Abstract

Objective: Increasing evidence supports the efficacy of body-oriented psychotherapy for schizophrenia. Yet, so far no research has investigated outcome in relation to therapy process: why and how body-oriented psychotherapy is effective. In this study we qualitatively explore participants' experience of a manualized body-oriented psychotherapy (BPT) for schizophrenia to shed light on the process of therapeutic change. Method: We conducted in-depth interviews with 6 participants who completed a 10-week BPT group intervention. Interviews explored participants' experience of change and helpful aspects of therapy and were analysed using interpretative phenomenological analysis. Findings: We identified 6 master themes across the interviews: (a) Being a whole: body-mind connection; (b) Being agentic and being able; (c) Being unique and worthy: being accepted for who one is; (d) Changing interactions: engaging in authentic interpersonal contact; (e) Being part of a group: feeling integrated; (f) Hope and investing in the future. Conclusion: We discuss the clinical implications for each theme and bring the findings together by describing therapeutic change in schizophrenia as a recovery of sense of self at different but interlocked levels.

Moreover, we put forward recommendations for both specific and common factors for schizophrenia therapy.

Keywords: process research, psychosis/severe mental illness, qualitative research methods, body-oriented psychotherapy, interpretative phenomenological analysis

Toward the recovery of a sense of self: An interpretative phenomenological analysis of patients' experience of body-oriented psychotherapy for schizophrenia

Body-oriented psychotherapy (BPT) is a clinical approach that focuses mainly on implicit and pre-reflective experience: it mostly makes use of nonverbal techniques, focusing on processes such as bodily resonances, body memory and embodied affectivity (Fuchs & Koch, 2014; Koch, Caldwell, & Fuchs, 2013; Röhricht, 2000, 2009). BPT is underpinned by embodied and phenomenological approaches that describe and explain human experience as being always rooted in the body and dynamically embedded in the physical and social environment (Koch & Fischman, 2011; Röhricht, Gallagher, Geuter, & Hutto, 2014). According to this perspective, psychological processes emerge from the continuous interaction between organism and environment, and even the most basic mechanisms of perception are influenced and shaped by the meaningful interplay involving the moving body, the way it makes sense of the world and the environment (Thompson, 2007). Because perception, cognition and

emotion are tightly intertwined and rooted in the body, BPT considers as necessary the inclusion of bodily and pre-reflective aspects in the treatment of psychological disorders (Galbusera & Fuchs, 2013; Röhricht, 2009). Affective neuroscience and developmental psychology support this view by showing the direct link between emotions and movement (e.g. Gallese, 2005) and the important ontogenetic role played by implicit, pre-reflective and non-representational processes, especially in early infant development (e.g. Fivaz-Depeursinge & Corboz-Warnery, 1999; Reddy, 2008).

Although the focus on the body and pre-reflective experience is a general common tenet of BPT, a specific and unified theoretical background that defines this field of psychotherapy and distinguishes it from other therapeutic approaches is still missing (Röhricht, 2009). BPT includes a rather heterogeneous range of therapeutic models, which are -to different extents- influenced by the main therapeutic schools (Röhricht, 2000). In the present paper, we focus on the specific BPT intervention Röhricht (2010) developed for schizophrenia, especially for chronic patients.

BPT and schizophrenia

BPT for schizophrenia was initially introduced by the pioneering work of Swiss dancer and performer Trudy Schoop. She viewed schizophrenia as a fundamental disorder of the self and therapy as aimed at re-building the 'patient's disintegrated ego-structure'. She observed in these patients a basic disconnection from their bodies and thus integrated in her clinical work nonverbal means such as body rhythms, embodied

emotional expression, perception of body postures and boundaries, and experience of interaction through the moving body (Schoop, 2000, 2007). These therapeutic techniques became known as *body-ego techniques* (Goertzel, May, Salkin, & Schoop, 1965; May, Wexler, Salkin, & Schoop, 1963). Schoop's therapeutic principles were further developed by Scharfetter (1999), who defined schizophrenia as a disorder of ego-consciousness (Scharfetter, 1981). Ego-consciousness is described as a basic and pre-reflective sense of self: the experience of being a vital and self-present subject of experience, self-determining and separated from others, a unit of body and mind, identical and coherent in time. Scharfetter (1999) thus delineated specific therapeutic techniques that directly address these aspects of pre-reflective ego-experience.

The conceptualization of schizophrenia as a disorder of the self is shared by different clinical and philosophical approaches, including phenomenological psychiatry, which places a particular emphasis on the bodily and pre-reflective level of selfhood (Parnas & Henriksen, 2014). Contemporary phenomenological psychiatry indeed describes the core disturbance of schizophrenia as an ipseity disorder, i.e. a disturbance of the pre-reflective sense of being a first-person subject of awareness and action (Parnas & Sass, 2001; Sass & Parnas, 2003). The phenomenological exploration of the bodily and pre-reflective disturbance in schizophrenia (Sass & Parnas, 2003; Parnas et al. 2005, Fuchs 2005) informs the theory and practice of current BPT (Röhricht, 2009).

Phenomenological theories of schizophrenia accord well with Scharfetter's (1981) definition of ego-disorders, which in turn offers more empirically oriented and clinically applicable notions and descriptions. Scharfetter's therapeutic techniques have been recently systematized and integrated by Röhricht (2010) into a manualized and standardized BPT group intervention for schizophrenia.

Specific therapeutic techniques are described in Röhricht's (2010) treatment manual and are organized according to five different phases, in which each therapy session is structured: opening circle, warm-up phase, structured tasks phase, creative phase and closing circle (for a description of these phases see also Röhricht & Priebe, 2006). In the opening circle participants take part in "ice-breaking" activities that promote interaction and the overcoming of communication barriers. Both verbal interaction, activity-based tasks and use of objects are integrated to this aim. In the warm-up phase different nonverbal techniques are used to promote self-awareness and reality-testing through the body: e.g. grounding techniques, self-exploration of body surface and body-parts, exploration of the personal kinesphere and of the natural body rhythms (e.g. heart beat, breathing).

Structured tasks, which are introduced in the next phase, specifically address anomalous experiences typical of schizophrenia, such as loss of boundaries, alteration of body-schema and feeling of disconnection (social withdrawal). For example, the use of bodily expressiveness, interpersonal distance and posture play a crucial role for

supporting constructive experiences of interaction, boundaries and emotions. In the creative phase, more freedom and more room for spontaneity and initiative is left to participants. The focus is on the development and exploration of patients' creative potentials. Different objects and prompts such as balls, coloured tissues and musical instruments can be used to support activities. Finally, the closing circle serves as a space for verbalization and integration of experience. Bodily techniques such as guided relaxation, breathing exercises and self-massages can be used as a means to a gradual closure of the group process.

Investigating the process of therapeutic change

BPT has received increasing clinical and scientific recognition for its efficacy in the treatment of schizophrenia (Röhricht, 2009; Xia & Grant, 2009). The manualization of BPT by Röhricht (2010) has also allowed the implementation of randomized controlled trials showing a significant reduction of patients' negative symptoms after BPT (Priebe et al. 2016; Röhricht, Papadopoulos, Holden, Clarke, & Priebe, 2011; Röhricht & Priebe, 2006; Martin, Koch, Hirjak & Fuchs, 2016). These results are even more significant if one considers the lack of effective treatment for negative symptoms (Arango, Buchanan, Kikpatrick, & Carpenter, 2004) and the impairing side effects of pharmacological treatment (Leucht, et al. 2013). In a comparison with other clinical trials, Röricht and Priebe (2006) have found that manualized BPT improved negative symptoms (mean reduction of 20-25%) better than atypical antipsychotic (mean

reduction of 3-15%). Beyond the symptomatic improvement, a recent study has also shown that BPT improves patients' pre-reflective social relations, which were behaviourally assessed with interactional bodily synchrony measures (Galbusera, Finn & Fuchs, 2016).

Notwithstanding the positive results of these outcome studies, so far no research has been done on the actual therapeutic change process of BPT. Randomised controlled trials measure intervention outcomes, but do not provide information on how or why it is achieved. By adopting a change process research framework (CPR; Greenberg, 1986), this study aims at investigating the relation between specific BPT processes and outcome, to inform and support the clinical practice as well as to further improve therapy manual guidelines (Elliott, 2010; Goldfried & Wolfe, 1998; Orlinsky, Rønnestad, & Willutzki, 2004). We conceive of the present study as theory-building qualitative research in the sense of Stiles (2007). In contrast to RCTs' statistical hypothesis-testing, which is limited to the confirmation or rejection of a specific statement, exploratory qualitative research can indeed contribute to the very construction and development of a theory.

Within the CPR framework there has been a growing awareness that in order to understand how psychotherapy facilitates change we should consider the experience of the subjects of change (Hodgetts & Wright, 2007; Knight, Richert, & Brownfield, 2012; Elliott, 2008). Elliott (2010) has also advocated for the use of qualitative methods for

grasping the complexity and depth of the phenomenon at stake. Following these lines of research, in this study we directly asked patients about what they found helpful (or hindering) in therapy (*helpful factor design*; Elliott, 2010) and aimed at getting a qualitative in depth understanding of their experience.

Patients' first-person experience is not per se a guarantee of validity; several influencing factors (both at the individual, interpersonal and contextual level) play a role in the process of verbally expressing a recalled experience in a specific intersubjective context. These aspects should be thus taken into consideration when attempting to understand participants' experience. In a previous paper (Galbusera & Fellin, 2014) we discussed the methodological issue of how to validly gauge the first-person experience of others in clinical research. We briefly critiqued the Interpretative Phenomenological Analysis method (IPA; Smith, Flowers, & Larkin, 2009) as a useful qualitative method for understanding research participants' experience (Brocki & Wearden, 2006). Whereas IPA strives to grasp an understanding of the other that gets as close as possible to the person's original experience, it also takes into account all the contextual aspects in which meaning is embedded and co-constructed, including the researcher's expectations and subjectivity, at both conscious and tacit level. From a phenomenological-hermeneutic stance, understanding others takes the form of an interpretative and collaborative endeavour that unfolds in a circular movement, which goes from the participant, to the researcher and back (Smith et al., 2009).

In this paper we thus use the IPA method for analysing patients' experience of BPT. The aim of this analysis is to get a fine-grained understanding of how participants experienced therapeutic change and to identify, across participants' accounts, common themes regarding helpful aspects of BPT.

Method

Participants

Seven participants were initially recruited for the BPT program: six of them completed it, one dropped out after three therapy sessions and could not be included in the study[1]. Six participants were thus included in the study, two women and four men aged between 38 and 57. Five participants were White and native German speakers, whereas one belonged to a different ethnic group, with different mother tongue. Yet, this participant also had a good knowledge of the German language[2]. The inclusion criteria were a diagnosis of schizophrenia spectrum disorder F20- F29 (with exclusion of F23- acute and transient psychotic disorder) according to the ICD-10 (1992). Exclusion criteria were substance induced psychosis, inpatient treatment, intellectual disability and organic brain syndromes. All participants were treated in outpatient

[1] The participant who dropped out was a woman diagnosed with a schizoaffective disorder. Her younger age, different needs and expectations might have contributed to the interruption of treatment.
[2] To preserve confidentiality, the ethnicity and mother tongue of this participant will not be specified.

setting at the time of recruitment and throughout the whole intervention. This included pharmacological therapy and occasional meetings with the treating psychiatrist[3]. All participants suffered from a chronic condition as they had a previous history of relapses and hospitalizations for several years (>10). Participants were informed about the study procedure and their right to withdraw and they all gave written informed consent, agreeing to the use of audiotaped material for research purposes. Data were treated confidentially and we used the following pseudonyms to ensure anonymity: Martin, Wolfgang, Carlo, Sebastian, Hanna and Franziska.

Procedure

This study was implemented at the Clinic for General Psychiatry of the University of Heidelberg, with the approval of the ethical committee of the medical faculty. It is contextualized within a larger multicentre clinical trial on the efficacy of BPT and constitutes a qualitative complementation of the quantitative studies conducted within this framework (Martin et al., 2016; Galbusera et al., 2016).

Participants took part in the BPT manualized intervention, led by a qualified BPT therapist together with two co-therapists; LG (first author) participated as co-therapist[4]. According to the manual guidelines (Röhricht, 2010), the treatment program

[3] During the BPT treatment, participants did not receive other types of psychotherapy on a regular basis.
[4] Before the beginning of the intervention, the therapist and co-therapists participated in a training workshop on the BPT manual, held by Frank Röricht and Nina Papadopoulos. LG is a clinical psychologist, the other co-therapist was a novice.

was implemented in a group therapy format and included twenty 90 minute biweekly sessions. Upon completion, all six participants were interviewed by LG about their experience of psychotherapy (mean duration of interviews: 57min). Qualitative interviews followed the semi-structured script of the Change Interview (Elliott, Slatick, & Urman, 2001), which explores participants' experience of psychotherapy and its helpful and hindering aspects, with a particular focus on experienced therapeutic change. Since the focus of this study is on BPT, the original script was integrated with an additional area of investigation concerning how patients experienced their body and change at this level.

Interviews were conducted according to qualitative and phenomenological principles (Knox & Burkard, 2009; Nordgaard, Sass, & Parnas, 2012). They followed a rather unstructured, conversational pattern, and the focus was mainly on the participants and on what was relevant for them. Participants were encouraged to ground their answers in specific examples or description of significant moments in order to avoid general and abstract answers and to increase the richness and validity of descriptions.

Analysis

IPA was performed by LG following Smith et al.'s (2009) guidelines. After reading the transcripts several times for familiarization, the first emergent themes were

identified through a process of initial coding, which included descriptive, linguistic[5] and conceptual comments. The emergent themes were then grouped into higher-order categories, creating a list of superordinate themes for each interview. After having analysed each interview separately, connections among the superordinate themes across the interviews were looked for. Thereby, six common master themes that are significantly present for all the participants were identified. Although the emergent and superordinate themes expressed a great deal of complexity spanning across the different topics of the Change Interview, the focus of this last analytical step was specifically on the experience of therapeutic change and on the helpful aspects of therapy.

The last step of the analysis consisted in tracking back each theme to the correspondent quotes in the text, in order to check for the rigor and trustworthiness of the interpretation. According to the principle of "interpretation from within" (Smith et al., 2009), all interpretative accounts throughout the analysis steps were checked against the narrative from which they emerged. The authority for the interpretation therefore relied on participants' words, rather than on preconceived theories or expectations. To ensure transparency, an audit trail of the analysis was kept, so that each analytic step from the transcript to the master themes (and the other way round) can be tracked.

[5] At this stage, aspects of para- and nonverbal behavior, emotional tone of conversation and the specific feelings and impressions of the interviewer were integrated in the analysis. To this purpose, LG wrote detailed minutes immediately after each interview. Although the IPA guidelines do not require such a detailed integration of the recollection of interview in the coding procedure, those recollected aspects provide important information about the implicit and relational context of the elicited data, which we believe is extremely important for the analysis process (see also Galbusera & Fellin, 2014)

Thereby, LF (second author) could independently check the trustworthiness of the analysis. Five master themes were initially identified by LG (for preliminary results see Galbusera, 2014); after discussion with LF, we added one master theme concerning the intersubjective dimension of therapeutic change.

Reflexivity

Whilst we do not have a specific commitment to BPT as a therapeutic approach, we did expect that the results of this study would reflect some of the main principles of BPT. We therefore anticipated that patients would report that factors specific to the BPT model were helpful to them. Our findings ran contra to these expectations, instead indicating the therapeutic value of the so-called common factors of psychotherapy (see below, results and discussion sections). LG's expectations towards BPT specific helpful factors became evident in the IPA preliminary results (Galbusera, 2014), where the intersubjective dimension of therapeutic change was mostly left out. LF, who is an experienced psychotherapist but also external to the BPT field, noticed and stressed the central role that intersubjective common factors played in the participants' words.

LG participated in BPT as co-therapist, conducted the research interviews, and implemented the IPA analysis. Her intense involvement in all the research phases allowed a more complex and nuanced understanding of the therapeutic process. In the interview setting, a sharing of deep and emotional experiences was enabled by the trusting relationship established between patients and LG during the course of the BPT.

In order to engage with her own feelings and expectations in a controlled and systematic manner, LG used detailed recollections of interview, supervision and discussion with co-authors.

Language and translation issues influenced both the interview and analysis process. During interviews, not being a native German speaker was both a hindrance and a resource for LG. As sometimes she could not understand some expressions or words (especially dialectical ones), she continuously asked for clarifications (thus engaging in a sort of continuous respondent validation of semantic meaning), which allowed for richer and more precise descriptions[6]. To ensure accuracy, the verbatim transcription of interviews was implemented by a first language researcher. Descriptive coding was performed by LG in German, while the linguistic comments were annotated in English for a three-fold reason. First, at this stage the shift from the participant's point of view to the researcher's own observational stance and reflections is pivotal. Second, all the meaningful instances related to the very translation process (e.g. German words that do not have English translation, particular dialect expressions) could directly be annotated within the linguistic codes. To deal with linguistic issues, LG also used constant discussion and supervision by researchers who are native German speakers. Thirdly, this enabled LF's independent audit.

[6] See, for example, the first quote reported in the theme "Being a whole: body-mind connection".

Summary of findings

We identified six master themes related to participants' experience of therapeutic change. The sub-themes express the nuances of meaning within each master theme. All master themes and sub-themes are listed in Table 1. We here only aim at conveying the core meaning of each master theme, without going into the details of each sub-theme[7]. (Please insert Table 1 about here)

Being a whole: body-mind connection

A first aspect of therapeutic change in BPT regarded the way participants experienced themselves as subjects: a shift from disembodied to embodied subjects. In contrast to a sense of fragmentation and detachment from the body, participants described the feeling of being a whole body-mind unity:

> Wolfgang: Therapy was constructive for body and soul.
> Interviewer: What do you mean by "constructive for body and soul"? (…)
> W: Constructive? Well, supportive.
> I: Ah ok, supportive.
> W: Yes and... And… mh, constructive…Don't you know this expression? Constructive?
> I: Yes I know it from…
> W: (interrupts) Building together.

[7] The master themes were significantly present in all interviews and are grounded in several quotes from all participants. However, due to space limits, each theme will be presented here only with few exemplary quotes. More wording has been used to describe some themes, as it was required by the complexity of some topics. Yet, it is important to stress that all six themes are equally relevant.

Participants talked about the beneficial effect of movement through which they could sense and feel their body and recover an awareness of it.

> And there one feels the body again much more intensively…How shall I say… Otherwise one does not feel the body at all, it is always fully unconscious. Or at least this is what I experience. I find that such things…Somehow movement brings me body-awareness. (…) Bodily awareness. That I can feel my body and that I can feel it as nicely activated and relaxed (Wolfgang).
>
> *[It was helpful]*That one can sense oneself in movement (Carlo).

Yet, experiencing movement in therapy "cannot be compared to sport: in sport one is constantly overwhelmed" states Hanna. She reiterates "The therapy session was not overwhelming. I think this is important: one feels uncomfortable in the body when it gets tired". Hanna here seems to be saying that even "being tired" was an important experience in that she could feel and sense the tiredness in her body and she could act accordingly (e.g. taking a break). Drawing on this and on other similar extracts, we deduce that it is not movement per se, but body-awareness -the experience of feeling and sensing the body- that is considered crucial. Talking about their experience of BPT, participants positively described the feeling of being more centred, more grounded and more in their body.

> Hanna: I feel safer and more confident in my body (…) And one has a safer stand, one is more inside oneself. Otherwise one is always in the head or in conversation, and there only thinking is required. And there is the body, and one is more centred; I see it so… And this is not obvious but rather subtle that one feels centred.
> Interviewer: What does "centred" mean?
> H: When you have a circle and you make a dot in the middle. That one is more inside oneself and that one is more solid.

It is here worth noticing the particular semantic valence of Hanna's words. She uses very concrete and physical terms such as stand, centre, solid, inside. This solid geometry she vividly depicts expresses her feeling of being grounded and is opposed to a sense of being up in thoughts and in the head, which might be pictured by contrast as an abstract, diffuse, unstable and indefinite psychological state. This stark semantic contrast was reflected in other participants' words as well.

The experience of being a whole, a body-mind unity, and thus the importance of implicit and pre-reflective experience emerges also in the way participants talked about moments of change. When they talked about transformative moments, they often used expressions such as "I could experience it" (Sebastian). It seems that therapeutic change was not yielded by processes of understanding or insight, but through pre-reflective experience: "I believe that it has an effect on people at the unconscious level. I mean, the movement psychotherapy. (…) And it is so good when one…When one can experience it. This helps the healing process enormously" (Wolfgang). In the following quote, Carlo provides a rich and insightful description of this process:

> Carlo: This kind of psychotherapy goes in a different direction than normal therapies… Or than the normal way they want to solve your problems in the health system.
> Interviewer: What do you mean?
> C: It regards a kind of sensitiveness…It involves the senses. That one…It involves movement and… With the body, something to… To show and to involve the body and not in order to think. Because usually, what one always wants or what one believes is that people are missing knowledge, and if people would know how it works then…
> I: Then…

> C: Then they change. But this is wrong, this is not true. This is… This is like in mathematics. That when you have A and B, then C always follows.
> I: But this is not…
> C: But with human beings, this doesn't work. (…) *[this therapy was different]* because it takes it from the other side. (…) The point is not the knowledge.
> I: Yes, it is more complicated.

As Carlo emphasized, in opposition to an instructive and rational mode, therapeutic change was experienced as "coming from the other side", i.e. as arising from implicit and bodily experience. "Because the bodily feeling influences the feeling of the soul; as one says 'mens sana in corpore sano'" [trans. "healthy mind in a healthy body"] (Wolfgang).

Being agentic and being able

The second master theme regards the helpful experience of feeling able and agentic: indeed, it appears that, through BPT, participants gained self-confidence and trust in themselves. In relation to this, we could also recognize in their descriptions an active and agentic stance towards therapy and in general towards their own wellbeing.

Some participants depicted themselves as previously being unable, not good enough and lacking self-confidence:

> Usually, when I am in the Bible reading group and there are some tasks, I am first withdrawing because I think 'Oh no, I am not able'. And this didn't happen at all here in therapy. (…) Or also when I was in school, always when something new came up, I was first so 'no'.(...) And now it wasn't like that at all (Franziska).

As Franziska describes, it seems that the initial fear and insecurity changed during the course of therapy, leaving room to a feeling of self-confidence.

> It was helpful for me when I could do things in front of the others and they were repeating what I was doing, they were following me. (...) When I was 7 years old and I was in Kindergarden, I also wanted to be practically a kind of leader, and this exercise reminded me of that. In this moment I really had the feeling of being a leader, I could experience it (Sebastian).

The shift from experiencing themselves as unable to feeling able was described by participants as something that happened at the pre-reflective level. Their words suggest that they directly and pre-reflectively experienced themselves as able and agentic through the body and action. As Franziska describes here: "What do I now do when I am walking somewhere outside? I walk, and I look for a point in space, and I walk straight to that point. (…) This is simply a feeling of being self-confident. That I am also someone."

We see this sense of self-confidence as being tightly related to an active and agentic stance, which also emerged from the interviews. After BPT, participants presented themselves as active subjects pursuing their own wellbeing, also outside the therapy room: "I have the feeling that I am not so tired anymore. I don't know. And somehow, I now want to buy a chair, like the one we had in therapy and I want to keep sitting upright" (Franziska). In the accounts of some participants (Wolfgang, Carlo, Hanna) this active stance was explicitly contrasted to the way they passively received other types of therapy:

> Hanna: I think that I could profit from continuing this therapy: I would become more and more confident, I would move more, I would become more assertive, at least a bit, and that is what I meant with centred: that I would initiate thoughts and actions from my centre. Otherwise, usually everything is thrown on you.
> Interviewer: What do you mean with "thrown on you"?
> H: So inactive, thrown on you from the outside. So many thoughts, so many deficits, as if one does not do it right. And this other *[therapy]* is different, it is a bit liberating. It is liberating to move with your body.

This quote expresses well two opposing directions of agency: from the person's center to the outside world (active stance), and from the outside world on the patient (passive stance). We also interpret Hanna's words as expressing a contrast between a psychotherapy approach only focused on (correcting) thoughts and one involving the body, which was experienced as beneficial and liberating. Broadening this issue, one might also view the contrast verbalised by Hanna as the one between a focus on deficits and a focus on resources.

The active participation and agentic stance of participants also connects to the therapist's attitude and the way it was perceived by them:

> She was radiant, she had a kind of aura somehow and from the movements she did, the way she did it, one could see that she is in flow somehow, and this was given to us. And I found very good the way she did it. Also the different movements and the way she then animated us to do some movements, to find out our own movements, so to say. This was really good (Wolfgang).

In our interpretation, the key expression in this description is the metaphor of "giving", which might indicate the therapeutic relationship. The act of giving necessarily involves (at least) two persons and implies that what is given is accepted from the receiver. Following this parallel, it appears that in BPT participants were free to accept

or refuse what was offered by the therapist and they learnt to recognize what was good for them and what not. The therapist thus seems to have adopted what we might call an empowering stance: she did not instruct the patients but she encouraged them to find their own way. Based on our interpretation, this played a crucial role for enabling a shift from the experience of fear and insecurity to self-confidence and agency.

Being unique and worthy: being accepted for who one is.

The third master theme concerned the experience of being accepted and recognized as a worthy person. Participants also felt supported and encouraged to recognize and discover their personal qualities and unique identity. This was contrasted to the feeling of being labelled and reduced to their 'illness'.

Throughout the interviews, the topic of being labelled as a psychotic emerged as a crucial one. The emotional weight of this label and the sufferance it yields becomes evident from the patients' words.

> Hanna: Before I got ill I was a normal person and after that, I am still no different person. (…) I have an illness and this is treated with medicaments but my personality didn't change. I am exactly as sensible, exactly as intelligent… Maybe this a bit less… But exactly as responsible. I was in a managerial position before…
> Interviewer: Mhm…
> H: And this *[the label of schizophrenia]* disintegrates everything. One *[the other persons]* only has the label of schizophrenic before the eyes (Hanna).

Hanna describes her experience of just being defined by and reduced to the label. With the wording "they only have the label of schizophrenic before their eyes", she seems to

say that people can't see her anymore in her entirety. One gets the feeling that what she mentions as her skills and competences, her personality and identity are obliterated by this "disintegrating" stigma. In contrast, participants described BPT as a non-judgmental space where they were taken seriously as whole persons, and thus, we add, not being reduced to a mere diagnosis. The therapist's stance again seems to play a crucial role here: participants experienced it as helpful when she acknowledged, listened and took them seriously, thus also acting upon what they proposed:

> She always asked us at the beginning of the session what would be good for us and when we said it, as for instance to walk in space, then we also did it. From there she then built up the therapy session. I found it good. (Franziska)
>
> She always totally adapts to and engages with the group (Franziska).

It appears that this open and acknowledging attitude may have helped participants feel free to engage without fearing judgement; they reported feeling worthy and even proud of themselves:

> What I found particularly helpful, and I take this experience with me, is when *[the therapist]* said: let's walk around proud. Because with this illness one does not feel worthy and when I straightened up it felt good. And sometimes I still think, now I walk proud, and this gives me a different feeling. It is so good. (Hanna)

We view the experience of feeling accepted and recognized as unique persons as crucial for gaining back this sense of worthiness: to be seen as fellow human beings, instead of being objectified for their diagnosis. For instance, Martin describes this experience in the following quote:

> Martin: I felt secure, I felt accepted, simply being with the other people. That I was allowed to be there with that who I am.
> Interviewer: Yes…
> M: With my whole person, with my whole being human
> I: Mhm…
> M: And I felt, as I said, accepted, I always felt accepted. (…) Fully recognized and integrated.

Similarly, in Sebastian's words, acceptance and recognition were described as a pre-condition for engaging and opening up in therapy: "This is something…one feels…one feels safe and feels accepted and one does not need to be afraid and can open freely" (Sebastian).

In our interpretation, this feeling of worthiness led to a growing interest in themselves as unique persons. Participants commented how helpful it was to explore and discover their particular needs, qualities and personality. In the following quote, Sebastian describes an exercise where each participant had to find three gestures that would fit their own personality:

> Sebastian: The three gestures…The three bodily forms that were fitting one's own person. I found this exercise very interesting and good.
> Interviewer: What was good in these gestures? I mean, why…?
> S: Because one could reflect and wonder what is beneficial for oneself and what kind of identity one has. And one could experience it (Sebastian).

Participants enjoyed bringing into therapy their own personal contribute: "It was so good that each person could bring his own music" (Wolfgang) and "That everyone could contribute with his own movements. I found this also…I found it really good" (Wolfgang). Not only did they apparently start to express and appreciate themselves as

unique persons, but they also seemed to adopt a similar attitude towards others: *"[I liked]* when we painted. Paint on the wrapping paper. (...) Because I find ... it represented the personalities of the others ...I have perceived the other persons, each one in his own kind" (Martin).

Changing interactions: engaging in authentic interpersonal contact

The fourth master theme regards the experience of interaction. Although participants felt initially threatened by interactions, they also describe positively the experience of relating and engaging with others in BPT. The experience of interactions was first identified as a difficult one: participants said that they often experience oddness in interactions and feel unable to respond and to "be in the flow". This odd feeling of disturbed interaction seems to characterize participants' everyday experience, as if they were used to it. Yet, from their wording also emerges that this oddness yields distress and frustration: "I sensed it in this exercise on personal distance, that it affects me a lot when it *[the interaction]* was not right, when it is not harmonious, I sense it" (Hanna). In this regard, it is particularly significant that participants mentioned as helpful those moments in which they could positively experience intersubjective engagement and enjoy it.

> Carlo: It was not always the case that one was in front of a person who would answer. Because sometimes… The other person just stands still and I… I don't judge it, I found it normal, when one cannot do it, or does not want to do it or like always. But I felt, when it happened, I felt weird, that I moved and the other

> didn't, he did not answer back. But when… One could manage something together in this context, I felt good. It was a good experience. And… And afterwards I was satisfied that I did it.
> Interviewer: How did you feel?
> C: Mhm… *[thinks for a long time]* That simply… Like normal life is, that one is in front of someone else and one does not need to do something special or weird or exaggerated, on the contrary, something small is enough and it yields… Like an interaction, like an interplay, we are two persons without anything, without having thought much. Like it is normal, one meets someone else… And sometimes is not important about what… But one is simply there with the other. And in therapy I have…I have felt and experienced this situation, like one is in front of the other person and does something. But without thinking, without forcing oneself or…
> I: So spontaneously…
> C: Exactly. And I found this simply beautiful. It was for me like experiencing a kind of normality. Like how normal life is and I really liked it.

In Carlo's words one can notice the contrast between what he describes as his usual experience of interactions, "that people would or could not answer", and what he defines as how normal life should be, "that one can just be together with others without thinking or forcing oneself". Here emerges the contrast between a modality in which a person needs to think and force herself to interact and a spontaneous mode where one can simply pre-reflectively engage with the other: "one does not need to do something special, weird or exaggerated", simple actions and immediate reactions are enough to directly engage with other people. This experience of engagement seems to be very important for Carlo and he notes it as a positive and transformative one.

It is important to mention that positive experiences of intersubjective engagement appear to be characterized by the maintenance of interpersonal boundaries, as Sebastian states when talking of an exercise involving nonverbal interactions:

> Sebastian: The question-answer task, I found it very good. But I was always afraid of it. (…)
> Interviewer: Was it a negative experience?
> S: No, it was positive because, because a certain degree of distance *[between me and the other person]* remained .

Participants observed moments of deep interpersonal contact with the therapist: "She was very open and she looked for personal contact with me. We also had moments of very deep contact. Not so much at the beginning but she slowly and sensitively got close to each of us and also to me, and I experienced this as beneficial" (Hanna). These experiences seemed to be fostered and supported by the therapist's authentic way of engaging with participants, by the fact that she was present and congruent, without hiding behind pre-defined roles. For example, talking about what he experienced as significant and helpful, Sebastian said: "*[The therapist]* was often smiling, apart from when she was not feeling well" and "It was good that there were two co-therapists (...) and I believe it was also a good help for *[the therapist]*, wasn't it?". Immediately afterwards, Sebastian acknowledged that he also needed help and support and he could accept that. This link may suggest that Sebastian, following the therapist, felt free to be authentic, without hiding his weakness. Indeed, it is okay to be in need and rely on other persons: everyone may need help, even the therapists.

Authentic interactions were also established among the participants. For instance, Martin explained that what motivated him to attend every session was "the humanity, the relation to each other". "This was so important. That I managed to

interact and relate to other human beings. It was important, it was essential": Martin here stresses the importance of establishing a contact with the "human being" in the other person, or as we would rephrase it: to authentically relate as fellow human beings without barriers, masks or roles. The experience of deep and authentic interpersonal engagement might thus be considered as a crucial transformative aspect of BPT.

Being part of a group: feeling integrated

Withdrawal and disengagement are very common in schizophrenia and are also related to the problem of social stigma and exclusion: these issues emerge in participants' narratives. In relation to this, the experience of belonging to a group and feeling integrated was described as helpful aspects of BPT. Although the participants expressed the wish of being integrated and recognized by the wider society, feeling integrated and belonging to a group emerged as a crucial helpful experience per se, irrespectively of what group one belonged to. As Wolfgang explains here, even to be in a group of "excluded people" was experienced as helpful, as it made the very feeling of belonging possible: indeed, if all group members share the same label, the label disappears and it cannot be a cause of rejection and exclusion anymore.

> It was helpful to get to know other people, that are in the same… *[hesitates]* One has, for example a label *[hesitates]* to be psycho, to be a psychotic, one has a label. So people say about him: 'he is a psy- *[hesitates]* psychotic. Well, this label then goes away *[in the therapy group]* (Wolfgang).

Notwithstanding the sufferance and shame (especially evident from the paraverbal connotations) related to the experience of stigma, Wolfgang describes the experience of being with similar people (all with the same label) as a positive and a helpful one, in that he felt integrated and included. A similar attribution can be found in Franziska's words. She describes her experience of feeling self-confident during therapy, in contrast to the withdrawal and insecurity she always felt: *"[my being confident]* It is probably related to the fact that the others also somehow have a handicap and one does not need to prove oneself". There seems to be something positive in being in a group of people that share a label, a "handicap": one is not afraid of being judged and rejected.

It appears that an atmosphere of inclusion was constructed within the BPT group and that participants felt very close to each other, building a strong relational bond as a group:

> Interviewer: Before coming to therapy sessions, were you looking forward to it?
> Wolfgang: Yes I was, sure!
> I: And to what were you looking forward… I mean, if you think…
> W: To see the others and somehow…
> I: The others.
> W: Yes and to do something with them. And it didn't matter if it was with a ball or otherwise anything else…But it became always more…The more we saw each other, the more we grew together (Wolfgang).

Hope and investing in the future

The last master theme is about hope, which seemed to play a crucial role for the process of therapeutic change:

> The movement, where one could also creatively contribute with one's own movements… Somehow I found it really good because… Something like this yields joy and joy for movement. And one can see that there is still something somehow, and when one sees it, then one has hope somehow and this is really… It was beautiful… I have been in psychiatry since 1981, because since then I always started again with drugs and all sorts of things (…) And such a movement-therapy; people see that there is still something that creates joy and is constructive. And this aspect alone is really really important somehow. And this is also very good when one… When one can experience it. And this enormously helps the healing process. (Wolfgang)

On the one hand, Wolfgang tells that he has been stuck with his difficulties for thirty years and he has never managed to recover: a hopeless picture emerges, as he had always relapsed "with drugs and all sorts of things". On the other, a scenario of hope springs, where a person can see that there is still something worth in life to be lived. According to Wolfgang, joy and fun play a crucial role in this realisation: when people can enjoy, even little things, they can hope again.

Expressions such as "it was fun" were used by participants throughout the interviews and were often associated to the account of helpful experiences: "People laugh again and they have a smile on their lips. And this is so good, it is an enormous improvement. I really believe that this is important" (Wolfgang). Our interpretation is that joy and amusement were related to therapeutic change in that they yielded hope in the participants, the experience that there is still something to be enjoyed in life. This also seems to have a direct positive influence on their everyday lives:

> It was new for me, that I enjoyed movement (…). And I experienced that I am keen on moving and I like it. And I didn't know this from my everyday life, because it is always the same and always very quiet and I sleep a lot. It was a

> new experience for me. That I was happy about moving and I was relaxed (Hanna).

Participants experienced a change, but what we believe of utmost importance is that they experienced the very possibility of hoping, changing and developing. From a hopeless and static stance, where the cyclical pattern of their "illness" defined both their past and their future, participants seemed to shift to a pro-active stance, where they looked at their future as offering possibilities for change and development.

Discussion

Helpful factors of BPT for schizophrenia

The six master themes are tightly intertwined and show several meaningful overlaps. For the sake of discussion, we here embed them in a conceptual frame of three categories, which reflects different levels of therapeutic change: a bodily dimension, an intersubjective dimension and a social dimension.

The bodily dimension. In the first theme "being a whole, body-mind connection", participants described the recovery of a direct and unmediated sense of their body. They shifted from experiencing their body as disconnected to the experience of being embodied subjects, a body-mind unity. This outcome supports the BPT theoretical model: to borrow Schoop's (2007) words, "bringing the patient back in his body" (p.127) has always been one of the central clinical aims of BPT. These findings

are also coherent with previous research by Röhricht et al. (2009), who found a positive effect of BPT on patients' ego-consistency, which is defined by Scharfetter (1999) as "being mentally and bodily united, consistent and coherent being" (p.13).

In describing the way this helpful experience was brought about, participants emphasized the pre-reflective nature of therapeutic change. This is also coherent with BPT theory, where the mechanisms of therapeutic change are described as happening primarily at the implicit embodied dimension (Koch & Fishman, 2011; Röhricht, 2000). In BPT the body becomes the main medium for self-perception, empathic interactions, expression of emotions and communication (Behrends, Müller, & Dziobek, 2012; Crawford & Patternson, 2007). Movement and action are conceived as directly influencing the emotional and cognitive levels in a circular and dynamic process (Koch, Fuchs & Summa, 2007; Koch, Morlinghaus, & Fuchs, 2014).

A recovery of agency is described in the second master theme "being agentic, being able": instead of being passively defined from outside, patients started to feel agentic, self-confident, and able. They thus began to act upon their own needs and wishes. This feeling was mainly experienced and described at the bodily level: feeling agentic through the body and action. Another important aspect of this theme regards the therapist's empowering attitude[8], which played a crucial role in fostering agency.

[8] Although an intersubjective component of the therapist's empowering stance is present in this theme, we still decided to categorize it under the "bodily dimension" of therapeutic change. This is mainly because of the strong emphasis on the body and action which participants put in describing agency and

Instead of being instructive and directive, the therapist encouraged active participation and individual initiative. Thereby BPT was often co-constructed rather than being unidirectionally steered. The crucial role that agency, self-determination and self-esteem play for the process of recovery in schizophrenia has been repeatedly stressed in previous literature (e.g. Avdi, Lerou, & Seikkula, 2015; Frank & Davidson, 2014; Grealish, Tai, Hunter, & Morrison, 2013; Harder, 2006). Empowerment has received increasing attention in the last decade, as it has proved to constitute a core healing factor for schizophrenia (Seikkula & Arnkil, 2014; Warner, 2010).

In summary, two main implications can be drawn. First, these findings provide support for the BPT model; indeed, in both themes, the focus on the bodily and implicit dimension of experience has been shown to be crucial for therapeutic change. Second, a key helpful factor has been also identified in the therapist's empowering stance, which fosters patients' agency. This has also general implications for rethinking common psychiatric practice, where responsibility and self-determination are often taken away from patients (Seikkula & Arnkil, 2014).

The intersubjective dimension. In the third master theme, participants described the beneficial experience of being addressed as fellow human beings and of

their experience of it. The three dimensions of therapeutic change presented here have been separated for conceptual purposes but, when looking at the complexity of the accounts, one can often notice that these boundaries are blurred.

being recognized and valued for who they are. This seemed to foster the recovery of a sense of worthiness and the discovery of their unique identities and personalities.

From the participants' words emerges how the acknowledging stance of the therapists allowed them to open up and engage in the process of therapy without the fear of being judged or rejected. This very intersubjective stance created a safe context in which they felt free to engage and thus, we argue, constituted a pre-condition for therapeutic change. Borrowing Laing's (1961) notion of "ontological security", Davidson and Johnson (2012) describe this feeling of safety as addressing the most basic level of existence and thus as being related to the core fear, namely of the loss of personhood. The essential role of intersubjective recognition and acceptance for the process of therapeutic change in schizophrenia has been repeatedly highlighted in previous literature (e.g. Davidson, 2003; Deegan, 1993; Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013; Le Lievre, Schweitzer, & Barnard, 2011). According to Davidson (2003), and coherently with our analysis, feeling recognized and esteemed as a valuable person opens up a space for affirming, exploring and redefining the worthiness and uniqueness of one's own self.

Within the intersubjective sphere, the fourth master theme regards the experience of deep and authentic interpersonal encounters, which were described as significant and helpful moments of therapy. According to participants' words, interpersonal engagement was happening first and foremost at the pre-reflective level

and was characterized by the maintenance of interpersonal boundaries. When talking about the therapists' attitude, participants seemed to stress the importance of personal authentic contact as a helpful aspect of the therapeutic relationship. One might argue that an authentic stance on the side of the therapists called forth authentic reactions and behaviours in the participants, and that such posture also allowed the establishment of more human and collaborative relations.

The role of intersubjectivity for the healing process of schizophrenia has been emphasized in phenomenological, psychodynamic, systemic and dialogical psychotherapy approaches (e.g. Atwood, 2012; Stanghellini & Lysaker, 2007; Seikkula & Arnkil, 2014). In this IPA, two core helpful aspects seem to be crucial at the intersubjective level of psychotherapy process: feeling recognized and engaging in authentic interpersonal contact. These two aspects highlight a twofold therapeutic stance characterized by openness toward the other and authenticity in the encounter with the other[9]. Such characteristics of the therapeutic relationship were also emphasized in the early BPT work of Schoop (2000):

> As for our practice, I feel that therapy is a dialogue. It includes "me", who *I* am- and the patient: who *he* is. I cannot enforce my "me" on his "him". We are two persons with the equal right to choose the time when we can engage in mutual correspondence. And that, in my opinion, is as it should be. As we work together, I don't want to tranquilize: I want to incite- so that we both become totally involved- intensely preoccupied with living (p. 100).

[9] For a more detailed discussion on this twofold therapeutic stance see Galbusera & Kyselo, under review.

Notwithstanding, Röricht's (2010) BPT manual does not focus on the therapist-patient relationship. Indeed, intersubjective aspects have received little if no attention in the more recent literature on BPT. Our qualitative analysis of the process of change in BPT calls for a further investigation of the intersubjective processes at play in this approach and for an integration of such aspect in the manual. The clinical relevance of these intersubjective factors also goes beyond a specific body-oriented approach, as these relational aspects concern and may inform any type of clinical encounter.

The social dimension. The social dimension of therapeutic change has been distinguished from the intersubjective dimension, as it concerns the social implications of therapy at a different level. Whereas the latter concerns the embodied intersubjective processes of the here and now encounters and interactions within therapy, the social dimension refers to the wider social and cultural context of participants' life.

Two central helpful factors of therapy have emerged at this level. First, our IPA shows the helpful effect of group therapy for schizophrenia. The BPT group offered a possibility to experience social inclusion and to temporarily free participants from the social stigma, which is a major hindrance to their recovery (Davidson, 2003; Davidson et al., 2001). Yet, in the wider social context, they still had to deal with social stigma and rejection and with its influence on their identities and lives. This point touches upon a limitation of the BPT approach, as it does not address the social context patients live in. As long as BPT only focuses on the individual, one might wonder how long

therapeutic change could last, once participants return to their unchanged social environment. This master theme emphasizes the important influence of the social context in supporting (or hindering) patients' recovery. This might point to potential future directions for the development of BPT theory and practice.

Second, the last master theme emphasized the importance of hope for therapeutic change. Our IPA pointed to an important source of hope: those very simple moments in therapy, where participants could laugh and truly enjoy themselves. These findings are coherent with previous literature on recovery from schizophrenia, where hope has been shown to play a crucial role (e.g. Andresen, Oades & Caputi, 2003; Davidson 2003; Kelly & Gamble, 2005; Perry, Taylor, & Shaw, 2007). Interestingly enough, Davidson (2003) also stressed the importance of joy and amusement for the recovery process in relation to hope.

Common and specific helpful factors

In summary, our analysis points to both specific and common therapeutic aspects. The first helpful factor (related to the bodily dimension) is specific to BPT, whereas all other therapeutic factors (related to the intersubjective and social dimension) might be shared by other therapeutic approaches.

The focus on bodily processes and pre-reflective experience highlights the importance of the BPT core tenet and might also call for the integration of nonverbal and pre-reflective aspects in other therapeutic approaches. It is important to emphasize

that what we have enclosed within a single theme -for the sake of categorization- is actually overlapping and present also in others. We have already stressed the importance of bodily experience for the feeling of agency. Similarly, also at the intersubjective level, it is first of all nonverbally that patients were able to engage and enjoy interactions with others. The "bottom-up" nature of therapeutic change is expressed in participants' accounts throughout the different master themes, which further emphasizes the relevance of this factor.

The qualitative nature of this study allows to go beyond a mere endorsement or rejection of BPT. As mentioned in the introduction, the aim of this study is theory-building (Stiles, 2007), that is, a better understanding and further development of schizophrenia therapy within and beyond BPT. The following can be conceived as common helpful factors of the therapy process: a therapeutic stance of empowerment; an intersubjective stance of openness towards the other and of authenticity; an inclusive atmosphere in the group and joyful moments, which respectively fostered the feeling of social inclusion and the feeling of hope. Although these aspects are not specific to BPT, this does not make them any less important or clinically relevant. On the contrary, we believe that the intersubjective and social aspects described in our analysis might contribute to an integration and further development of BPT. Moreover, these common therapeutic factors converge with previous literature on schizophrenia therapy and, at

the same time, offer richer descriptions and interpretations of these key clinical processes.

Toward the recovery of a sense of self

So far we have sifted the master themes in order to extrapolate helpful factors of BPT and elaborate on their clinical implications. To conclude, we now look at the findings as a whole. Altogether, the six master themes point towards an understanding of change as a recovery of a sense of self at different but interrelated levels: an embodied self, a body-mind unity (master theme A); an agentic and active self (master theme B); a self that is worthy of recognition and is unique among others (master theme C); a self that can engage in intense intersubjective encounters, albeit maintaining the individual boundaries (master theme D); a socially contextualized and integrated self (master theme E); and finally, an ever changing and developing self that is oriented towards the future (master theme F).

This is not to claim that after BPT all participants achieved a 'full recovery' in all these dimensions. After BPT we could find hints of this process to a different extent and degree for each patient. Yet, on the basis of their accounts and descriptions, we can coherently conceptualize therapeutic change as a dynamic path towards the recovery of a sense of self throughout these different but intertwined dimensions. Literature on recovery from schizophrenia has highlighted the decisive role that the strengthening, reconstruction or enhancement of a sense of self plays for the healing process (e.g.

Andresen et al., 2003; Schrank et al., 2014; Sells, Stayner, & Davidson, 2004; Weinberg et al., 2012; Lysaker & Roe, 2012). In Davidson's (2003; Davidson & Strauss, 1992) work, recovery from schizophrenia is conceptualized as a development of a stable and dynamic sense of self and the process of change is characterized by specific aspects such as agency, acceptance, supporting relationships, joy and hope. Our analysis also concurs with findings of previous literature based on first-person accounts of schizophrenia investigating psychotherapy process and outcome (e.g. Dennick et al. 2013; Grealish et al., 2013; Messari & Hallam, 2003, Rapsey, Burbach, & Reibstein, 2015). This provides further support for the efficacy of BPT and enhances the development of its theory and practice. Nevertheless, we hope that this study might be informative for other therapeutic approaches too and contribute to a better understanding of what could help and hinder people struggling with schizophrenia.

Limitations

The exploratory nature of this study should be acknowledged. Although the sample size is appropriate for an in depth IPA analysis[10] (which is based on prototypical rather than statistical generalization), a replication with a larger sample size will be needed in order to validate these findings. In this paper we have focused on the helpful aspects of BPT and we have left out other aspects of the IPA analysis, e.g. hindering or difficult aspects. In general, hindering aspects mirrored the helpful ones, e.g. if a

[10] See Smith et al. (2009) and Lyons & Coyle (2016).

participative stance by the therapist was perceived as helpful, a directive attitude emerged as hindering. Yet, a more detailed description of these aspects would be needed for a better understanding of BPT. More detailed information about participants, especially about medication and level of functioning, would have been helpful to situate and better understand the findings. Unfortunately, due to the pilot and exploratory nature of this study, this information was incomplete or missing. Due to practical reasons, a proper post-hoc respondent validation was not possible. This would have enhanced the trustworthiness of results and empowered participants. We hope that these considerations might inform and improve further research on the topic.

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