The role of interpersonal connection, personal narrative, and metacognition in integrative psychotherapy for schizophrenia: A case report

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Abstract: The recovery movement has not only challenged traditional pessimism regarding schizophrenia, it has also presented opportunities for the possibilities for psychotherapy for persons with the disorder. Though in the past psychotherapy models were often pitted against one another, recently there have been emergent reports of a range of integrative models sharing an emphasis on recovery and a number of conceptual elements. These shared elements include attention to the importance of interpersonal processes, personal narrative, and metacognition, with interest in their role in not only the disorder but also the processes by which people pursue recovery. This paper explores one application of this framework in the psychotherapy of a woman with prolonged experience of schizophrenia and significant functional impairments.

KEYWORDS: integrative psychotherapy, schizophrenia, metacognition, narrative, interpersonal,

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The role and relative prominence of psychotherapy in the treatment of persons with schizophrenia has been debated for over a century, as vacillating attitudes toward the benefits of psychotherapy, emphases on medication and psychosocial rehabilitation treatment, and competing theoretical models of the disorder have all impacted views of psychotherapy as a treatment of choice for persons with schizophrenia. A number of recent trends appear to have once again reignited interest in psychotherapy for schizophrenia. First, cognitive-behavioral treatments for schizophrenia have enjoyed increased attention and research support (Dickerson & Lehman, 2011; Turkington, Dudley, Warman, & Beck 2004). Additionally, a number of recent publications suggest a resurgence of interest in psychodynamic treatment approaches (Harder & Folke, 2012; Rosenbaum et al., 2012). Importantly, both of these trends have occurred in parallel to the recovery movement that has not only challenged conventional pessimism regarding outcomes for schizophrenia, but has also established that recovery in schizophrenia involves both objective and subjective aspects of well-being (Roe, Mashiach-Eisenberg, & Lysaker, 2011), thus highlighting additional possibilities for psychotherapy.

Historically, psychotherapy models have at times been pitted against one another (Paley & Shapiro, 2002; Tarrier, Haddock, Barrowclough, & Wykes, 2002). Potentially signaling a shift away from this tradition, recent literature includes a number of integrative psychotherapy approaches for schizophrenia. These treatment models, while derived from different theoretical influences, do not seem to be in opposition with one another as has often been the case for psychotherapy approaches, but rather appear compatible with each other and share an emphasis on recovery. It appears that the findings from the recovery movement have provided an

opportunity not only for reconsideration of the possibilities for psychotherapeutic intervention, but have also provided a framework that might prompt increased attempts to bring together valuable contributions from literatures that were at time previously viewed as incompatible.

We have previously suggested that the compatibility of these integrative approaches may stem from a conceptual framework emphasizing at least three common elements: interpersonal connection and attachment, personal narrative, and recognition of metacognitive deficits in schizophrenia (Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013). Relying on this underlying framework, integrative psychotherapy approaches aim to 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. Although published case reports exist detailing courses of psychotherapy from specific integrative models (e.g. Lysaker, Buck, & Ringer, 2007; Salvatore, Russo B., Russo M., Popolo, & Dimaggio, 2011), further elaboration of the application of this broader integrative conceptual framework may provide additional value to clinicians' efforts to further integrate and refine therapy approaches.

This paper will offer a brief review of this integrative framework. Following this, we will turn to a case illustration of the early phases of psychotherapeutic engagement with a woman with prolonged schizophrenia experiencing profound functional impairment. The case illustration will offer a view to the therapeutic process, case formulation, and technical considerations when operating within this shared integrative psychotherapy framework. Additionally, an important lesson from the recovery movement is found in the notion that recovery in serious mental illness need not depend on remission from distressing symptoms, but that recovery-oriented treatment approaches might engage the person with serious mental illness, regardless of the severity of symptoms or the prolonged nature of a given person's experience of

the disorder. The case illustration provided here will not only shed light on one possible application of an integrative psychotherapy approach, but we believe also provides an illustration of what recovery-oriented psychotherapy might look like in work with a person who under previous models of care would be labeled 'treatment-resistant' or 'incurable.'

Emergent Integrative Psychotherapy Approaches: A Shared Framework for Recovery

As detailed in a previous review, emergent descriptions of a range of integrative psychotherapy approaches for the treatment of persons with schizophrenia are available, each drawing from differing theoretical backgrounds, with differing technical practices (Hamm, Hasson-Ohayon, Kukla, & Lysaker, 2013). First, drawing from cognitive, interpersonal, and developmental approaches, a psychotherapy model for intervention following first episode of psychosis has been described that attempts to assist the person in restoring a disrupted personal narrative (Gumley & Clark, 2012). Second, integrative supportive psychodynamic psychotherapy models have been suggested (Harder & Folke, 2012; Rosenbaum et al., 2012) that incorporate findings from attachment and intersubjective literatures and emphasize connections between attachment processes and metacognitive deficits. A third integrative approach can be found in psychotherapy models (Salvatore et al., 2012; Lysaker et al., 2011) which place an emphasis on metacognitive deficits and the utilization of narrative episodes within session in approaches generally referred to as metacognition-oriented therapy. These approaches employ cognitive and psychodynamic principles, as well as existential and dialogical models of self-experience. A fourth category for integration found in recent literature, rather than offering a specific integrative psychotherapy model, instead suggests integrating intersubjective approaches with any number of existing cognitive-behavioral based therapies (Hasson-Ohayon, 2012).

Although each of these approaches to integrative psychotherapy draws upon different theoretical traditions and implements different techniques, we suggest that they share the three core elements mentioned earlier: a focus on attachment and interpersonal connectedness, recognition of the importance of personal narrative, and emphasis on the role of metacognitive processes.

Each of these 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 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.

Consistent with the emphasis that recovery involves redefining self, each of these approaches is driven by an understanding of the connection between the coherence and richness of personal narrative and health. Personal narrative as we employ it here does not refer simply to a collection of autobiographical facts, but rather an evolving, meaningful, storied sense of one's life (Lysaker et al., 2010). Common to descriptions of the various approaches are efforts to elicit persons' stories of their lives. Therapy is viewed as a platform to assist clients to evolve and use this storied account to make meaning of their experiences and allow clients to perceive themselves as active agents in the world.

The third element shared by these integrative approaches is attention to metacognition, understood here as the processes by which persons form complex ideas of themselves and others (Lysaker & Dimaggio, 2014). Each of the integrative approaches is concerned with helping patients to identify their own mental states and those of others and to synthesize that information into more complex representations of themselves and others. Consistent with the recapturing of

personhood and directing one's own movements towards recovery, 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 know that people (including themselves) can view events differently at different times in their lives.

A range of techniques appears to be utilized in the different approaches, though it seems to us that the basic conceptual principles appear to be more strongly emphasized than any particular combination of techniques. Despite this apparent de-emphasis on the superiority of a particular technical application, there is still value in exploring how one might practically operationalize and apply this integrative framework in psychotherapy with a person with schizophrenia. As just one example of such an effort, we will now offer a case illustration of the early stages of psychotherapy with a woman with prolonged experience of schizophrenia.

Case Illustration: Simone

Client Description

Simone is a single Caucasian-American female in her late 50s with a long history of involvement in psychiatric services. At the time of referral to her therapist (JH), Simone had been placed on court commitment to treatment, which for the last several years had consisted of requirements to follow prescribed pharmacological treatment, as well as placement in a residential facility. Review of medical records indicated that Simone’s most recent inpatient psychiatric hospitalization was approximately four years prior to beginning therapy. While on commitment, she was reluctantly willing to be administered a traditional antipsychotic every two weeks in the form of a long-acting injection, but refused all oral medications, as well as any additional medical assessments or treatment for any concurrent medical conditions. Per

available clinical history, Simone had continuously experienced prominent delusions and hallucinations. For many years, Simone had demonstrated profound functional impairments. Although generally pleasant with staff, she had limited engagement in milieu treatment services available at the facility, remaining in her room the majority of the time, where she would tend to sit quietly for hours in a chair looking out her window. With prompting, she would come into the common areas for meals, but remained socially isolative, with virtually no social engagement with the other residents or staff. Simone refused to participate in community outings, citing beliefs about "demons" that would destroy her if she stepped outside of the facility. She engaged minimally in activities of daily living such as personal hygiene, and then typically only reluctantly after repeated staff prompting. At the time of the referral she was in possession of minimal belongings, consistently declining staff offers to take her shopping for clothes and other personal items.

Knowledge of Simone's psychosocial history is sparse. For her part, Simone offered only a highly fragmented and impoverished personal narrative. She also has consistently endorsed a range of claims about her life associated with numerous delusional beliefs. She reported that she is hundreds of years old. She reported that she invented jokes, bread, and candy. She stated that she has dozens of children, at times reporting that she is currently pregnant with multiple children. In addition to these claims, Simone expressed a number of persecutory beliefs, including maintaining a range of claims about demons causing her harm and tenaciously endorsing the belief that staff members regularly poison her meals.

Simone's treatment team was able to offer minimal collateral information pertaining to her psychosocial history other than to report the presence of a daughter who would occasionally stop by the facility to visit. Drawing from the available fragments of narrative, it appears that

Simone was born and raised in the Western United States, and relocated to the Midwest with some members of her family when she was either an adolescent or young adult. She reported having maintained some factory work during a portion of her life, but her account of this tends to be so fragmented and intertwined with grandiose and persecutory claims that it is difficult to discern much of her work history. She reported having attended high school through the 8th or 9th grade, but similar to her reports of work, her descriptions of her educational experiences are quite fragmented and clouded by delusions.

Case Formulation

In terms of diagnosis, Simone met full criteria for schizophrenia. She demonstrated a long history of tenaciously held delusions, daily auditory hallucinations, and disorganized thought processes. She also experienced a range of negative symptoms, including social detachment, restricted range of affective expression, diminished self-care, and avolition. There was a marked loss of the sense of personal agency, with Simone attributing nearly every decision to the direction of supernatural beings who spoke to her continuously. In a related sense, she appeared to have substantial deficits in her ability to form complex mental representations of herself and others, and even graver difficulties in utilizing this type of information to assist her to navigate life challenges. She was initially unable to voice a psychological problem, stated that she had no thoughts of her own, though also stated that she knew everyone's thoughts (which were all the same), and in a more synthetic sense, was utterly unable to form and share an account of her life with another person, being entirely dependent upon delusional fragments to describe her experience. She generally viewed the residential staff as sources of persecution, despite remaining generally polite in her demeanor toward them.

In short, Simone not only appears to have experienced prolonged schizophrenia, but her degree of disability and her long history of reluctance to engage voluntarily in treatment would likely be considered through conventional models of treatment as a poor candidate for psychotherapy, due to being 'treatment resistant.'

Course of treatment

Simone was referred to JH by residential staff, not for psychotherapy per se, but rather for evaluation and recommendations for the residential staff in their efforts to address Simone's refusal to go outside of the facility. Weekly psychotherapy sessions commenced following the initial consultation. Sessions lasted between 40-50 minutes and Simone never ended a session early. Although Simone was on legal commitment to treatment and placement at the facility, her involvement in psychotherapy was voluntary.

At the time of the initial consultation, her therapist had been told that Simone had not left the facility in nearly a year, due to her reports that demons would destroy her. In the initial visit, Simone met with JH in an office inside the residential facility, where she offered a fragmented account of her experiences and motivations for her unwillingness to follow the recommendations of the residential staff to participate in recreational activities, sign paperwork, go shopping for new clothes or personal hygiene products, or to bathe regularly. Her therapist avoided aligning with these mandates, and instead asked basic questions about Simone's subjective experience. JH asked how long she had been at the facility, asked her to describe interactions with staff, and how she spent her days. Despite the high level of disorganization and interference from delusions, it was clear that Simone displayed an intact sense of humor, and responded favorably to judicious use of playfulness in session. After the first session or two, JH gently inquired if sessions could be held on the screened porch of the facility. Simone indicated that she would be

safe from the demons on the porch, and they sat outside. As rapport began to develop, interventions relied primarily on basic reflections highlighting Simone's cognitive functions in the moment (e.g., "You are having a thought that...", "You are remembering…"). JH inquired about her life, and asked for specific narrative episodes. Early on, these were generally sparse and interwoven with a range of grandiose and persecutory reports. However, with continued effort to avoid focusing entirely on symptoms and a willingness to consider how Simone was making meaning of these episodes of her life, JH began to discover remnants of a personal narrative. Simone believed that she was constantly harassed and intruded upon by demons, but she also could briefly remember that when she was young she enjoyed the music of Bob Dylan and Ray Charles. She believed the staff members were trying to poison her at meal times, but she also remembered that she used to enjoy sitting on a porch drinking tea with a neighbor. Exploration of these past experiences was a precarious endeavor, as her therapist would notice that if he asked her a question that sounded too clinical, or inquired in a manner that required a more complicated mental representation of her experience, Simone would tend to respond with increased delusional content and/or occasional suspicious accusations that JH was playing dumb about something he already knew.

After only a few sessions, and without reference to the threat of demons, Simone agreed to hold therapy sessions at a bench in the courtyard outside of the facility. At approximately this stage, JH learned that Simone had also agreed to go into the community with staff and the other residents for ice cream. A few weeks later, Simone informed JH that she had gone on another outing, this time for a cookout with the other residents. The week after the 12th session, Simone agreed to allow a staff member to take her shopping for some new clothes and other personal items. Of note, after each of these latter two outings, which the residential staff appeared to view

as tangible positive developments, Simone presented in the following therapy session with increased delusions, negative reports of her experience in the community, and decreased ability to offer narrative material. Staff reports though suggested that outside of these sessions, Simone was pleasant and in good humor on the outings, with increased responsiveness and friendliness to staff upon return to the facility.

Both the staff and Simone's therapist felt increased optimism following these objective developments. Shortly following the shopping trip, though, Simone experienced a major loss, as she was informed that her daughter had died suddenly. JH was notified by staff of the death and that Simone had been informed of the loss, and met the following day for a scheduled appointment. Without prompting, Simone disclosed to JH her loss, and with increased affective expression described the tremendous pain she was experiencing as a result. Although her account was limited and relied heavily on concretized descriptions of her painful affective states, remarking "I have a great pain here" while pointing to her chest, she allowed herself to shed tears and sat quietly for much of the session. She shared with JH that her daughter had been removed from her care by child protective services when she was a small child to be raised in a foster home, and that she had been reacquainted with her when she was an adult. She reported that her daughter had also long been prescribed psychiatric medications. While these reports were sparse, they struck her therapist as particularly poignant, conveying a tenderness of emotion and vulnerability that was often kept at bay in prior sessions. During this conversation, there was limited interference from delusions or hallucinations.

The sessions that have occurred following this loss have involved a combination of discussing the ongoing experience of loss, frustration, and disappointment at being unable to live with her family, as well as acknowledged difficulties in understanding and remembering her life.

She has disclosed that she is informed by the "demons" of a range of different activities that she has no memory of but is led to believe occurred in her life. These inform a belief of having lived longer than her chronological reported age, and include confusion about being told that she spent ten years incarcerated for murder, despite having no personal memory of this (no collateral information to suggest that this event occurred). Increased focus has developed on Simone's longing to "return home" to live with family, and clearer descriptions of her perceptions of compulsory involvement in psychiatric services. Most recently, Simone mentioned having been connected with numerous therapists over the years, and noted that they had always emphasized monitoring whether or not she had been taking her medicine and inquiring about side effects.

Integrative Framework Components

Interpersonal Connectedness. From a technical perspective, the early phase of treatment has involved major emphasis on the establishment of therapeutic alliance. Rapport-building has been pursued through direct but gentle inquiries into her lived experience, along with selective and intentional use of self-disclosure by the therapist. JH resisted inquiring solely about Simone's symptoms of dysfunctional beliefs and rather than aligning with the demands and desires of Simone's residential team, he allowed space for intersubjective processes to develop in the context of a therapeutic relationship. The prominence of delusions and disorganization in speech has prompted JH to monitor and resist internal responses of hopelessness and pessimism for Simone, attitudes she appears to have commonly faced in her treatment providers in her treatment history. In a possible paradox, JH at the same time has found the need to resist adopting an overly protective approach to Simone, an internal response possibly triggered by JH's perceptions of pessimism of others toward Simone's prognosis.

Early on, inquiries into interpersonal experiences relied on exploration of Simone's interactions with the facility staff. This progressed to reflection on interactions between Simone and JH. As rapport developed and Simone was increasingly able to offer fragments of narrative, thus allowing JH the opportunity to form a more integrated conceptualization of her, opportunities became available to inquire about her interactions with her daughter, as well as memories of her family of origin. Though these reports were initially quite difficult to follow, gentle persistence and curiosity has led to the emergence of a generally consistent narrative of a close relationship Simone had with one of her cousins throughout childhood. When her daughter died, additional information emerged as Simone remembered and shared how difficult a loss she had suffered when this beloved cousin had died several years ago.

Her reports of her relationships with the residential staff have also become relatively richer over time as well. She now will discuss certain staff members by name in contrast to making general remarks about the entire group, and will now offer thoughts about specific interactions with them. For instance, she reported appreciating a staff member who sat quietly with her the evening she was notified of her daughter's death. She also has been able to share in more specific terms particular perceived slights and insults she has detected from staff during the few outings she has engaged in during the course of therapy.

Regarding the therapy relationship, rapport has continued to develop slowly but steadily. Simone will occasionally become upset and seem to indicate the belief that JH has willfully neglected not only his ability to hear the voices she hears, but also his knowledge of the various atrocities she regularly experiences. In an effort to address this, JH will make direct and honest reflections about the apparent difference between his thoughts and Simone's. At other times, JH has been compelled to directly tell Simone that he has no intention to harm her, and in other

moments has stated directly that while his intention is to understand her, there are times when he does not. These interventions have at times been made with a playful, self-deprecating tone regarding his own limitations, while at others have taken a more direct, matter-of-fact tone. Simone has consistently been responsive to these, often directly thanking JH. These more difficult and explicitly distrusting moments tend to be transient, and Simone is generally quite pleasant. Efforts have been made throughout to avoid an "expert" stance, opting instead to attempt to reduce the hierarchical dynamic and establish a "consultant" role as therapist. Of note, intentional effort has been made in these interventions to avoid offering significant amounts of warmth or sympathy, as it appears that Simone often feels further threatened or potentially patronized when staff adopt these more nurturing stances toward her. Simone appears to have responded favorably to these efforts, often adopting a familiar, collegial tone in her interactions with JH.

Importantly, focused efforts are made every session to identify and address possible ruptures in communication and the therapeutic alliance. Near the conclusion of each session, JH inquires about Simone's view of that day's conversation, and also if there were any moments in which he seemed to fail to understand her. In a recent session, Simone noted a specific comment in which she believed JH "smarted off" to her. JH responded by honestly noting that he has been accused of smarting off throughout his life, and that he had not intended to do so with Simone. Simone noted that she had been similarly accused of this, thanked JH for his efforts, and offered that maybe they could both work together to improve this habit. These exchanges require the therapist to not only be able to tolerate a good deal of uncertainty in session, but also to be willing to demonstrate vulnerability as an important and intentional component of the interventions.

Personal Narrative. Psychotherapy with Simone has relied heavily on the role of personal narrative from both a conceptual and technical perspective. Conceptually, at the outset of therapy, Simone was seen as a person whose personal narrative had been utterly disrupted. She was unable to articulate a storied account of herself as a multi-dimensional person existing across a span of time. Her personal narrative was thus profoundly impoverished and fragmented. The majority of her autobiographical remarks in the first few sessions were characterized by grandiose and persecutory claims.

Throughout therapy, JH focused on attempting to elicit narrative episodes. Early on, these were heavily colored by delusions, or were only sparse fragments from her childhood and early adulthood that were not grounded in discrete memories or events from her life. In an effort to counter Simone's early claims of not having thoughts and being unable to remember her life, JH attempted to key on any indication of a previous interest or non-threatening experience. Once Simone disclosed her interest in music, JH inquired about specific artists she liked. After discovering specific favorite songs from her past, for a few sessions, JH called up one of these songs on Youtube and played it for Simone. This not only provoked the emergence of positive affects, but also stimulated brief narrative episodes related to the time in her life during which she had enjoyed that particular song.

From a technical perspective, JH's efforts at elicitation of narrative episodes focused on a descriptive level of exploration. Rather than inquire about Simone's explanation or theory for why something might have happened in a given narrative episode, JH attempted to elicit as many descriptive details of the memory as Simone could provide. In fact, as Simone tended to drift into explanations that were highly colored by delusional content, gentle redirection back toward descriptive aspects of episode in question was a central aspect of JH's activity.

JH attempted to understand these narrative episodes and see how they related to Simone's current situation. After a few sessions, Simone acknowledged difficulty in remembering her past, and appeared to express some desire to be able to better access autobiographical memory, though she also acknowledged ambivalence due to ostensible extensive amount of painful memories from a life characterized by disorder and disappointment. Most recently, Simone has shared some discrete narrative episodes that have increased detail and also appear linked with discrete painful affective states. As therapy continues, these episodes appear relatively less fragmented from one another, beginning to slowly lay the foundation for coherence of a personal narrative, albeit one rife with emotional distress, disappointment, and confusion.

Metacognition. Simone is conceptualized as someone with pronounced deficits in synthetic metacognitive capacity. In the initial consultation, she appeared to have virtually no ability to develop or articulate a complex mental representation of herself, her therapist, or any others. It appeared difficult for her to form an idea of others having separate lives, a difficulty underlined by the prominent persecutory/grandiose delusions that generally placed her in the center of all activity. Additionally, there appeared to be little ability to identify a plausible problem, and her strategies for managing apparent distress were restricted to isolating in her room and refusing to follow suggestions of staff.

Rather than adopting interventions that Simone appears to have encountered repeatedly in other treatment contexts, JH has endeavored to not focus on symptoms, but to tailor interventions at the perceived level of Simone's metacognitive capacity, attempting to offer questions and reflections that invited her to slowly attempt more complicated forms of self-reflection and consideration of others' mental states. Early on, JH would share observations of Simone's demonstrated cognitive operations and would draw her attention to the events taking place inside

her mind to increase her awareness of them (e.g. “You are thinking that…”; “You have the idea that…”; “You are having a memory of…”; “You wish that…”).

In a brief period of time, there is evidence of some fluctuation in her metacognitive capacity and early indicators of progress in developing enhanced metacognition. She now has the ability at times to identify and distinguish between her own cognitive processes, and she has some ability to identify affective states. As more affect has emerged, and Simone has shown indications of increased ability to engage in reflective acts, the reflections have likewise been modified to match her more complex metacognitive abilities. JH has increasingly framed comments such as “it is difficult to discuss this…”, “it seems like it feels good when we talk about these memories…”, or “you get upset when I don’t understand you.” These subtle shifts in the wording of reflections have been based upon ongoing informal clinical assessment of metacognitive activities with the intention to generally intervene at the level of perceived capacity.

There continues to be limited evidence that Simone can acknowledge that her own thoughts are fallible, or to begin to integrate cognitive functions and affective states to make sense of experiences in her life. She appears to be beginning to form an idea about JH and his thoughts, though she still has limited acceptance that she does not always know his thoughts or that JH might not share a particular belief or perceptual experience with her. She is better able to identify plausible psychological problems and has moved away from only discussing persecutory beliefs about demons, and instead more regularly directs her frustration toward her placement in the residential facility, acknowledges sadness and grief over her inability to be with family, and recently, tremendous shame and regret over past actions. Additionally, the sessions

immediately following the unexpected death of her daughter involved the emergence of grief reaction that was generally consistent with that of a person without prolonged psychosis.

Outcome and Prognosis

Psychotherapy with Simone is ongoing and remains in the relatively early stages relative to her long-standing impairments and involvement in other forms of treatment. Despite this, there have been a number of promising and positive developments even at this early stage of engagement that appear at odds with previously held pessimistic views of the possibilities available to Simone. Symptomatically, Simone continues to experience high levels of positive and negative symptoms. However, since beginning therapy interference from these symptoms has reduced enough to allow for occasional involvement in community activities. They also have proven to interfere markedly less in therapy sessions, despite remaining often present during portions of sessions. Of note, no medication changes have been made during the course of therapy. Simone remains prescribed a maintenance dose of a long-acting injectable traditional antipsychotic.

Simone remains isolative in the home, but appears slightly more receptive to suggestions from staff and has gone with the other residents on multiple outings. Additionally, she displays increased affective reciprocity and is showing subtle increases in her ability to reflect upon her own mental states in therapy, identifying cognitive functions as well as a range of affective states related to plausible psychological problems. She now acknowledges that she has a number of painful memories from her past, and tremendous distress and longing over her inability to live with and care for her family. She is able to identify and discuss specific frustrations associated with the often compulsory nature of her involvement in psychiatric services over the years.

With regard to prognosis, Simone's long history of impairment and lack of supportive social network in the community continue to pose significant barriers to recovery. However, the promise shown by the positive developments and progress noted in a relatively brief therapeutic engagement instill optimism that Simone could continue to develop and pursue recovery goals, even in the face of persistent symptoms.

Clinical Practices and Summary

We believe that the work with Simone highlights a number of implications for clinical practice. As has been suggested elsewhere, successfully engaging Simone in psychotherapy underscores apparent possibilities for psychotherapy, even in cases of the most profound states of disorder. As demonstrated here, meaningful engagement in integrative psychotherapy with a focus on recovery does not require that a person achieve improved functioning and decreased symptomatology before being able to benefit from psychotherapy. Indeed, adopting the framework suggested may help clinicians to tailor interventions that might assist persons even with severe symptoms of psychosis to begin to make sense of their experiences and pursue recovery.

In this regard, it is clear that for the clinician a genuine belief that recovery is possible even in the most profound states of disorder and that an openness to making sense of even the most unusual sounding experiences must be implicit in the approach. Additionally, we believe that while varied technical approaches might be similarly effective, adopting the framework described above seems to naturally lead to an emphasis on self-disturbances as being viewed as a core problem in schizophrenia. Integrative models allow for the flexibility to address these self-disturbances as well as providing an effective framework for early engagement. In this manner, integrative models such as this may not only allow for a richer theoretical grounding linked with

psychopathology research and recovery, but also may better accommodate a technical approach that allows for creativity and flexibility in designing interventions. The flexibility offered by integrative approaches creates optimism and adaptability in the treatment of psychosis and offers a valuable avenue to help assist persons in pursuing recovery.

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