Psychology Research and Behavior Management

Dovepress

open access to scientific and medical research

Open Access Full Text Article

REVIEW

Individual psychotherapy for schizophrenia: trends and developments in the wake of the recovery movement

This article was published in the following Dove Press journal:
Psychology Research and Behavior Management
5 August 2013
Number of times this article has been viewed

Jay A Hamm[1]
Ilanit Hasson-Ohayon[2]
Marina Kukla[3]
Paul H Lysaker[1]

[1]Richard L Roudebush VA Medical Center, Department of Psychiatry, Indianapolis, IN, USA; [2]Bar-Ilan University, Department of Psychology, Ramat Gan, Israel; [3]Health Services Research and Development Center of Excellence on Implementing Evidence-Based Practice, Richard L Roudebush VA Medical Center, Indianapolis, IN, USA

Abstract: Although the role and relative prominence of psychotherapy in the treatment of schizophrenia has fluctuated over time, an analysis of the history of psychotherapy for schizophrenia, focusing on findings from the recovery movement, reveals recent trends including the emergence of the development of integrative psychotherapy approaches. The authors suggest that the recovery movement has revealed limitations in traditional approaches to psychotherapy, and has provided opportunities for integrative approaches to emerge as a mechanism for promoting recovery in persons with schizophrenia. Five approaches to integrative psychotherapy for persons with schizophrenia are presented, and a shared conceptual framework that allows these five approaches to be compatible with one another is proposed. The conceptual framework is consistent with theories of recovery and emphasizes interpersonal attachment, personal narrative, and metacognitive processes. Implications for future research on integrative psychotherapy are considered.

Keywords: schizophrenia, psychotherapy, recovery, metacognition, psychosis, integrative psychotherapy

Introduction

The history of schizophrenia has been marked by vacillations in attitudes regarding prognosis and approaches to treatment. Within the general context of treatment, the role and relative prominence of psychotherapy has fluctuated significantly across time. At certain points in the last century, psychotherapy has been placed as a core treatment modality, while at other times it has virtually disappeared. Debates have also ensued regarding what psychotherapy for schizophrenia might best entail. For instance, should psychotherapy seek to reduce distressing symptoms, or instead focus on understanding inner conflicts and subjective components of schizophrenia?

Recently, the recovery movement has not only challenged previously held contentions about the prognosis of schizophrenia but has also highlighted how recovery involves attaining both objective and subjective markers of wellness.[1] This has led to many calls for a recasting of the kinds of services that should be offered for persons with schizophrenia, renewing debate about the potential role of psychotherapy, including its purposes and nature relevant to schizophrenia. Specifically, one consequence of this work has been proposals that many of the different threads involved in the psychotherapy of schizophrenia could now be integrated under newly developing holistic models of mental health.

To address this issue, in this paper we propose to review the history of psychotherapy for schizophrenia and then explore several possibilities we think the recovery movement

Correspondence: Paul Lysaker
Richard L Roudebush VA Medical Center, 1481 West 10th Street – 116H, Indianapolis, IN 46202, USA
Tel +1 317 988 2546
Email plysaker@iupui.edu

poses for the future of psychotherapy for schizophrenia. Following a brief review of the history of psychotherapy for schizophrenia, we will explore how this paradigm shift, occurring as a result of the recovery movement, has spurred trends toward the integration of previously opposing treatments that assist persons with schizophrenia to make sense of their condition, choose an adaptive course of living with mental illness, and achieve a reasonable degree of personally defined wellness. Specifically, five different newly developed integrative approaches will be detailed. After comparing and contrasting these models, we will examine the underlying theoretical structures that connect them to one another and discuss needs for a future research agenda driven by the possibilities inherent in these treatments.

Of note, we are neither proposing to position psychotherapy as more or less essential than other treatments, nor attempting to resurrect a fruitless debate about psychotherapy versus medication. Instead, we intend to explore a range of exciting possibilities regarding its potential to become uniquely helpful to some people with schizophrenia seeking to find a satisfying and fruitful life.

A brief history of psychotherapy for schizophrenia

Well before the advent of psychotherapy as a treatment for psychological distress, the manner in which one might intervene with a person with schizophrenia served as a matter of debate. Early models for the management of serious psychological disturbance often involved harsh procedures and forced isolation from persons and communities.[2] As a response to these conditions, prominent reformers such as Pinel and Tuke[2] advocated for alternative treatments, including the development of "moral treatment" for mental illness. Although the changes in this model from conventional approaches in asylums were myriad,[2] one important component may have been related to the practice of engaging in dialogue with those afflicted, treating them with dignity and respect, and inquiring about their lives, experiences, interests, and goals.

Roughly a century later, the development of psychoanalysis signaled another major shift in the treatment of a wide range of psychopathology, including schizophrenia. Although Freud[3] himself maintained that psychoanalysis with persons with schizophrenia was impossible, by the 1940s reports from a variety of settings described accounts of meaningfully engaging in some form of psychoanalytic psychotherapy with persons with schizophrenia.[4–8] These also noted that persons with schizophrenia were commonly receptive to the possibility of treatment and able to attain some form of recovery. As such, psychoanalytic psychotherapy emerged as a treatment for helping persons with schizophrenia to develop a healthier sense of self through the use of the therapy relationship as a means for understanding affective states and communication processes in relationships outside of therapy. Although employing different techniques and theoretical understanding of psychosis than found in moral therapy, there appears to have been a shared interest in meeting with persons with schizophrenia and having conversations about their lives with the intent to promote meaningful change. One way this work may have advanced the work of moral treatment was to suggest that the patient's deeply confusing behaviors and painful emotional states could be understood, and that the discussion and understanding of those behaviors and emotions could lead to significant relief.

While the literature on psychoanalytic psychotherapy produced anecdotal evidence of psychotherapy contributing to wellness, little scientific evidence was available to support the efficacy of such approaches. As widely noted, randomized controlled trails failed to find significant benefits for psychoanalytic psychotherapy for persons with schizophrenia.[9–15] Additionally, some have suggested that interest in the psychoanalytic theoretical basis of schizophrenia had already begun to wane as the theory had become anemic by some accounts, neglecting the phenomenology of the disorder and becoming overly focused on locating a discrete origin of disorganized self-experience in early relationships, an etiological explanation of schizophrenia that emphasized a causal role of family dynamics.[16,17]

After psychodynamic approaches to psychotherapy for schizophrenia began largely to fall out of favor, there appears to be a period during which psychotherapy for persons with schizophrenia in general receded from the public eye. Without any reference to psychotherapy, treatment began primarily to emphasize medication management, and later rehabilitation efforts that stressed the development of discrete skills and connections with community resources.

More recently, however, the field has witnessed a resurgence of emphasis on the place of psychotherapy within the treatment of schizophrenia. Beginning around the 1990s, cognitive–behavior therapy (CBT), initially developed for use with depression, began to receive support for its application to schizophrenia. Cognitive therapy for schizophrenia promotes a shift away from looking at the form of symptoms to the personal meaning people draw from the content of symptoms, and generally applies the generic cognitive–behavioral model to psychosis, suggesting that the way people interpret

experiences leads to distress. CBT combines these basic cognitive concepts and a stress-vulnerability model. For instance, delusions might be understood as a sequence of increasingly maladaptive beliefs developed out of the interaction of stressors and biological vulnerabilities.[18] Stemming from this model, CBT for schizophrenia suggests that cognitive interventions provided from a warm, collaborative therapy relationship might be used to normalize and modify maladaptive beliefs related to psychotic symptoms, situating the beliefs on a continuum of normal mental life, and thereby reducing the level of distressing symptoms.[18,19] A growing body of evidence has suggested persons with schizophrenia accept CBT, and have shown reductions in dysfunctional cognitions, positive symptoms, and recidivism rates, as well as improvements in psychosocial functioning.[20–27] It has received support for use with first-episode patients and older adults, and has been extended for application in group-based treatment modalities. Meta-analyses have found acceptable effect sizes for the effectiveness of CBT for schizophrenia, and it has received enough support for several countries to have adopted guidelines suggesting that it be routine care.[28,29]

Recently and in parallel, there has also been renewed interest in the potential of psychodynamic approaches.[30,31] Related to these findings has been ongoing debate regarding the relative merit of CBT and psychodynamic approaches to schizophrenia, with some suggesting treatment equivalence,[32,33] while some proponents of CBT reiterate the stance that psychodynamic approaches for schizophrenia have been discredited and suggest that they should not be widely investigated or applied.[34]

Recovery movement and implications for the evolution of psychotherapy for schizophrenia

While interest in psychotherapy has been regenerated by the application of CBT to schizophrenia and renewed interest in psychodynamic approaches, the field has also witnessed a larger paradigm shift that offers an opportunity to revisit what the purposes of psychotherapy should be within treatment regimens. This major shift is expressed through the recovery model.

Large-scale cross-sectional and longitudinal studies have revealed that contrary to long-standing pessimistic views regarding prognosis, persons with schizophrenia are commonly able to achieve meaningful recovery.[35–38] Researchers, clinicians, and persons with schizophrenia have described recovery from schizophrenia as a complex, multidimensional process with both objective and subjective elements.[17,39–41] For instance, recovery might involve regained occupational functioning, reduction of symptoms, the ability to acquire adequate housing, recaptured enthusiasm for a past interest, falling in love, or any combination of these. Recovery may also include persons developing the ability to experience themselves as agentic individuals with rich histories and the potential to influence their own futures and successfully navigate life's challenges, regardless of fluctuations in level of dysfunction or symptoms.[36,38,42,43] In this regard, a central process in recovery from schizophrenia may involve emerging from a state in which the self has been experienced in lessened terms of vitality and agency.[44–49] It is possible that growth in the domain of self-experience represents a process wherein persons can recognize their ability to direct their own recovery.

These findings naturally raise questions about how current psychotherapies fit in with these parameters and how psychotherapy itself should evolve. As previously discussed, there is substantial evidence supporting CBT as effective in reducing symptoms, but it is not clear if these approaches adequately address other targets of treatment raised by the recovery movement, as they typically do not explicitly involve an emphasis on self-experience. Psychodynamic approaches, meanwhile, may enhance interpersonal functioning, but may not adequately address how a person with schizophrenia might agentically employ their knowledge of themselves and others to move toward recovery.

Recent trends in the literature suggest that one response to the challenges posed by the recovery movement has been a shift away from further refinement and specialization of existing parallel psychotherapies, and movement toward integrative models of psychotherapy that synthesize elements of existing treatments on the basis of theories of recovery.[50,51] Rather than provoking a final debate regarding the relative superiority of a particular psychotherapy approach, the recovery movement may be offering goals that allow for the integration of treatment packages that were previously seen as incompatible. Consistent with this, several integrative psychotherapy models for persons with schizophrenia have been proposed in recent literature, drawing from a range of theoretical influences. We will next briefly describe five independent but compatible integrative approaches.

Five models of psychotherapy integration

In the first of the five models we will present, Gumley and Clark[52] offer a psychotherapy approach for intervention

following a first episode of psychosis that draws on cognitive, interpersonal, and developmental theoretical approaches to affect regulation and emphasizes assisting an individual to restore a disrupted personal narrative. They draw on attachment literature to propose that a developmental and interpersonal understanding of affect regulation is intertwined with mentalization processes, and suggest that therapy might facilitate the development of what they refer to as a "compassionately toned" personal narrative that exists within a historical, interpersonal, and developmental context. Gumley and Clark emphasize the development of a collaborative working alliance as central to promoting recovery, and suggest that this relationship provides the necessary framework for engaging in the key therapeutic task of their model: the development of a narrative timeline. A coherent narrative timeline is suggested here to allow for a person to develop an understanding of their responses to psychosis, identify developmental interpersonal roots of adjustment, and explore underlying cognitive and affect-regulation processes. These processes are proposed to lead to psychotherapeutic change.

A second model can be found in the work of Harder and Folke.[53] They offer an integrative supportive psychodynamic psychotherapy model that incorporates findings from attachment and intersubjective literature. The model offered by Harder and Folke emphasizes connections between attachment processes and some type of mentalization or metacognitive deficits. Harder and Folke's[53] approach more explicitly emphasizes intersubjective processes as a route to enhancing metacognitive capacity and affect regulation, thereby reducing sensitivity to stress and dissociative processes. Harder and Folke recommend an initial assessment of the client's attachment style, stress sensitivity, dissociative processes, and metacognitive capacity, followed by therapeutic tasks aimed to reduce stress sensitivity. The therapist is entrusted to carefully monitor the therapeutic relationship, with particular attention to attachment-related affects. Through the development of the therapeutic relationship, the therapist is encouraged to provide a supportive and safe environment and work toward opportunities for the client to acknowledge and regulate painful affective experiences in session, thereby promoting the development of a secure attachment representation. Concurrently, metacognitive capacities are to be enhanced by tailoring verbal interventions to the client's level of metacognitive functioning and then stimulating metacognition through mutual meaning-making and increased understanding of interpersonal encounters. Rosenbaum et al[30,31] have suggested a model similar to that of Harder and Folke, and both encourage other general technical approaches from supportive psychodynamic psychotherapy, including confirmation and validation of clients' experiences, elaboration and integration of subjective experiences, and proposing alternative views.

A third integrative approach can be seen in the similar approaches offered by Salvatore and colleagues[54] and Lysaker and colleagues,[55] which both place an emphasis on metacognitive deficits and the utilization of narrative episodes within session in an integrative, metacognition-oriented therapy. These authors suggest that deficits in metacognitive capacity make it difficult to develop complex representations of oneself and others, and to use this information to respond adaptively to life's challenges and form meaningful connections with others. Although not discounting the importance of early relationships, these authors conceptualize metacognitive deficits as multidetermined and approachable through a range of interventions. This approach employs cognitive as well as psychodynamic principles, as well as existential and dialogical models of self-experience with a specific focus on agency. Lysaker[55] and colleagues suggest that the therapist, through tailoring interventions to the appropriate level of metacognitive capacity, could assist the client to recapture or rebuild the capacity to think about themselves and others in relatively complex manners. Consequently, as an active agent, they may be more likely to make deeper meaning of the challenges facing them and find ways to adapt to the limitations imposed on their life by their illness. These authors[55] promote the use of the client's elicited narrative episodes as opportunities to stimulate metacognitive processes. They emphasize the importance of the interpersonal context, with specific attention to the development of a nonhierarchical therapeutic relationship.

A fourth category for integrative approaches can be seen in work suggesting the integration of approaches extending beyond psychotherapy, including the practice of linking recovery-oriented psychotherapy with other more specialized interventions, such as psychosocial rehabilitation.[56] Consistent with this are multicomponent integrative approaches that target specific elements of recovery. Examples of this type of treatment include work by Pijnenborg and colleagues,[57] whose REFLEX intervention offers an integrative approach to target poor insight. The intervention is a twelve-session group training, comprised of three four-session modules that address coping stigma, personal narrative, and social cognition, respectively. Another example of this type of multicomponent integrative approach would include narrative enhancement/cognitive therapy[58] (NECT), which is a group-based approach that integrates cognitive interventions and narrative elements to attempt to reduce internalized

stigma. NECT is divided into four sections, consisting of the elicitation and assessment of self-stigma, provision of psychoeducation, cognitive restructuring, and finally narrative enhancement.

A fifth category for integration has been suggested by Hasson-Ohayon,[59] who rather than offering a particular integrative psychotherapy model, instead offers recommendations for integrating intersubjective approaches with any number of existing cognitive–behavioral-based therapies. Hasson-Ohayon suggests that traditional CBT-based approaches may not adequately address existing metacognitive deficits in schizophrenia, and contends that facilitating growth in this domain may be accomplished through the use of an assimilative integration strategy to incorporate intersubjective processes between therapist and patient into CBT interventions. Some recommendations Hasson-Ohayon offers include highlighting disturbances in intersubjectivity, focus on here-and-now, the I–you relationship between therapist and patient, shared meaning-making, and therapist self-disclosure. She goes on to offer specific recommendations for applying this general strategy to the implementation of the Illness Management and Recovery Program[60] and Social Cognition and Interaction Training (SCIT),[61] as well as NECT.[58] As previously mentioned, NECT itself can be classified as an integrative treatment. In this way, Hasson-Ohayon not only offers recommendations for integration but also uses the practice of integration to attempt to build off and refine previous integrative efforts. The central elements of each of these five approaches are included in Table 1.

A shared framework for recovery: interpersonal attachment, personal narrative, and metacognition

Each of these five approaches to integrative psychotherapy draws upon different theoretical traditions and implements different techniques. However, despite their differences, these models do not appear to be in opposition to each other, as has often been the case for past parallel-psychotherapy movements, raising the question of what underlying structures these models might have in common. Specifically, we suggest that three core elements, synthesized differently across approaches, form a basic conceptual framework that serves as a foundation for integration. These core elements are interest in attachment and interpersonal connectedness, recognition of personal narrative, and emphasis on the role of metacognitive processes.

First, consistent with the emphasis that recovery involves full reintegration within one's community,[62] each of these different approaches is in part driven by recognition that recovery takes place within an interpersonal field. All seek to intervene in some manner that will help persons with

Table 1 Central Elements of Five Integrative Approaches

Authors	Modality	Key theoretical roots and backgound	Core elements
Gumley and Clark[52]	Individual psychotherapy	Cognitive Attachment Interpersonal Developmental	• Metacognitive deficits related to problematic attachment style • Capacity to mentalize emerges within context of secure attachment • Emphasizes importance of disrupted narrative
Harder and Folke[53]	Individual psychotherapy	Attachment Intersubjective Psychoanalytic	• Early attachment central to approach • Attachment style related to affect-regulation processes, stress reactivity, and metacognitive difficulties • Approach is grounded in developmental perspective
Lysaker et al[55] Salvatore et al[54]	Individual psychotherapy	Cognitive Existential Psychodynamic Dialogical	• Metacognitive deficits closely intertwined with inability to form coherent, temporally stable personal narrative • Narrative episodes used as means to stimulate metacognitive growth in therapy • Difficulties in metacognition result in intersubjectivity, experienced as threatening
Multicomponent models (eg, Pijnenborg et al[57])	Group psychotherapy	Skills training Social cognition Cognitive Narrative	• Multiple interlocking components in a temporal sequence • Self-reflective processes moderate relationship between insight and interrelated prerequisites for insight, including perspective-taking, self-stigma, and neurocognition
Hasson-Ohayon[59]	Individual/group psychotherapy	Cognitive–behavioral Intersubjective	• Emphasizes intersubjectivity and interpersonal context as critical for therapy • Provides assimilative strategies for integrating intersubjectivity into existing cognitive–behavioral approaches

schizophrenia navigate interpersonal contexts, understand others whom they encounter, and develop and sustain meaningful relationships, with several specifically focusing on addressing the processes by which human beings form and sustain attachments.

Second, consistent with the emphasis that recovery involves redefining self,[63] each of these approaches is driven by an understanding of the connection between the coherence and richness of personal narrative and health. By personal narrative, we are referring to a meaningful account of oneself, an evolving and storied sense of one's life, not simply a collection of facts.[64–66] Each approach, albeit in a somewhat different manner, seeks to elicit patients' stories of their lives, helping them to evolve and use this storied account of their life to make meaning of their experiences and to allow them to act as an agent in the world. Across each is a respect for the processes by which human beings construct stories of their lives, how those stories evolve and change naturally over time, and an implicit or explicit awareness that such stories form the context for the possession of a temporally stable sense of self, ie, as a being with some consistency over time. In this way, the act of communicating the personal meaning of psychotic experiences is valued beyond any specific approach to psychotherapy.[67]

The third component that we believe links these different approaches involves attention to the very processes by which persons form complex ideas of themselves and others. Whether the process of thinking about oneself and others is referred to as mentalization, theory of mind, social cognition, or metacognition, each of the integrative approaches is concerned with helping patients to identify what they think and experience, and to synthesize that information into more complex representations of themselves and others.[52–59] Consistent with the recapturing of personhood and directing one's own movements toward health, each approach is in some way interested in helping patients move to a state in which they can distinguish appearance from reality, recognize that events can be seen as something that can be misperceived or misremembered, acknowledge that others may have different perspectives, and to know that people (including themselves) can view events differently at different times in their lives. The various terms (eg, mentalization, metacognition) in question here, although at times used interchangeably, have meaningful differences in the research, and an emphasis on a particular construct may point to subtle corresponding differences in therapeutic approach.

Of note, the first two elements proposed here – attention to meaningful relationships and the development of the self as an active agent who narrates his or her own story – correspond with the dialectic of needs for agency and relatedness, a concept that has been expressed in a number of different psychological and philosophical theories.[68] The third element, metacognition, is deeply entwined with agency and relatedness, both seeming to arise from and to allow for the development of agency and relatedness. This shared conceptual framework is generally consistent with what Wampold[69] has described as the contextual model of psychotherapy. Whereas a medical model of therapy emphasizes the superiority of specific techniques and interventions as contributing to treatment outcome, the contextual model emphasizes the importance of common factors shared by all psychotherapy approaches. Among these elements are the development of relationship and enhancing the sense of mastery of the client.[70] These two elements seem to be highly related to the three suggested core elements for integration suggested in this paper, as they all focus on both the relationship and the experience of the self.

Turning back to similarities and differences in the five integrative psychotherapy models, Gumley and Clark[52] appear to share a view with Harder and Folke that early attachment and metacognition are intimately intertwined, with problematic attachment related to disruptions in metacognitive processes and difficulties developing and managing later interpersonal relationships. Lysaker and colleagues and Salvatore and colleagues both relatively deemphasize the role of early relationships and attachment, suggesting that metacognitive deficits themselves make understanding oneself and forming connections with others difficult, and that these deficits might serve as the direct target of psychotherapeutic intervention. Gumley and Clark, Salvatore and colleagues, and Lysaker and colleagues share an emphasis on the disruptions of personal narrative in schizophrenia, although Gumley and Clark emphasize narrative as a means to understand attachment organization and promote cognitive and affective regulation, whereas Lysaker and colleagues suggest the use of personal narrative as a means to stimulate metacognitive growth and promote shared meaning-making. Although Harder and Folke do not explicitly discuss personal narrative, it would appear that, such as in Gumley's work, an interest in a developmental perspective necessarily implicates personal narrative. Consistent with the approaches offered by Gumley and Clark and Harder and Folke, Hasson-Ohayon emphasizes intersubjectivity and interpersonal context, as well as recognition of the importance of metacognitive processes within these, and advocates for incorporating intersubjective processes into cognitive interventions, including treatments

such as NECT that explicitly address narrative concerns. All five models described here, while specifying slightly different therapeutic tasks and outcome targets, appear to promote recovery from within this shared conceptual framework.

Conclusions and directions for future research

In summary, in this review we have offered a brief summary of the history of psychotherapy for schizophrenia, focusing on renewed optimism linked with both the recovery movement and the establishment of psychotherapy integration as a defined area of interest. We have suggested that the recovery movement has revealed limitations in traditional approaches to psychotherapy, and has also provided opportunities for integrative approaches to emerge as a mechanism for promoting recovery in persons with schizophrenia. As evidence of this, we have presented five approaches to integrative psychotherapy for schizophrenia and have suggested that these models, while drawing from varied theoretical traditions and employing different technical strategies, are compatible with one another, due to a shared conceptual framework that is consistent with theories of recovery and emphasizes interpersonal attachment, personal narrative, and metacognitive processes.

This review has limitations. As with any discussion that is placed in a historical context, emphasis here is placed on certain trends and aspects of history at the possible expense of others. In this regard, we acknowledge that the history is not as clear as we have presented it, and also that our discussion of recent trends in psychotherapy for schizophrenia focused on the emergence of CBT and psychodynamic approaches, possibly to the exclusion of considering work stemming more directly from the humanistic or phenomenological traditions. Likewise, the integrative models presented here do not comprise an exhaustive list of efforts at integrative psychotherapy for schizophrenia, neglecting, for instance, models of psychotherapy integration from the perspective of phenomenological theory that have been offered elsewhere.[71] In addition, the review did not explore potential implications between the findings here and developments in neuroscience research exploring neurobiological mechanisms involved in psychotherapy, including research suggesting that building metacognitive abilities through specific forms of learning during psychotherapy may also influence brain-based integrative processes as well.[72,73] There is also some evidence that the trend toward integration has begun to gain support even from some working within more specialized traditions, with at least one prominent CBT researcher positing a place for the integration of CBT and psychodynamic psychotherapy[74] after formerly suggesting that the approaches were incompatible.[18] Finally, the integrative models we have presented offer a promising start, but all require testing in future trials.

Importantly, we did not include sometimes-called third-wave behavioral therapies, such as acceptance and commitment therapy (ACT). ACT could be considered integrative in its attempt to incorporate mindfulness concepts into cognitive–behavioral traditions in applications to schizophrenia.[75] Although the efforts of ACT to deemphasize a focus on symptoms in favor of more holistic and subjective outcomes are consistent with recovery, we have chosen not to include ACT among emerging integrative treatments, as it seems less interested in integrating a range of theory in order to develop an understanding of the subjective experiences at play in schizophrenia and the processes by which persons recover, and instead more focused on extending the application of a treatment package to a different clinical group. Certainly, some might take a different stance on this issue, however, and we hope these thoughts stimulate debate on the issue.

Looking at the larger picture, we suspect this work is leading to the creation of a space between cognitive–behavioral and psychodynamic psychotherapy approaches that might allow for truly integrative work. We believe it possible for parallel attempts at integration, rather than competing against each other for superiority, to exist in concert with one another and inform further refinements and integrative efforts within each. However, there are other possibilities, and additional research, clinical work, policy decisions, and the passing of time will ultimately determine what impact integrative psychotherapy will have on trends in the field.

The developments described here raise important implications for future research. For one, the trends toward integration described here are consistent with developments in the broader field of psychotherapy integration in general, beyond psychotherapy for persons with schizophrenia. Psychotherapy integration has been a clearly defined area of interest since at least the 1980s, with many documented attempts made toward therapeutic rapprochement.[76–78] In light of the literature describing psychotherapy integration in general, it appears that both the recovery movement as well as the field of psychotherapy integration in general have formed the research basis that have allowed the emergence of the integrative approaches described here. Future inquiry may better consolidate the literature concerning integrative psychotherapy for schizophrenia and psychotherapy research in general.

A final implication for future research raised by these developments in the field of psychotherapy for persons with schizophrenia is the need not only to conceptualize treatment differently but also to conceptualize and measure outcomes differently. Specifically, we suggest developing strategies for understanding and measuring wellness in a more holistic sense. It would appear, for instance, that questionnaires asking people whether or not they have had specific experiences (positive and negative) may not be entirely sufficient to capture broader changes in how persons "narratize" their own lives and their place in the larger social fabric. Research efforts have just begun to attempt to measure such phenomena as narrative coherence and metacognitive capacity by gathering personal narratives and coding them with quantitative scales, but this work is in its infancy.[65,79,80] Further work needs to be done in this domain, as the development of these types of methods to track both subjective and objective elements of recovery may lead to a deeper understanding of both recovery and the manner by which one may effectively assist persons to pursue it.

Disclosure

The authors have no conflicts of interest to disclose.

References

1. Roe D, Mashiach-Eisenberg M, Lysaker PH. The relation between objective and subjective domains of recovery among persons with schizophrenia-related disorders. *Schizophr Res*. 2011;131:133–138.
2. Scull A, editor. *Madhouses, Mad Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*. Philadelphia: University of Pennsylvania Press; 1981.
3. Freud S. Neurosis and psychosis. In: Strachev A, Strachev J, translators. *Collected Papers, Vol. II*. London: Hogarth; 1957.
4. Fromm-Reichmann F. Psychotherapy of schizophrenia. *Am J Psychiatry*. 1954;111:410–419.
5. Hill LB. Psychotherapy of a schizophrenia. *Am J Psychoanal*. 1957;17:99–109.
6. Searles H. *Collected Papers of Schizophrenia and Related Subjects*. New York: International Universities Press; 1965.
7. Sullivan HS. *Schizophrenia as a Human Process*. New York: Norton; 1962.
8. Knight RP. Psychotherapy of an adolescent catatonic schizophrenic with mutism. *Psychiatry*. 1946;9:323–339.
9. Drake RE, Sederer LI. The adverse effects of intensive treatment of schizophrenia. *Compr Psychiatry*. 1986;27:313–326.
10. Fenton WS. Evolving perspectives on individual psychotherapy for schizophrenia. *Schizophr Bull*. 2000;26:47–72.
11. Grinspoon L, Ewalt JR, Shader R. Psychotherapy and pharmacotherapy in schizophrenia. *Am J Psychiatry*. 1964;124:67–74.
12. May PRA, Tuma AH. The effect of psychotherapy and stelazine on length of hospital stay, release rate, and supplemental treatment of schizophrenic patients. *J Nerv Ment Dis*. 1964;139:362–369.
13. Messier M, Finnerty R, Botvin CS, Grinspoon L. A follow-up study of intensively treated chronic schizophrenic patients. *Am J Psychiatry*. 1969;125:159–163.
14. Mueser KT, Berenbaum H. Psychodynamic treatment of schizophrenia – there is a future. *Psychol Med*. 1990;20:253–262.
15. Tuma AH, May PRA, Yalae C, Forsythe AB. Therapist experience, general clinical ability, and treatment outcome in schizophrenia. *J Consult Clin Psychol*. 1978;46:1120–1126.
16. Hartwell CE. The schizophrenogenic mother concept in American psychiatry. *Psychiatry*. 1996;59:274–297.
17. Lysaker PH, Glynn SM, Wilkniss SM, Silverstein SM. Psychotherapy and recovery from schizophrenia: a review of potential applications and need for future study. *Psychol Serv*. 2010;7:75–91.
18. Kingdon DG, Turkington D. *Cognitive Therapy of Schizophrenia*. Guilford; 2004.
19. O'Connor K, Lecomte T. An overview of cognitive behavior therapy in schizophrenia spectrum disorder. In Ritsner MS, editor. *Handbook of Schizophrenia Spectrum Disorders, Volume III: Therapeutic Approaches, Comorbidity, and Outcomes*. New York: Springer; 2011.
20. Lysaker PH, Davis LD, Bryson GJ, Bell MD. Effects of cognitive behavioral therapy on work outcomes in vocational rehabilitation for participants with schizophrenia spectrum disorders. *Schizophr Res*. 2009;107:186–191.
21. Sensky T, Turkington D, Kingdon D. A randomized controlled trial of cognitive behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Arch Gen Psychiatry*. 2000;57:165–172.
22. Gumley A, O'Grady M, McNay L, Reilly J, Power K, Norrie J. Early intervention for relapse in schizophrenia: results of a 12-month randomized controlled trial of cognitive behavioural therapy. *Psychol Med*. 2003;33:419–431.
23. Bachmann S, Resch F, Mundt C. Psychological treatment for psychosis: history and overview. *J Am Acad Psychoanal Dyn Psychiatry*. 2003;31:155–176.
24. Rector NA, Beck AT. Cognitive therapy for schizophrenia: from conceptualization to intervention. *Can J Psychiatry*. 2002;47:39–48.
25. Dixon LB, Dickerson F, Bellack AS, et al. The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr Bull*. 2010;36:48–70.
26. Wykes T, Steel C, Everitt B, Tarrier N. Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophr Bull*. 2008;34:523–527.
27. Turkington D, Dudley R, Warman D, Beck A. Cognitive behavior therapy for schizophrenia: a review. *J Psychiatr Pract*. 2004;10:5–16.
28. Pilling S, Bebbington P, Kuipers E, et al. Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychol Med*. 2002;32:763–782.
29. Dickerson FB, Lehman AF. Evidence-based psychotherapy for schizophrenia. *J Nerv Ment Dis*. 2011;199:520–526.
30. Rosenbaum B, Valbak K, Harder S, et al. The Danish National Schizophrenia Project: prospective, comparative longitudinal treatment study of first-episode psychosis. *Br J Psychiatry*. 2005;186:394–399.
31. Rosenbaum B, Harder S, Knudsen P, et al. Supportive psychodynamic psychotherapy versus treatment as usual for first-episode psychosis: two-year outcome. *Psychiatry*. 2012;75:331–341.
32. Paley G, Shapiro DA. Lessons from psychotherapy research for psychological interventions for people with schizophrenia. *Psychol Psychother*. 2002;75:5–17.
33. Shapiro DA, Paley G. The continuing potential relevance of equivalence and allegiance to research on psychological treatment of psychosis: a reply. *Psychol Psychother*. 2002;75:375–379.
34. Tarrier N, Haddock G, Barrowclough C, Wykes T. Are all psychological treatments for psychosis equal? The need for CBT in the treatment of psychosis and not for psychodynamic psychotherapy: comment on Paley and Shapiro (2002). *Psychol Psychother*. 2002;75:365–374.
35. Silverstein SM, Bellack AS. A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clin Psychol Rev*. 2008;28:1108–1124.
36. Harrow M, Grossman LS, Jobe TH, Herbener ES. Do patients with schizophrenia ever show periods of recovery? A 15-year multi-follow-up study. *Schizophr Bull*. 2005;31:723–734.
37. Lysaker PH, Buck KD. Is recovery from schizophrenia possible? An overview of concepts, evidence, and clinical implications. *Prim Psychiatry*. 2008;15:60–65.

38. Silverstein SM, Spaulding WD, Menditto AA. *Schizophrenia: Advances in Evidence-Based Practice*. Cambridge (MA): Hogrefe and Huber; 2006.
39. Kean C. Silencing the self: schizophrenia as a self-disturbance. *Schizophr Bull*. 2009;35:1034–1036.
40. Geekie J, Randal J, Lampshire D, Read J. *Experiencing Psychosis: Personal and Professional Perspectives*. Hove, UK: Routledge; 2011.
41. Scotti P. Recovery as discovery. *Schizophr Bull*. 2009;35:844–846.
42. Davidson L. *Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia*. New York: New York University Press; 2003.
43. Resnick SG, Rosenheck RA, Lehman AF. An exploratory analysis of correlates of recovery. *Psychiatr Serv*. 2004;55:540–547.
44. Atwood GE, Orange DM, Stolorow RD. Shattered worlds/psychotic states. A post-Cartesian view of the experience of personal annihilation. *Psychoanal Psychol*. 2002;19:281–306.
45. Horowitz R. Memory and meaning in the psychotherapy of the long-term mentally ill. *Clin Soc Work J*. 2006;34:175–185.
46. Laithwaite H, Gumley A. Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clin Psychol Psychother*. 2007;14:302–316.
47. Seikkula J, Alakare B, Aaltonen J. Open dialogue in psychosis II: A comparison of good and poor outcomes cases. *J Const Psychol*. 2001;14:247–265.
48. Roe D. Recovering from severe mental illness: mutual influences of self and illness. *J Psychosoc Nurs Ment Health Serv*. 2005;43:35–40.
49. Lysaker PH, Lysaker JT. *Schizophrenia and the Fate of the Self*. Oxford: Oxford University Press; 2008.
50. Lysaker PH, Roe D. The process of recovery from schizophrenia: the emergent role of integrative psychotherapy, recent developments, and new directions. *J Psychother Integr*. 2012;22:287–297.
51. Lecomte T, Lecomte C. Are we there yet? Commentary on special issue on psychotherapy integration for individuals with psychosis. *J Psychother Integr*. 2012;22:375–381.
52. Gumley A, Clark S. Risk of arrested recovery following first episode psychosis: an integrative approach to psychotherapy. *J Psychother Integr*. 2012;22:298–313.
53. Harder S, Folke S. Affect regulation and metacognition in psychotherapy of psychosis: an integrative approach. *J Psychother Integr*. 2012;22:330–343.
54. Salvatore G, Russo B, Russo M, Popolo R, Dimaggio G. Metacognition-oriented therapy for psychosis: the case of a woman with delusional disorder and paranoid personality disorder. *J Psychother Integr*. 2012;22:314–329.
55. Lysaker PH, Buck KD, Caricione A, et al. Addressing metacognitive capacity for self reflection in the psychotherapy for schizophrenia: a conceptual model of the key tasks and processes. *Psychol Psychother*. 2011;84:58–69.
56. Lysaker PH, Roe D, Kukla M. Psychotherapy and rehabilitation for schizophrenia: thoughts about their parallel development and potential integration. *J Psychother Integr*. 2012;22:344–355.
57. Pijnenborg GH, Van der Gaag M, Bockting CLH, Van der Meer L, Aleman A. REFLEX, a social-cognitive group treatment to improve insight in schizophrenia: study protocol of a multi-center RCT. *BMC Psychiatry*. 2011;11:161.
58. Yanos PT, Roe D, West ML, Smith S, Lysaker PH. Group-based treatment for internalized stigma among persons with severe mental illness: findings from a randomized controlled trial. *Psychol Serv*. 2012;9:248–258.
59. Hasson-Ohayon I. Integrating cognitive behavioral-based therapy with an intersubjective approach: addressing metacognitive deficits among people with schizophrenia. *J Psychother Integr*. 2012;22:356–374.
60. Gingerich S, Mueser KT. Illness management and recovery. In Drake RE, Merrens MR, Lynde DW, editors. *Evidence-Based Mental Health Practice: A Textbook*. New York: Norton; 2005:395–424.
61. Roberts DL, Penn DL, Combs DR. *Social Cognition and Interaction Training (SCIT): Treatment Manual*. New York: Oxford University Press. In press 2013.
62. Substance Abuse and Mental Health Services Administration. *National Consensus Conference on Mental Health Recovery and Systems Transformation*. Rockville (MD): Department of Health and Human Services; 2005.
63. Davidson L, O'Connell M, Tondora J, Lawless M, Evans AC. Recovery in serious mental illness: a new wine or just a new bottle? *Prof Psychol Res Pr*. 2005;36:480–487.
64. Bruner J. *Acts of Meaning: Four Lectures on Mind and Culture*. Cambridge (MA): Harvard University Press; 1992.
65. Lysaker PH, Ringer J, Maxwell C, McGuire A, Lecomte T. Personal narratives and recovery from schizophrenia. *Schizophr Res*. 2010;121:271–276.
66. France CM, Uhlin BD. Narrative as an outcome domain in psychosis. *Psychol Psychother*. 2006;79:53–67.
67. Hasson-Ohayon I. Exploring the meaning of visual and auditory hallucinations: a commentary on Pixley's discussion of the difficulties in addressing hallucinations during psychodynamic therapy. *J Psychother Integr*. 2012;22:393–396.
68. Safran JD, Muran JC. *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York: Guilford; 2000.
69. Wampold B. *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah (NJ): Lawrence Erlbaum; 2001.
70. Frank JD, Frank JB. *Persuasion and Healing: A Comparative Study of Psychotherapy*. 3rd ed. Baltimore: Johns Hopkins University Press; 1991.
71. Pérez-Álvarez M, García-Montes JM, Vallina-Fernández O, Perona-Garcelán S, Cuevas-Yust C. New life for schizophrenia psychotherapy in the light of phenomenology. *Clin Psychol Psychother*. 2011;18:187–201.
72. Gabbard GO. A neurobiologically informed perspective on psychotherapy. *Br J Psychiatry*. 2000;177:117–122.
73. Kandel ER. Biology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. *Am J Psychiatry*. 1999;156:505–524.
74. Garrett M, Turkington D. CBT for psychosis in a psychoanalytic frame. *Psychosis*. 2011;3:2–13.
75. Bach P, Hayes S. The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. *J Consult Clin Psychol*. 2002;70:1129–1139.
76. Goldfried MR, Pachankis JE, Bell AC. A history of psychotherapy integration. In: Norcross JC, Goldfried MR, editors. *Handbook of Psychotherapy Integration*. 2nd ed. New York: Oxford University Press; 2005:24–60.
77. Wachtel P, Kruk JC, McKinney MK. Cyclical psychodynamics: an integrative relational therapy. In: Norcross JC, Goldfried MR, editors. *Handbook of Psychotherapy Integration*. 2nd ed. New York: Oxford University Press; 2005:172–195.
78. Norcross JC. A primer on psychotherapy integration. In: Norcross JC, Goldfried MR, editors. *Handbook of Psychotherapy Integration*. 2nd ed. New York: Oxford University Press; 2005.
79. Lysaker PH, Ringer JM, Buck KD, et al. Metacognitive and social cognition deficits in patients with significant psychiatric and medical adversity: a comparison between participants with schizophrenia and a sample of participants who are HIV-positive. *J Nerv Ment Dis*. 2012;200:130–134.
80. Lysaker PH, Gumley A, Luedtke B, et al. Social cognition and metacognition in schizophrenia: evidence of their independence and linkage with outcomes. *Acta Psychiatr Scand*. 2013;127:239–247.