences from school, my grades were never affected. I can't remember ever being bullied or abused in school, but I was never part of any groups and I felt like a complete outsider. I spent breaks alone in the playground, usually reading. When other kids tried to get me to play with them, I was terrified of making a fool of myself or saying something embarrassing.

I made some friends in secondary school, but I generally preferred to be quiet and to keep apart. In the second year of upper secondary school [Bachillerato], I began to experience what I later learned to be psychotic "symptoms". I was convinced that my classmates and the people at school were talking about me and criticizing how I looked and what I wore. I heard them talking everywhere and even heard them whispering, although I was nowhere near them. I felt as if everyone was looking at me and judging me. Later, I began hearing voices in my head criticizing me all the time. At the time of the final exams, I had to be admitted to hospital by my parents, where they told me that I was suffering from paranoid schizophrenia and they gave me antipsychotic medication. I was discharged after 2 weeks and sent to my local mental health centre. After various visits to my psychiatrist, who adjusted my medication, I was sent to the clinical psychologist.

11.3 The Phenomenological Approach

Psychologists try to understand the experiences of the people who seek their help. This can be particularly difficult with people who are suffering psychotic symptoms, as this usually means dealing with unusual human reactions that are not shared by the majority. Karl Menninger used the metaphor of a fish on a hook to describe the behaviour of people with unusual difficulties, "When a trout rising to a fly gets hooked and finds himself unable to swim about freely, he begins a fight which results in struggles and splashes and sometimes an escape.... In the same way, the human stuggles … with the hooks that catch him. Sometime he masters his difficulties; sometimes they are too much for him. The struggles are all that the world sees, and it usually misunderstands them. It is hard for a free fish to understand what is happening to a hooked one". Some professionals suggest that the way to break this deadlock might be to return, in the words of the founder of phenomenology, Edmund Husserl, "*to the things themselves*" (The Lancet Psychiatry, 2021). The phenomenological approach aims to be able to describe and understand experience, that is, understand the biographical context of the *self* and its circumstances. It is interesting for being able to describe the meaningful organization of people's experiences, expressions, and behaviours, proposing a narrative understanding of each individual. This narrative understanding relates the scenario of action with that of consciousness in order to make sense of people's experiences and behaviours (Stanghellini, 2010; Stanghellini & Lysaker, 2007). It is, therefore, a phenomenology that is interested in the interrelationship between experience, behaviour, and

culture (Pérez-Álvarez et al., 2009). From this perspective, psychopathological syndromes are not mere associations of "symptoms", but rather express characteristic disorders of human existence and the *way-of-being-in-the-world* (Stanghellini & Mancini, 2017).

11.4 Psychosis as a Disorder of the Self or Ipseity

From a phenomenological perspective, and in line with the proposals from Parnas and Sass (2008; Sass & Parnas, 2003), psychosis and associated disorders can be understood as disorders of the experience of the self, or ipseity. Ipseity refers to the basic sense of *selfhood* as the core of one's own experience. This disorder affects the whole structure of the self, including the reflexive self, the narrative self, and the social aspects of the self. While the concept of schizophrenia as a problem of the brain involves a narrative of chronic illness that ends up being interiorized by sufferers and their families, schizophrenia as a problem of ipseity involves a narrative and a change of discourse towards oneself based on the recovery of the sense of self, where one contemplates leaving the condition behind (Davidson, 2003; Pérez-Álvarez et al., 2010; Hasson-Ohayon & Lysaker, 2021).

If we conceptualize the disorders on the psychosis spectrum as problems of ipseity, psychotherapeutic interventions should be aimed at restoring and strengthening the first-person experience and the sense of self, where intersubjective context and understanding are fundamental for a possible recovery. Phenomenology considers possible recovery to involve mutual recognition as people and the creation of shared meaning. The issue is re-establishing the weakened connection between feelings and interpersonal situations in the here and now and in the You and I relationship. This can be achieved through the therapeutic relationship (Stanghellini & Lysaker, 2007). If the therapeutic relationship creates the intersubjective context needed to re-establish ipseity, the hermeneutic relationship contributes to the creation of narratives that help reconstruct the sense of self (Pérez-Álvarez et al., 2010; Hasson-Ohayon & Lysaker, 2021).

With this approach, the patient has much to say and much to contribute. To begin with, the role of the clinician is not so much diagnosis but rather to be a participant who listens and tries to understand and make shared sense of particular experiences. It is not about trying to "indoctrinate" someone in the theory of ipseity, but instead it is about creating a holistic, intersubjective context in which it is possible to work together.

11.5 Ipseity and the Role of Metacognition

As indicated above, people who experience psychotic phenomena can find it difficult to construct an idea of what they have experienced psychologically and socially once those phenomena appear, and therefore may not be sure of how to respond or

to manage them. They may also find that their place in the world and their relationships with others have changed or have become irreconcilable (Davidson, 2003; Firmin et al., 2021). One way of understanding these disorders in ipseity is to think of them as the result of problems in metacognition (Lysaker & Klion, 2017).

Metacognition is a complex set of processes that allow a person to have a sense of who they are in relation to others, what is happening now, what happened in the past, and what will happen in the future. The term means "thinking about thinking", but it also allows people to perceive the relationship between what they think, feel, and desire in order to then use that information to monitor and change their own behaviour adaptively (Dimaggio et al., 2020; Lysaker et al., 2020b; Moritz & Lysaker, 2018). In international samples, research has found that people with diagnoses of disorders on the psychotic spectrum experience a more fragmented sense of self and others compared to control groups and compared to others diagnosed with other mental disorders (Lysaker et al., 2020c). The highest levels of these kinds of metacognitive deficits have also been related to reduced awareness of the difficulties produced by the disorder (Lysaker et al., 2019), worse psychosocial functioning (Arnon-Ribenfeld et al., 2017), particularly in areas related to seeking intrinsically motivating activities, and difficulties in feeling and expressing emotions (Arnon-Ribenfeld et al., 2017; Dmitryeva et al., 2021; Lysaker et al., 2020c).

Metacognitive skills allow us to, for example, recognize the characteristics of others' behaviour and identify our own patterns of thinking or mental frameworks when it comes to understanding autobiographical interpersonal events (Vohs et al., 2015). When metacognitive processes work, they allow us to perform a variety of mental operations simultaneously, automatically, and adaptively. They also provide a flexible, multifaceted, multidimensional sense of oneself and the world in line with the changing needs of the context. This model of metacognition, in short, means a networked psychological process, with interdependent cognitive processes that cannot operate in isolation and which ultimately allow us to face life's psychological and social challenges (Inchausti et al., 2018).

When it comes to psychosis, this model suggests that metacognitive processes play a central role in recovery and that they occur and develop in a clearly intersubjective context. In other words, the beliefs of people with these types of experiences, no matter how elaborate, are formed in interpersonal situations over time, which means that they are representations that can be shared and recognized by others (Cortina & Liotti, 2010; Hasson-Ohayon, 2012; Tomasello et al., 2005).

In addition, metacognitive processes are organized hierarchically. People must be able to perform simple metacognitive tasks first (e.g. recognizing thoughts as their own) before performing more complex, holistic tasks (e.g. recognizing that thoughts and emotions are connected in day to day life). Therefore, if a process does not work properly, none of the higher processes will be able to function as they would need information from the lower level processes (Lysaker et al., 2005; Lysaker & Klion, 2017).

11.5.1 Metacognition in Patient J.M

Returning to the case of J.M, the negative "symptoms" and metacognition were evaluated before and after treatment using the Positive and Negative Syndrome Scale (PANSS) and the Metacognition Assessment Scale-Abbreviated (MAS-A) (see Table 11.1). J.M.'s scores in metacognition indicated that although he had few thoughts, he recognized that they were his and not from an external source, and he was able to differentiate between various cognitive processes such as desires, decisions, and memories. Nonetheless, he was not able to understand that his emotions and beliefs about himself and others could change over time. He also found it difficult to connect his thoughts and emotions both at the present and over time.

With regard to his ability to understand the minds of others, he recognized that other people had their own thoughts, but had difficulties differentiating different cognitive processes in others. He was unable to think about how others felt and seemed not to be able to form complex representations about other people's internal worlds.

In terms of his capacity for decentration, J.M.'s scores indicated that he was able to recognize that other people had lives which were independent of his, but he found it difficult to understand that there were different interpretations and points of view about a given situation. With regard to his mastery skills, J.M. recognized the existence of psychological problems. For example, he expressed his desire to take more initiative in his life. However, he was unable to suggest various alternatives to resolve his problems beyond calling his mother or sister to ask them what to do. This had also caused notable stress in the family, as J.M. was quite able to call his mother up to five times a day just to ask her advice.

11.6 Phenomenologically Oriented Psychotherapy

It is important to begin by recognizing something that may seem obvious, but is a sine qua non of the psychotherapeutic approach to psychosis: the therapeutic relationship. This is not solely the construction of a good therapeutic alliance or establishing a co-operative relationship, it is also about a thorough interpersonal meeting aimed at understanding the altered experience of *being-in-the-world* rather than repairing the supposed malfunction of a mechanistic system (Nelson et al., 2008). Much has been spoken about chemical imbalances, but the important thing in psychotherapy for psychosis is the "chemical aspects" of the therapeutic relationship. Validation, empathy, and curiosity in trying to understand a person's experience and accept it must be the basis underlying the process of working towards recovery (Davidson, 2003). In addition, the efforts of the therapist in constructing a sound therapeutic relationship must not be limited to just the beginning of the process; it should be reviewed and tended to throughout. Empirical evidence has shown the importance of monitoring and reviewing the different psychotherapeutic elements

Table 11.1 Structure of the Metacognition Assessment Scale-Abbreviated (MAS–A)

Level	Self-reflection	Understanding the mind of others	Decentration	Mastery
0	Complete lack of awareness of their own mental activity	Complete lack of awareness of others' mental activity	Thinking that one is the Centre of everything that happens	Lack of awareness of problems
1	Some awareness of their own mental activity	Some awareness of others' mental activity	Recognizing that other people have independent lives	Awareness of problems as insoluble
2	Awareness that thoughts are their own	Awareness that others have their own mental activity	Awareness that there are different ways of understanding a single event	Awareness of problems as something that can be solved but lacking responses
3	Differentiation of their own cognitive operations (thoughts, fantasies, memories, etc.)	Differentiation of others' cognitive operations (thoughts, fantasies, memories, etc.)	Awareness that facts are the result of multiple, complex factors	Passive responses
4	Differentiation of different emotional states	Differentiation of different emotional states in others	–	Help-seeking responses
5	Recognition that their own thoughts are fallible	Plausible supposition about the mental states of other people	–	Responses with specific actions
6	Recognition that desire is not reality	Complete descriptions of others' thinking over time	–	Responses with changes
7	Incorporation of their own thoughts and emotions into a narrative	Complete descriptions of others' thinking over their lives	–	Responses based on their own knowledge
8	Incorporation of various narratives recognizing patterns over time	–	–	Responses based on others' knowledge
9	Recognition of thoughts and emotions connected through their own life	–	–	Responses based on a broad understanding of life

Note. Adapted from Lysaker et al. (2005)

(including the therapeutic alliance), which can be key in achieving treatment objectives (Gimeno Peón, 2020).

Stanghellini and Lysaker identified four principles of phenomenologically oriented psychotherapy (Pérez-Álvarez et al., 2011):

1. *The importance of intersubjective disturbances*

   Intersubjective difficulties are the core of psychotic disorders rather than epiphenomena resulting from supposed neurobiological anomalies, psychodynamic conflicts, or idiosyncratic cognition (Nelson et al., 2008). As we explained above, understanding psychosis as a disorder of ipseity involves a disorder in the intersubjective arena, whether in a person's relationship with their symptoms or the experiences that they have getting on with others around them. In fact, better intersubjective participation in the world is understood to facilitate management of "symptoms" such as delusions and hallucinations. In this regard, the therapeutic relationship can provide a context in which a person's relationship with psychotic experiences can be changed, be it hallucinations (e.g. voices) (Pérez-Álvarez et al., 2008) or delusions (Ritunnano & Bortolotti, 2021), and those experiences can be given meaning and be incorporated into the person's own life story.
2. *Establish a shared interpersonal space*

   Shared interpersonal space refers to establishing mutual recognition as people, something which is necessary for restoring a first-person perspective and therefore the reappropriation of one's own experience. Phenomenologically oriented psychology does not have "internally" directed space, but instead is open in the "external" space between the therapist and the person. As Nelson et al. (2009) showed us, a therapeutic relationship ruled over by an attitude of concern about understanding the other and honest curiosity provides a space in which the patient can develop more robust pre-reflexive self-awareness while at the same time being a meeting in which they feel they are able to share their own emotional states and work to understand and be aware of others' mental and emotional states.
3. *Concentrate on the here and now, on the You and I relationship*

   The intent is to help the person to re-establish the connection with their current context. As Stanghellini and Lysaker put it, "psychotherapy can serve as a 'dialogical prosthesis' to help re-establish the lost connection between bodily feelings (emotions) and interpersonal situations". Although considering emotions as bodily sensations is not universally accepted, one might argue here the importance of corporality and intersubjectivity in phenomenology. The You and I relationship in psychotherapy is understood to mean the sensation of being there, a physical presence for the other which is mutual.
4. *Constructing shared meaning*

   This therapeutic method proposes the co-construction of stories which help to reconstruct a person's self, stories which need both internal and external consistency. While internal consistency is needed for the patient to develop meaningful understanding of their own psychological states, external consistency refers to

the interpersonal aspects that make the narrative meaningful to others. The therapist acts as the arbiter, catalyst, and reference framework in meaningful narratives. It goes without saying that both the construction of dialogical prostheses and the construction of a shared vocabulary require a detailed, descriptive exploration of the structure of the person's experience. This ability gains meaning within the phenomenological framework and requires specific training to apply, as well as practice that is supervised by the therapist. Phenomenological psychotherapy is not simply listening to the patient and understanding them with sympathy and empathy, but rather, and above all, capturing essential experiences and offering personally meaningful interpretation. Stanghellini and Lysaker (2007) show that this intersubjective method can help those with schizophrenia to develop both a first-person perspective for themselves and a second-person perspective when they are with others, opening up a path to recovery.

Various psychotherapies have been developed for psychosis over recent years based on these principles (Hasson-Ohayon et al., 2021). Their therapeutic objectives have mainly focused on improving interpersonal functioning (Inchausti et al., 2018) and reducing psychotic "symptoms" (Salvatore et al., 2018; Vitzthum et al., 2014). Given the close relationship between phenomenology and metacognition in psychosis, in the following section we present Metacognitive Reflection and Insight Therapy, or MERIT, developed over the last 10 years by Paul H. Lysaker and colleagues (Lysaker et al., 2020a; Lysaker & Klion, 2017).

11.7 Starting Situation in Patient J.M

At the time of the first consultation, J.M. had been living independently in a shared flat for almost a year. With psychosocial support, he was able to successfully complete his Bachillerato exams and the university entrance tests and was able to start studying at university. At the weekends, he helped his parents in the family restaurant which allowed him to cover some of his living costs. His psychiatrist had stabilized his medication on low doses of Aripiprazol (10 mg/day). Nonetheless, the critical voices persisted, but with notably reduced impact, and his self-referential delusions disappeared completely. The same did not happen with the negative "symptoms", which progressively increased. Over time, there were increasingly noticeable signs and "symptoms" of alogia (sharp reduction in spontaneous language and content, frequent speaking blocks, and increased latency in responses), abulia (notable difficulties in making decisions, even simple day-to-day decisions, university attendance, and relating to others), and feelings of emptiness. Consequently, J.M. spent most of his time sitting in his room doing absolutely nothing. Despite wanting to interact with people, J.M. found himself almost completely isolated, except for the scant contact with his flat mates and his family. When he conversed with them, he had serious difficulties starting or maintaining conversations, he did not know what to say or ask and usually ended conversations quickly.

11.8 Metacognitive Reflection and Insight Therapy: MERIT

MERIT is an inclusive psychotherapy that combines the findings from the field of metacognition with the emerging psychotherapeutic models for recovery from psychosis. It's main objective is to help people with psychotic disorders to recover through stimulating metacognition. There are two core aspects of MERIT: (1) in order to encourage recovery it is essential to train those processes which allow people to develop a broad, flexible sense of self and of their world, in other words, metacognition; (2) people are able to improve their metacognition via a therapeutic relationship.

This therapy was created and developed in concert by clinicians from various countries with broad experience in long-term psychotherapy with people diagnosed with severe mental disorders. From that cooperation, MERIT has an inclusive concept of psychotherapy, which is why it sets out general principles to encourage change in people regardless of the preferred psychotherapeutic approach of the potential therapist. These principles aim to create an ideal relational context which encourages the development of metacognition rather than establishing a rigid set of psychotherapeutic techniques and activities. MERIT does not consider metacognition to be a discrete phenomenon which one can do or not, but rather an ordered continuum of psychological processes that a person can develop with time and practice.

As noted above, another central feature of MERIT is that people are able to improve their metacognitive skills in the context of a therapeutic relationship. Within the inclusive framework of metacognition, MERIT accepts that, as people can do more complex metacognitive tasks, they develop a better sense of themselves and the world, which encourages them to seek recovery.

MERIT sessions are governed by eight general principles which facilitate the promotion of metacognitive skills which have been damaged, weakened, or undeveloped. Each principle describes a quantifiable mental process that can occur regardless of the issue that the person brings to the session. All of the principles are conceptually and synergistically interrelated, but can be addressed and evaluated independently (Lysaker & Klion, 2017). The eight principles can be split into three subtypes (see Table 11.2).

11.8.1 Implications for Psychotherapy

Professionals working with patients with psychosis should follow at least five general principles which are summarized in Table 11.3 and outlined below:

1. *Process-oriented rather than content-oriented.* The clinician has to give up the attitude of being the "knowledge giver". In contrast it is the person, with their own experiences and difficulties, who will share their knowledge about what is happening to them. There should be a focus on how the person understands and

Table 11.2 Principles of Metacognitive Reflection and Insight Therapy (MERIT)

Subtype	Principle
Content	1. Talk about the person's present objectives, desires, and specific needs (or agenda). 2. Talk about the person's reactions to the therapist's thoughts, emotions, and behaviour as a consequence of the agenda (i.e. the transfer that produces counter-transfer). 3. Talk about the person's important life experiences via analysis of specific, minimally abstract autobiographical episodes during the session. 4. Talk about the psychological challenges arising from the three types of intersubjective content above.
Process	5. Reflect on and discuss the therapeutic relationship, as the context in which the person reflects about themself and others. 6. Reflect on and discuss the psychotherapeutic progress, both in terms of notable psychological results (e.g. improved self-esteem) and physical results (e.g. weight loss).
Super-ordinate	7. Think about themselves, others, and the world, in line with their current metacognitive abilities. 8. Examine skills of mastery (or problem solving) in line with their current metacognitive abilities.

Table 11.3 General principles for the clinical approach to psychosis

The clinician should be oriented towards…	The process (rather than the content). The objectives (rather than the problems). Recovery as an intersubjective phenomenon. Recovery as a changing phenomenon. Metacognition.

thinks about their psychopathological (their "symptoms") and psychosocial challenges (interpersonal, workplace, academic, occupational conflicts, etc.), which will involve access to complex, and occasionally painful biographical material.

2. *Objective-oriented rather than problem-oriented.* It is not just a person's difficulties that must be addressed, but also what they seek and what they want beyond the present "symptoms" and problems (the agenda of the person being treated). Ignoring an individual's objectives will make it harder to develop shared meaning of the recovery process. This does not mean unconditional support for the patient's agenda, but rather the construction of a dialogue that allows better understanding of the challenges underlying a potentially problematic treatment agenda.
3. *Oriented towards recovery as an intersubjective phenomenon.* The therapeutic relationship is the essential vehicle for encouraging and developing an ever richer, more flexible reflective dialogue.
4. *Orientation towards recovery as a changing phenomenon.* The treatment agenda can (and should) develop over the course of the recovery process. It should be accepted that treatment objectives can change unexpectedly.

5. *Orientation towards metacognition.* Any psychological intervention must adapt to the patient's capacity for reflection at any given moment and should systematically encourage the growth of metacognition, i.e. the skills of self-reflection, awareness of the minds of others (theory of mind), decentration (cognitive and emotional), and problem-solving.

11.9 Intervention with MERIT in Patient J.M

In this section we describe the psychotherapeutic intervention with J.M. and its results. The intervention was performed in a public mental health centre (CSM) by a clinical psychologist with extensive experience of psychotherapy with severe cases of psychosis and a resident psychologist intern (PIR) acting as co-therapist. The treatment followed the eight MERIT principles described in this chapter, as well as the general provisions of evidence-based practice and deliberate practice (Prado-Abril et al., 2017).

11.9.1 Principle 1. Talk About the Person's Objectives, Desires and Specific Needs (or Agenda) in the Present

When the clinical psychologist asked J.M. what he wanted to talk about in the first session, he responded with just "*I don't know*". It was as though he wanted to hand over all responsibility for what was to happen in the session to the therapist. In addition, he was clearly uncomfortable with long pauses in the conversation. The therapist asked him about his objectives in relation to the therapy. J.M. responded that he was only hoping that it would help him "*improve*" and be "*more normal, like everyone else*". He seemed to expect that it would also be the therapist who would tell him what he had to improve in order to be "more normal". With this attitude, J.M. put himself in a submissive role, dependent on the therapist, who he positioned in the role of the "expert". This made the therapist uncomfortable as they had to maintain the conversation and they had to decide what to talk about without asking questions that were too difficult at the same time as avoiding uncomfortable silences.

During the first few sessions, the therapist deliberately avoided being guided by this counter-transfer in order to try and make J.M. feel more at ease with the therapy and only dealt with superficial topics. Once J.M. felt more comfortable, the therapist chose to be explicit about their strategy in order to stimulate reflection, and in the next session asked:

T *What would you like to talk about today?*
JM *I don't know.*
T *You don't know what to talk about because you want me to decide.*

J.M. nodded silently and the therapist remained quiet. This seemed to make J.M. uncomfortable. The therapist continued reflecting on that:

T *Your mind is blank, you don't know what to talk about, but today I don't either, and you feel uncomfortable.*

JM (shyly) *Yes…(pause) I don't know what the proper things are to talk about. What do you think we could talk about?*

T *I don't know what the right topics are either, I don't know you very well… and I can't decide what's important to you. So I would really like it if you could decide yourself what you wanted to talk about today. I don't mind what we talk about, I'm sure any topic would be fine. I don't mind sitting in silence for a little bit while you think about what you'd like to talk about. Silence doesn't bother me in the slightest.*

This seemed to calm J.M. down, and after a few moments' silence, he was able to verbalize his fears of bringing up "stupid" topics and his fear that the therapist might criticize him. This led to a conversation about J.M.'s first objective or agenda: avoid being criticized by the therapist. Following this insight, the therapist decided to start all of the sessions the same way: "*What would you like to talk about today?*". This question continued to trigger J.M.'s fears of criticism in various sessions, but progressively he was able to reflect on his agenda: "*not doing anything wrong in the session and not being criticized by my therapist*". After 15 sessions, J.M. began to feel more relaxed and open, and by session 25, he was used to deciding the topics of conversation. From then on, when the therapist asked the question, J.M. would smile and say "*I knew you were going to ask me that!*", before beginning to verbalize what was on his mind that day, allowing himself and the therapist to be aware of his desires and intentions.

11.9.2 Principle 2. Talk About the Person's Reaction to the Therapist's Thoughts, Feelings, and Behaviour

The second principle of MERIT requires the therapist to share their thoughts about the person's behaviours and mental activities without invalidating their agenda. The objective is to help the patient develop better awareness of the mental states of the therapist. In the beginning in this case, the therapist avoided introducing their thoughts to make sure that there was enough space for the patient's mental state and agenda to appear. As noted above, J.M. began to share his internal state once he felt safe and free from possible criticism. This process allowed him to recognize what the therapist thought and it influenced how he spoke about himself. For example, in one session, he was able to verbalize how difficult he found it to occupy or entertain himself when he had no specific activity planned for the day.

JM *So, I feel like I have all this time in front of me and I don't know what to do… I don't know where to start… But I shouldn't moan, right? I should just get up and do something. Yes, that's what I should do…*

T *Do you think that's what I'm thinking now? That you shouldn't moan and you should get up and do something in this situation?*

JM *Yes, I complain too much but I don't do anything.*
T *In fact, I'm not thinking that at all. I'm thinking that it must be very hard for you to be in this situation, not knowing where to begin and feeling so lost.*

This triggered an interaction in which J.M. identified that he had, in fact, been using a phrase of his mother's ("*stop moaning and start doing something*") to second guess the therapists thinking. Again, this *insight* allowed him to question his hypothesis about the therapist's thoughts. After this *insight* was repeated various times over the sessions, J.M. finally became aware of his tendency to ascribe criticism and hostility not only to the therapist's thoughts, but also to the thoughts of others. From there, J.M. began to question his suppositions about the internal states of others rather than assuming them to be true unilaterally and was able to understand that a single situation can be read in many ways.

11.9.3 Principle 3. Talk About the Person's Important Life Experiences Through Analysis in the Session of Autobiographical Episodes

The third principle means that the therapist must work with detailed narrative episodes of the person's autobiographical events. The analysis of these events will ensure that the resulting narratives are connected to each other and not too abstract. This will help the patient to relate their thoughts and feelings over time.

Once J.M. identified his initial agenda, he was able to remember various episodes that were related to it. In one session, for example, he said that that week, he had felt like an outsider at a family party. The therapist and patient then reflected on the chain of events: how they began and unfolded, who knew, what they thought, and what they felt at the time. J.M. was able to explore how he had experienced that situation and was more aware of his thoughts and feelings at the party. With the therapist's help, he was also able to connect different events and situations over time and see how his thoughts and feelings were related in previous, similar social situations. In the final session, J.M. was able to integrate various previous narrative episodes in a detailed life history; this narrative included how his hearing problems in infancy had prevented him from attending school regularly and how this caused specific situations in which other children forgot about him or ignored him. These events led him to believe that he was boring and he began to reject social relationships. In high school, he continued being shy, withdrawn, and worried about not being accepted socially.

Similarly, he was able to talk about situations in which his siblings, who were very good at making friends, had made him feel socially inferior. This reinforced his belief that he was boring and that other people were not interested in him. These beliefs were evident when he began to hear critical voices in his head. This led him to withdraw even more and avoid social situations. He was convinced that he could not maintain friendships as he had never experienced that in his life. At the end of the therapy, he was able to understand that he had automatically accepted these

beliefs without taking into account the important role of his hearing problems, school absence in childhood, the psychotic episode, and negative thoughts about himself when it came to making and keeping friends. In addition, he understood that his belief that other people did not want to be with him had led him to be isolated, which in turn made it more likely that others would not want to spend time with him. During the therapy, various strategies were discussed aimed at modifying this dysfunctional interpersonal pattern.

11.9.4 Principle 4. Talk About Psychological Challenges that Arise from the Three Previous Types of Content

Talking about challenges with J.M. happened naturally once he had clarified his agenda and had discussed various narrative episodes. At the beginning of the therapy, J.M. was already able to identify and express psychological problems, which made the therapist's job much easier.

In the fourth session, for example, after analysing an episode in which he had been alone in his room without doing anything, J.M. said, "*I wish I was able to entertain myself… I didn't know what to do…*". This led him to identify the psychological problem of feeling incapable of starting something, which he associated with thoughts of incompetence.

In general, patient and therapist must take enough time to identify the core psychological problems underlying the narrative episodes. In J.M.'s case, the idea that he was boring or his difficulties connecting with others were psychological problems that were repeated throughout the sessions. As he advanced with the therapy, J.M. was able to recognize these issues both in his agenda and in his narrative episodes, which allowed him to use this awareness to assess possible alternatives for dealing with his problems (Principle 8).

11.9.5 Principle 5. Reflection and Discussion About the Therapeutic Relationship

As mentioned above, working on the therapeutic relationship is fundamental, as it is the context in which the patient thinks about themselves and others in order to help improve their understanding of their maladaptive interpersonal patterns. As discussed in the first principle, J.M. usually put the therapist in the position of "expert" and himself in submission. The therapist had to deal with this pattern on various occasions over time, as well as manage their counter-transferal impulses to "rescue" him or solve his problems by telling him what to do or what to talk about. This pattern was addressed on various occasions by open, continued reflection about the therapeutic relationship. As a result of these reflections, J.M. became aware of his tendency to put himself in an inferior position, both with the therapist and with others, particularly his parents.

11.9.6 Principle 6. Reflection About the Psychotherapeutic Progress

So that the patient reflects on the progress of the session and the therapy, MERIT encourages the therapist to examine how the patient experienced the session. To that end, the therapist asked J.M. how they felt about the session at the end of each one. This was quite difficult for J.M. because of the intense fear he felt about being rejected by the therapist if he said anything critical. Consequently, when the therapist asked this question, J.M. would respond by saying that everything had been good and that he was satisfied, without truly reflecting on how the session had gone. The therapist had to address this fear directly and naturally, assuring him on various occasions that they would not be at all irritated or annoyed if J.M. said that anything had not been good. They also reiterated that the ultimate aim of this question was to improve the sessions, which is why it was important for J.M. to give honest answers rather than responding automatically. After 20 sessions, J.M. was able to cautiously begin expressing disagreement with some specific parts of the session. For example, on one occasion, the therapist made an incorrect consideration about J.M.'s thoughts. This caused an interruption in the conversation and made J.M. close off. When the therapist asked at the end of the session how it had been for J.M., he was able to reluctantly express the idea that he had felt he had not been understood and had felt disappointed with the therapist at that moment. The therapist reinforced J.M.'s honest *feedback* and apologized for what had happened. They also told J.M. that they tried as far as possible to understand J.M.'s perspective, but occasionally they were unable to do so and reiterated their intention to avoid any similar occurrence in the future. This reaction from the therapist was a very important corrective emotional experience that encouraged J.M. to more easily express his criticism and improved the clarity of the communication. This event also helped, in subsequent sessions, when dealing with difficulties of communication with other significant people.

11.9.7 Principle 7. Think About Oneself, Others, and The World

This principle means that the therapist stimulates skills of self-reflection and *insight* into the minds of others in line with, or slightly above, the current level of the person's metacognitive ability. The ultimate aim is for the patient to construct ever more developed, flexible thoughts about themselves and others. At the beginning of the therapy, J.M. was able to recognize his own thoughts but not his feelings. At times he reported feeling "uncomfortable" or that he "didn't feel right". The therapist had to encourage J.M. to dig into and label his emotions in the session and in his narrative episodes: "*You feel very sad. What do you feel exactly? Was it sadness or anger? Or both?*" or "*You seem to feel embarrassed because you don't have many thoughts today*". J.M. began to identify his emotions more often and was

progressively deploying clearer, more detailed ideas about his feelings. The therapist also stimulated J.M. so that he understood that his thoughts changed over time and that his desires and intentions did not always become reality. At the end of the therapy, the therapist offered J.M. their thoughts about stimulating the connection between different thoughts and feelings in the present and over time. Over 40 sessions, J.M. made significant progress, which was not linear. This pattern of peaks and troughs (improvement, worsening, improvement) is common in metacognitive therapies with people with psychosis. Because of that, the therapist must be cautious about adapting their interventions to the patient's current level, as well as about identifying and managing their possible frustration in those troughs so that patients do not feel devalued or not understood. In J.M.'s case, when these setbacks were seen in the MAS-A, the therapist was able to identify and manage their counter-transferential responses to adjust their interventions to J.M.'s level.

In terms of awareness of the minds of others, at the beginning of the therapy, J.M. was able to identify that other people had independent thoughts, but was unable to distinguish between different cognitive operations. Owing to J.M.'s fear of being rejected by others, the therapist avoided reflecting on the minds of others in order to gain better awareness of J.M.'s internal states. It was only after various sessions that the therapist began to ask questions about what J.M. thought that they were thinking and even occasionally what others were thinking, expecting, or wanting in the narratives. As a result of these reflections, J.M. became more aware of his tendency to anticipate criticism of himself in the thoughts of others (principles 2 and 3). Nonetheless, at the end of the therapy, J.M. was still unable to produce clear pictures of other people's thoughts.

11.9.8 Principle 8. Reflection and Stimulation of Mastery Skills (Problem-Solving)

The final principle of MERIT aims for the therapist to stimulate the person's ability to use intersubjective information in the resolution of psychological problems. At the beginning of the therapy, J.M. was aware of the existence of problems, but the way he dealt with them was basically calling his mother or sister for advice. When J.M. understood that his thoughts could change over time and that there were multiple ways of interpreting the same situation, he made real advances in his abilities to solve his problems. The therapist tried to stimulate these skills with questions such as "*Is there another way of looking at this problem?*", "*What can you say to yourself in order to feel a little better?*", and "*How can you manage to maintain a positive view of this problem?*". For example, J.M. was able to realize that his view of himself as boring or uninteresting was interfering in his participation in social situations. This reflection helped him to think more flexibly about himself. On his own initiative, he made a list of topics of conversation that interested him and tried to update it every day. This helped him to initiate conversations and be more involved

in social situations. However, the belief that he was boring kept reappearing, although he was able to begin questioning it and even occasionally adopt different points of view about himself. Similarly, he began to recognize how his belief that silence in a conversation meant the he was boring crippled him in conversations. To combat that, he convinced himself that he was not the only one responsible for conversations, and that occasionally silences happen naturally. This helped reduce the pressure he felt and helped him to relax and converse more naturally without freezing up.

11.9.9 Results

As we have been able to see, a central aspect of J.M.'s case was a sense of confusion and otherness about himself and others. This is closely related to the concept of ipseity that we examined at the beginning of the chapter. J.M.'s early experiences significantly affected how he constructed his perceptions of himself and others, and his ability to be involved in the world. During the treatment, these representations were clear, for example, the critical voices or the patterns and beliefs about himself as boring or uninteresting to others. Problems with metacognitive skills made it harder for J.M. to think about this way of understanding both his own experiences and mental processes and those related to the interpersonal arena, giving rise to complications in his everyday life. The work based on MERIT, with the importance placed on the therapeutic relationship, allowed J.M. to improve his metacognitive abilities, making him more aware of his thoughts and emotions, and thus allowing him to begin reconstructing his sense of *self*.

After finishing 40 sessions, two independent evaluators graded J.M. using the PANSS and MAS-A scales. This confirmed that his metacognition improved in the self-reflection, decentration, and mastery subscales. Similarly, his negative "symptoms" diminished generally, as indicated by the PANSS scores and the information from J.M. in the first person.

One important aspect of the therapy was that there was no increase in medication at any time, or hospitalization due to crises. In addition, J.M. did not need any additional treatment outside of the CSM (with psychiatrist, clinical psychologist, PIR, social worker, and specialist mental health nurse).

11.10 Current Scientific Evidence in MERIT

Although the data available so far are limited, it does point towards MERIT's viability, acceptability, and effectiveness for improving metacognition in people with severe mental disorders who are receiving treatment in natural clinical settings (Bargenquast & Schweitzer, 2014; de Jong et al., 2016; Vohs et al., 2018). A recent randomized clinical trial with 70 people diagnosed with schizophrenia replicated

the positive results of MERIT for improving metacognition, and specifically self-reflection skills (de Jong et al., 2019). MERIT's impact on people themselves has also been examined. In a quantitative study, Lysaker et al. (2015) examined the effects on people receiving at least 1 year of therapy with MERIT or other support psychotherapy. The results indicate that MERIT, unlike support therapy, produced significant improvements in both a sense of agency and the capacity to tolerate and manage levels of distress that had previously been perceived as incapacitating.

In terms of effects at a personal level and the level of individual needs, MERIT has been found to be associated with a significant increase in the number of notable goals people set, both in early phases of severe mental disorders and subsequently (Arnon-Ribenfeld et al., 2018; Hamm & Firmin, 2016; Hasson-Ohayon et al., 2017; Hillis et al., 2015; Leonhardt et al., 2016, 2018; van Donkersgoed et al., 2016). Looking at people without awareness of the disorder, Vohs et al. (2018) randomly assigned adults with their first psychotic episode and poor insight to MERIT or to conventional treatment for 6 months. At the end of the trial, 80% of the participants who received MERIT completed their therapy and there were statistically significant improvements in objective measures of awareness of the disorder without that causing increased hopelessness or distress.

MERIT therapy is an example of operationalization and integration of phenomenological aspects and metacognitive work, which was illustrated by the clinical case of J.M.

11.11 Summary

This chapter sets out a view of human beings that cannot be broken down into a collection of organs and tissue, but is instead part of an external world which makes them a person. The approach proposed here does not confuse the organ with the organism and is a long way from the concept of psychosis as a merely physical phenomenon which fails to understand that a paranoid thought or a hallucination has meaning or sense. In contrast to the inertia that biomedical models bring to the understanding of the phenomenon of psychosis, the proposal here is of reflection and approaching its nature and necessary relocation. The traditionally predominant idea has been of psychosis as a "chronic mental disorder originating in the brain". However, in recent years there has been a gradual change in how psychosis is thought of and growing interest in the process of personal recovery. This process goes far beyond achieving the absence of clinical "symptoms" and is more focused on the person developing various skills that allow them to give meaning to what is happening to them and to find new meaning in their lives (Fonseca-Pedrero, 2019). To that end, there needs to be a change in the model; we need to move on from possible reductionist explanations and try to understand the process of psychosis within the individual's context and life story (Pérez-Álvarez et al., 2016).

Inevitably, this requires a change of mentality, and the attempt to understand people's experiences and ways of "being in the world" in order to decide what

elements will make up part of the therapeutic work. Many authors suggest that this first-person emphasis is only possible if we re-engage with phenomenological perspectives. From phenomenology, understanding psychosis as a problem of the *self and* gives us the chance to understand it within the framework of people's relationship with their own mental and emotional states, and also in the external space of the interpersonal arena. In a complementary manner, metacognitive skills include all of the competencies needed to perform these processes and can be trained to help understand the nature of the lived experience and to give it meaning.

Considering psychotherapy from a phenomenological perspective for psychosis means understanding that all of the work aimed at restoring the *self* lies in the work "in" and "with" the therapeutic alliance. The shared space between therapist and patient is the ideal setting in which reflection can be encouraged about ourselves and others.

Ethical Statement This study was conducted in accordance with the Declaration of Helsinki. We obtained the patient's informed consent before publication. The patient grants his permission for his information to be published in this case report.

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