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Description of Psychotherapy and phenomenology psychotherapy for Schizophrenic Patients, Review Article

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Abstract: The goal of psychotherapy in a therapeutic of the schizophrenia patients has developed to minimize the forced isolation of people with the disorder and the authors are presented in the history of psychotherapy and what the steps followed after the success of psychotherapy. The types and symptoms of this disorder and what causes it are shown in this chapter. There are five different types of integrative psychotherapy for individuals with schizophrenia that are introduced, and the common conceptually structure is proposed that enables these five (5) approaches are to be consistent with each other. Personal narrative, interpersonal attachment, and metacognitive processes are all emphasized in the conceptual framework, which is congruent with recovery theories. Study in phenomenological-psychopathology has produced a huge array of observations over the past decades, which are invaluable for comprehension an experiential-environments of schizophrenia-patients. Although, we mentioned the fundamentals of Psychotherapy based on phenomenology for schizophrenia, dividing them into a following sub-groups: (1) overall objectives (2) attitudes in general.

Keywords: Schizophrenia, Psychotherapy, Phenomenology, Behaviors.

1. INTRODUCTION

Psychotherapy for schizophrenia patients entails meetings with a mental health professional such as a psychiatrist, psychiatric social worker, psychologist, or nurse on a regular basis. The patient talks about his/her problems with the therapist and also during the session the therapist will know the experiences, thoughts, feelings, or relationships of the patient. For the success of the therapy process, the sessions must be regular. When the patient discusses these problems with a specially trained person, this will lead to understanding the schizophrenic patients more concerning themselves and their issues. They also become able to distinguish real from fake events. A recovery statement released recently not only challenged a prognosis of schizophrenia but also demonstrated how recovery entails gaining both objective and subjective evidence of wellness. This has prompted numerous requests for a restructuring of the types of services that should be provided to schizophrenia patients, reigniting debate over psychotherapy's potential role, as well as its objectives and nature as they relate to schizophrenia.

In order to address this problem, in this chapter we'll go over the history of schizophrenia psychotherapy. and following a brief review of the types of psychosocial therapy, and then the symptoms and causes of the disorder are described to show a whole knowledge about schizophrenia. After comparing and contrasting five different newly established integrative techniques, we'll look at the theoretical underpinnings that link them, and this discussion will need a future research plan motivated by the possibility of these treatments.
Finally, we describe the phenomenological Psychotherapy for Schizophrenia; the research in phenomenological psychopathology during the last decades has been flourishing, resulting in a vast and comprehensive set of discoveries that, in our opinion, are essential for comprehending the lives of schizophrenia patients. This clinical-research allows us to gain a better understanding of what it's like to view oneself, others, and the world through the eyes of a schizophrenia patient.

1.1 Types of the Psychosocial Therapy

If a person with schizophrenia during treatment sessions shows improvement, they will likely need more assistant about how to become part of a community. This is where psychosocial treatment can help [1].

1.1.1 Training in social skills. The purpose of this type of program is to enhance social relationships and communication.

1.1.2 Rehabilitation. Schizophrenia frequently begins during the years when jobs are developing, thus rehabilitation may include work counseling, problem-solving assistance, and financial management assistance.

1.1.3 Family education. If you have enough knowledge about schizophrenia and how to use psychosis to deal with it, this will assist a friend or family member who has a patient with this disorder. According to researches, people with schizophrenia who have a strong support system perform better than those who do not have friends and family to encourage them.

1.1.4 Self-help groups. This point is important to improve the social skills through the participation of schizophrenia patients in outreach programs and community care by encouraging them by loved friends or family.

1.1.5 Coordinated specialty care (CSC). This is for folks who are having their first psychotic episode. It's a multidisciplinary strategy that mixes medication and psychotherapy. It encompasses social and employment services, and it makes every effort to include the family. The goal is to eliminate the disease's prognosis by treating it in its early phases. Patients with schizophrenia who receive early and intense treatment had the best long-term outcomes, according to research.

1.2 Symptoms of Schizophrenia

Symptoms of this condition are classified into three (3) groups: positive, negative, and cognitive symptoms, according to the National Institute of Mental Health [2].

1.2.1 Positive Symptoms

These types of symptoms are psychotic behaviors and these forms of symptoms do not normally occur in healthy individuals. People with these types of symptoms can "lose touch" with certain aspects of reality. These symptoms, for some people, come and go. Others remain stable. They might be serious and barely noticeable to others. Whether a person is getting therapy may influence the severity of positive symptoms. The following are examples of positive symptoms:

1.2.1.1 Hallucinations*:* These are sensory experiences that occur when there is no stimulus present. These can occur in any one of the five senses (hearing, vision, taste, smell, or touch). "Voices (auditory hallucinations) in schizophrenia are the most-common form of hallucination; many individuals with the condition hear sounds. A voice can either be an internal, or they can be external, appearing to come from inside one's head, in which case they can seem to be as real as any person who speaks. The voices may speak to the individual about his or her actions, offer advice, or warn the individual about danger. Sometimes a voice speaks to each other, and sometimes the voices they hear are articulated by persons with schizophrenia. Voices can be heard by people with schizophrenia for a long time before relatives and friends notice. Seeing or smelling individuals or objects that aren't there, smelling aromas that no one else notices, and feeling things like fingertips stroking their body when no one is there.

1.2.1.2 Delusions False values that are not compatible with the culture of the individual are firmly held. Particularly if there is proof that a convictions are not real or rational, illusions remain. People with schizophrenia may have odd delusions, such as believing that magnetic waves may affect their neighbors' actions. They may also assume that individuals direct special-messages to them on television, or that radio-stations relay their views to others aloud. These are called' comparison delusions.'

1.2.1.3 Thought disorders There are unusual or unorthodox ways of thinking. Disorganized thinking is a style of thinking in which a person has trouble arranging or rationally linking his or her thoughts. She or he will speak in the garbled way that is difficult to understand. This is sometimes called-the "word salad." Another type is called "thought blocking." This is when, in the middle of a thought, a person begins speaking suddenly. The person may say that when asked why he or she stopped talking, it seemed as though the thought had been taken out of his or her mind. Finally, a person with a thinking illness may invent meaningless words or "neologisms."

1.2.1.4 Movement disorders*:* they can appear as agitated motions of the body. Some movements can be replicated over and over by a person with a movement disorder. An individual can become catatonic at the other extreme. Catatonia is a state in which a person does not move or react to others. The-catatonia is uncommon today, but when the treatment for schizophrenia was not available, it was more common.

1.2.2 Negative Symptoms

Disruptions of natural emotions and actions are associated with negative symptoms. As part of the disorder, these signs are hard to identify and maybe confused for depression or other conditions. They contain the following symptoms: Flat effect (these individuals do not have an expression of feelings by facial expression or voice tone), they do not have daily life feelings of enjoyment or gratitude, trouble starting and maintaining tasks, and finally reduced vocabulary. For daily activities, people with depressive symptoms may need assistance. They may be neglecting fundamental personal hygiene. This can make them appear lethargic or unable of self-support, yet the symptoms of schizophrenia are the issues.

1.2.3 Cognitive Symptoms

Some people with schizophrenia have moderate cognitive symptoms, while others have more severe ones, and patients may notice changes or abnormalities in their memory or other elements of mind. Cognitive symptoms can be hard to identify as part of a condition, similar to negative symptoms. Sometimes, they are only identified when particular experiments are carried out. The following include cognitive symptoms:

- Deficient "executive functioning" (the ability to comprehend information and make judgments based on it)
- Focusing or paying attention trouble
- Working memory issues (the ability to put info to immediate use after learning it) Impaired cognition has been linked to poorer work and social results in schizophrenia patients, and it can be upsetting [3].

2.1 What causes schizophrenia?

Some scholars classify schizophrenia as a single disorder, but the subtype shares some similar characteristics as it is a cluster of disorders (table: 1). these diseases are associated with brain defects and genetic predispositions in most clinical studies.

Table 1: a subtype of a schizophrenia

Paranoid	Delusions or hallucinations, frequently with themes of persecution or grandeur
Catatonic	Extreme negativism and/or parrot-like repetition of another-expression or gestures in immobility (or repetitive, purposeless movement)
Disorganized	Disorganized-speech or flat or improper or feelings behavior
Residual	Withdrawal, after-hallucinations and delusions have disappeared
Undifferentiated	Many and varied symptoms

2.1.1Psychological factors

Besides the biological factors and genetic factors, the psychological factors consider the most important to discuss in this chapter. If schizophrenia is not caused on its own by prenatal viruses and genetic predispositions, it is not caused on its own by social factors or family. Psychiatrists who earlier attributed schizophrenia to frigid, irrational "refrigerator mothers" have long disproved this theory. "No environmental causes have been found that will invariably, or even with a moderate probability, cause schizophrenia in individuals who are not associated with a person with schizophrenia, or even with a moderate probability, cause schizophrenia in individuals who are not associated with a person with schizophrenia," Susan Nicol and Irving Gottesman [4] wrote nearly three decades ago.

2.2 The history of the psychotherapy for schizophrenia

A treatment of schizophrenia was included hard procedures and forced isolation from communities and people with more severe cases of disorder, which occurs when

psychotherapy absent as a treatment for psychological difficulty. As a result of this type of therapy, prominent reformers such as Pineland Tuke [5] alternative treatments, such as the establishment of "moral treatment" for mental illness, were recommended. Although there were numerous differences between this concept and traditional asylum practices, [5], participating in conversations with persons who are afflicted, treating them with dignity and respect, and acknowledging their lives, experiences, interests, and objectives may have been the most crucial factor [5].

Around a century later, psychoanalysis ushered in a new era in the treatment of a wide spectrum of psychopathologies, including schizophrenia. Although Freud [6] him-self established the impossibility of psychoanalysis with schizophrenic individuals, records from a variety of settings preserved accounts of considerable engagement in some type of psychoanalytic psychotherapy with schizophrenic individuals in the 1940s.s. Several authors have stated that people with schizophrenia are usually open to the possibility of therapy and that some form of rehabilitation is achievable [7, 8].

As such, psychoanalytic-psychotherapy has evolved as the treatment to help people with schizophrenia develop a better sense of self by using the therapeutic relationship as a way to understand affective-states and coping strategies in relationships outside-therapy. There also appear to be a shared desire to meet persons with schizophrenia and have conversations about their life in order to promote positive change. Moral counseling is used to explain the patient's perplexing behaviors and stressful emotional states, with the hope that talking about it may provide great comfort.

No scientific evidence has been found to support the efficacy of the relationship between psychotherapy and the well-being of schizophrenic patients. As generally noted, randomized controlled trials have not demonstrated major advantages for psychoanalytic-psychotherapy in individual with schizophrenia [9, 10]. Furthermore, others felt that interest in schizophrenia's psychoanalytic theoretical basis had begun to diminish., claiming that the theory had become anemic, an etiological schizophrenia theory that emphasized a causal role of family-dynamics, neglecting the condition's phenomenology and becoming overly dependent on seeking a separate cause of disorganized self-experience

As psychotherapy for schizophrenia became less common, the focus shifted to drug-management and eventually programs of rehabilitation that emphasized the developments of specific skills and links to community-resources.

In the 1990s, psychotherapy was resurrected again in schizophrenia treatment, cognitive-behavior-therapy (CBT), initially intended for depression usage and later used to treat patients with schizophrenia. The general psychosis cognitive-behavioral model suggests that the way people interpret encounters produces anxiety, and cognitive schizophrenia therapy supports a move from looking at kind of symptoms to a personal context of the substance of symptoms. These core cognitive ideas, as well as a stress-vulnerability model, are incorporated into CBT. For instance, delusions can be understood by the interaction between stressors and biological vulnerabilities as a series of increasingly maladaptive opinions [11]. According to this paradigm, cognitive therapies administered in a wet, collaborative therapeutic relationship can be utilized to normalize and alter maladaptive beliefs connected to psychotic symptoms, as well as to position the beliefs on a normal mental life continuum, and thus reduce the severity of distressing symptoms [11, 12]. Individuals with schizophrenia who used CBT demonstrated reductions in dysfunctional cognitions recurrence rates, and, positive symptoms, as well as gains in psychosocial functioning, according to the data [13,

14]. It has been approved for the treatment of first-episode patients and older individuals, as well as for use in group-based therapy modalities [15, 16].
Similarly, there has been a surge of interest in the potential of psychodynamic techniques [17, 18]. These findings have been linked to a long-running controversy about the relative merits of CBT and psychodynamic methods to schizophrenia therapy, with some claiming treatment equivalency [19, 20], Although some CBT proponents reiterate a stance that schizophrenia has been debunked by psychodynamic methods and claim that they should not be widely tested or applied[21].

2.2.1 Five models of psychotherapy integration

After the first episode of psychosis, Gumley and Clark present the first of the five models we'll present [22] includea psychotherapy intervention style that focuses on supporting a client in reconstructing a shattered personal narrative and depends on cognitive, interpersonal, and developmental theoretical methods to influence control. They propose that mentalization processes are interwoven with developmental and interpersonal-understandings of regulating effect, and that therapy could help people create what they call a personal "compassionately toned" narrative that takes place in a setting that is historical, interpersonal, and development. Gumley and Clark focus on the formation of a joint working alliance as essential to fostering rehabilitation and propose that this collaboration provides the necessary structure for their model's main therapeutic task: the production of a narrative timeline. Here, a cohesive narrative chronology is provided to help people understand their experiences to psychosis, uncover interpersonal developmental origins of adaptability, and investigate fundamental cognitive and effect-regulation mechanisms. These mechanisms are proposed to help with psychotherapy progress.
Harder and Folke's [23] works contain a second model. They offer an integrative support model for psychodynamic psychotherapy that includes attachment and findings from intersubjective research. Harder and Folke's paradigm stresses the links between attachment methods and mentalization or metacognitive deficiencies. More specifically, the approach emphasizes-intersubjective-processes as a way to enhance metacognitive ability and control regulation, thus minimizing-stress and dissociative process sensitivity. Harder and Folke propose an initial review of the attachment-style, stress-response, mechanisms of dissociation, and metacognitive ability of the individual, accompanied by therapeutic tasks aimed at minimizing the sensitivity of stress. With special attention to attachment-related consequences, the therapist is tasked with closely monitoring the therapeutic-relationship. A use of a therapist is recommended to create a positive and healthy-environment during the development of the therapeutic relationship and to work towards opportunities for the client to consider and in the session, deal with uncomfortable emotive experiences, there by facilitating the creation of a reliable attachment representation. At the same time, metacognitive capacities can be strengthened by adjusting verbal strategies to the individual's level of metacognitive functioning, and then boosting metacognition through reciprocal meaning-making and greater understanding of interpersonal situations. Rosenbaum et al [17,18] proposed a model that is similar to Harder and Folke's, and both advocate for other general technical approaches from positive psychodynamic psychotherapy, such as confirming and affirming clients' experiences, elaborating and combining subjective experiences, and providing alternate viewpoints.
A third integrative method can be found in the techniques presented by Salvatore and colleagues[24] and Lysaker and colleagues[25], both of which focus on metacognitive

deficiencies and the use of narrative episodes in integrative, metacognition-oriented therapy. These authors propose that metacognitive ability deficits make it difficult to build complex representations of oneself and others and to use this data to react adaptively to the challenges of life and to establish meaningful ties with others. While these authors do not dismiss the significance of early relationships, they conceptualize metacognitive deficiencies as multi-defined and accessible through a variety of interventions. With a focus on agency, this method incorporates cognitive and psychodynamic principles as well as existential and dialogical self-experience models. According to Lysaker and colleagues [25], the therapist can help the client regain or regain their ability to think about oneself and others in reasonably complex ways by tailoring treatments to the required level of metacognitive capacity. As successful agents, therefore, they will be more able to make better sense of a problems they face and find ways to respond to the restrictions their disease imposes on their lives. These authors [25] support the use of an elicited narrative episode of the client as an opportunity to stimulate metacognitive-processes. With particular attention to the creation of a non-hierarchical therapeutic relationship, they stress the significance of the interpersonal context.

The fourth type of integrative procedures can be found in research suggesting the convergence of modalities outside of psychotherapy, such as the practice of combining recovery-oriented psychotherapy with more advanced therapies like psychosocial rehabilitation [26]. Multicomponent integrative methods are consistent with this, targeting particular recovery components. Work by Pijnenborg and colleagues [27], whose REFLEX intervention provides an integrative strategy to target weak insight, is an example of this type of therapy. The intervention consists of three four-session modules on coping stigma, personal narrative, and social cognition. It is a 12-hour group training. Story enhancement/cognitive therapy (NECT), a group-based treatment that combines cognitive tactics and narrative components to try to erase internalized stigma, is another example of a multi-component integrative approach. NECT is broken down into four sections: psychoeducation, self-stigma elicitation and evaluation, cognitive restructuring, and narrative improvement.

Hasson-Ohayon [29] proposed a fifth category for integration, which instead of providing a new integrative psychotherapy model includes guidelines for combining intersubjective interventions with any number of current cognitive-behavioral-based-therapies.

Hasson-Ohayon suggests that conventional ideas focused on CBT do not sufficiently resolve established metacognitive deficiencies in schizophrenia, and argues that incorporating intersubjective processes between therapist and patient into CBT therapies using an assimilative integration technique can improve growth in this area. Highlighting intersubjective disturbances, focusing on the here-and-now, the therapist-patient interaction, mutual meaning-making, and the therapist's self-disclosure are some of Hasson-views. Ohayon's. She continues to give detailed guidelines for the application of the Illness Treatment and Rehabilitation Program [30] to apply this general approach. Social Cognition and Interaction Training-(SCIT) [31] and NECT [28] As stated above, it is possible to define NECT itself as an integrative-treatment. In this way, Hasson-Ohayon not only presents integration guidelines, but also draws on earlier integrative attempts to try to improve and build on them.

2.3 The Phenomenological Psychotherapy for Schizophrenia

Phenomenological psychopathology has a long history of using a comprehensive and systematic approach to studying abnormal and psychotic experiences in schizophrenia. We refer to phenomenological-focused research with the notion of 'phenomenology,' this is based on the phenomenological tradition in continental philosophy, which comprises well-known thinkers such as Martin Heidegger, Edmund Husserl, Maurice-Merleau-Ponty, and so forth. In other words, in Anglophone psychiatry, we do not use "phenomenology" in its ordinary sense, where it merely designates a "description of mental phenomena"[32]. "Currently, phenomenological-psychopathology, or "phenomenological-anthropological psychiatry," as it is often known, denotes, [33] "an continuing research effort rather than a theory or collection of categories that has been attained," as Wiggins and Schwartz put it.

There has been a wide and comprehensive spectrum of studies in phenomenological psychopathology over the last decades, which has flourished and resulted in invaluable insight into understanding the experiential-worlds of patients with schizophrenia. This direction of clinical-research helps us to consider partly what it would be like to perceive ourselves, others, and a world as schizophrenia patients sometimes do. It provides tools to understand the dynamics of experiential changes and the profound weakness that follows being in a world that might seem to be stripped of ontological stability and natural certainty (e.g., of time, space and causality) that otherwise, our existence would be grounded.

For any sound and careful psychotherapy, understanding the perspectives of patients is important. This may be important for schizophrenia psychotherapy, where the perspectives of patients may not always be readily available or comprehensible. Patients may, however, still benefit from psychotherapy, particularly psychotherapy based on a trusting relationship and saturated with emotional concerns for their well-being. However, if it is not based on a real understanding of their state, such psychotherapy can also be experienced as quite important. To put it another way, in schizophrenia, a psychotherapist must understand what she or he is handling, i.e., he or she must have, and express the awareness of a transformed experiential existence. The author will now examine the interactions of patients in depth through appropriate interviews and gain insights into their experiential-configurations and underlying limitations, and these thoughts will guide choices about how to prepare and proceed with effective psychotherapeutic interventions. Despite many forms of phenomenological psychopathology study, some observations have seldom been integrated into concrete approaches to psychotherapy. However, some great writers in phenomenological psychopathology support the ability of psychotherapy, and several of them even provide recommendations about how to apply their insights to genuine psychotherapy [34].

2.4 The fundamental of Phenomenological Psychotherapy for Schizophrenia

In this chapter, we will address only the aims and general attitude of schizophrenia's phenomenological psychotherapy.

2.4.1 Psychotherapy goals

The goals of schizophrenics patients treatment are the same as the goals of psychoanalytic therapy with anyone, that’s means, to live a more fully human life In psychotherapy for schizophrenia patients, focusing on a patient's experience of self-alienation, as well as estrangement from others and the shared environment, is most likely the best way to attain this wide goal. Loneliness, dread, and desperation, as well as feelings of being different from others, will be gradually diminished or relaxed, helping the patient to feel more at peace in the world, among other things. The aim of most therapists is to help patients to be strong in

their self-perception and self-presence, e.g., by assisting them in their strive for personal-solidarity and autobiographical, narrative-identity, that's means, to make them feel better integrated within themselves. The researcher discusses their attempts to help patients engage in healthy interpersonal relationships and retain them; as a result, their sense of embracing others and contributing to human society is strengthened. It's vital to keep in mind that many of the key events are trait-like rather than state-like, which means that patients aren't usually eased indefinitely. The investigator uses psychological terminology to describe his or her approach, which includes a range of tolerance, as well as a more neutral or even favorable evaluation of these events. They are a type of sensibility, openness, ingenuity, or knowledge of various points of view, among other things.

2.4.2 General Attitudes

The researcher explains many ways to accomplish these goals, first and foremost, you must strive to "remain with." a experience and avoid perceptions of the patients, this is something that is rarely seen in clinical practice or normal psychotherapy protocols. "If we are to genuinely study our patients' sensory life worlds and avoid misconceptions, we must stay long enough with the "how" of the experience and not rush to the "why," as the researcher put it, given her estranged relationship with her own body: "I have this void inside of me." I'm trying to stuff it with food, but it's not working." "I think the gap is a feeling of inadequacy, loneliness, a feeling of not being sufficient, and a lack of meaning," she replied when pressed to clarify. I have no idea who I am, what I'm meant to be doing, or why I'm here." The patient was asked if a void had a spatial position to clarify more about the essence of this encounter. She responded,

"Yes, I believe it is located in the solar plexus." It appears to be enormous, far more than my body. Perhaps a large Pilates ball. There's something I'm losing there. There is a void of significance. The void is palpable to me. I've had it for a long time. There is an empty place that hasn't been filled with anything. "There is nothing but a black abyss" [35]. "The significance of staying with the "how" of experience is explained in this example, She thinks she feels incomplete and lonely until being asked about "why" lacks importance, etc., clarifying the essence and meaning, although the latter is also psychotherapeutically relevant in due time. This style of therapy focuses on working with not only epistemic meaning but also a deeply emotional and relational value of the "how" of the experience. Patients frequently assume that they have been heard, understood, and that they are not being judged. It's the way patients' experiences are presented with a holding and confining attitude that allows for mental, relational, and bodily experience (as defined in psychoanalytic psychotherapy) [36].

The psychotherapist's function is similar to that of an anchoring, discussion companion, and interpreter or bridges to other people's thoughts, information, perceptions, and common sense reactions. The deep phenomenological and psychodynamic expertise, according to the researcher's definition, helps the therapist in listening honestly, knowing how to ask questions, what to ask and what not to ask, and when to move on in the psychotherapy phase are all important skills.

2. CONCLUSION

We provided a brief history of psychotherapy for schizophrenia in this chapter, stressing renewed hope for the integration of psychotherapy as a recognized field of interest. We've

provided five inclusive approaches for schizophrenia that draw on a variety of theoretical traditions and employ a variety of technical procedures that are all compatible. There are certain limits to this review. As with any conversation set in a historical context, the focus here is on particular historical directions and notions to the detriment of others. According to this situation, the history is not as clear as we have presented it, and our concept conclusion in schizophrenia psychotherapy emphasized the CBT and psychodynamic treatments have become increasingly popular, potentially to the disadvantage of work rooted more firmly in humanistic or phenomenological traditions. In addition, the integrative models described in this chapter do not represent a complete list of integrative psychotherapy efforts for schizophrenia, as they do not include, for example, the integration of psychotherapy models based on phenomenological theory is given. Even among those working in more specialized traditions, integration appears to be gaining support, with at least one well-known CBT researcher recommending a combination of CBT and psychodynamic psychotherapy74, while previously maintaining that the two approaches were incompatible. 18 The integrative models we've described are intriguing, but they'll all need to be put to the test in the future..
In this chapter, we'll look at some specific goals and general attitudes in phenomenological psychotherapy for schizophrenia. While we feel these are important and crucial in schizophrenia psychotherapy, we are not implying that they are described in phenomenologically informed schizophrenia psychotherapy. The particular value of phenomenology psychotherapy, its ability to grasp the heart of patients' experiences and weak points, then use these principles to psychotherapy interventions, is, in our opinion, what sets it apart.

Conflicts of interest
There are no conflicts of interest that need to be disclosed.

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