

# Integrating Interventions in Therapy for Psychosis Based on Psychological Readiness

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## Abstract

There is burgeoning evidence for effective psychological and psychosocial approaches to the treatment of psychosis. Further enhancing treatment efficacy requires better matching of clinical interventions from different theoretical models to the individual based on their current psychological status. In keeping with the objectives of integrative psychotherapy pertaining to psychological theories, this article describes the surviving, existing, or living (SEL) model as a conceptual framework for integrating different theories by timing interventions in psychosis based on the individual's clinical presentation and psychological readiness. Contemporary approaches to psychosis, including cognitive-behavioral and metacognitive theories, recovery models, phenomenological approaches, and psychodynamic models are incorporated. Use of the model for addressing trauma issues in psychosis is also discussed.

**Keywords:** Psychosis, psychotherapy for psychosis, schizophrenia, SEL model

There is accumulating evidence for the role of psychological therapies in the treatment of the psychoses, including for individuals diagnosed with schizophrenia (Brus et al., 2012; Dickerson & Lehman, 2011; Pfammater et al., 2006). Diverse theories—including cognitive-behavioral, psychodynamic, metacognitive, phenomenological, and family systems—each contribute important practices for enhancing treatment efficacy. Given the significant side effects, problems with adherence, and limitations in outcome associated with antipsychotics, research documenting greater efficacy combining psychotherapy and psychosocial interventions with lower-dose antipsychotics (e.g., Kane et al., 2016) is heartening.

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Effective approaches have evolved from a solely pharmacotherapy model to a comprehensive, person-centered approach that includes psychotherapy, medication, and family and peer support (see National Institute for Clinical Excellence [NICE], 2014). This is consistent with a recovery-based approach to psychosis, a more humanistic, holistic approach to care that emphasizes increasing optimism about outcome, empowering the individual, engaging the individual's active participation in their care and goal planning, and incorporating work and peer support into a recovery plan (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). Treatment outcome goals for any approach need to include fortifying and empowering the individual; enhancing interpersonal experiences; increasing adaptive, reality-based coping; reducing distress and intrusion of hallucinations and delusions; and improving overall functioning.

There remains more to do to improve outcomes, including intervening to assist people earlier, reducing the number of relapses and dropouts from treatment, and improving the overall quality of life for individuals experiencing psychosis. It is evident that no single approach or technique is effective for all people at all times (Fenton, 2000). Therefore, the next step in further improving psychotherapy outcome for psychosis is to determine what specific interventions are most effective at particular times based on the person's immediate clinical presentation and functioning.

By creating a means for determining which interventions to conduct when, many of the diverse treatment approaches currently in use may be integrated into a comprehensive, strategic approach to psychosis. In response, I developed the surviving, existing, or living (SEL) model while working with inpatients and outpatients of a psychiatric facility as a method for assessing the person's often fluctuating psychological capabilities and needs and choosing the type and timing of interventions accordingly. The model allows for integration of the many therapies in use into a strategic approach to care and recovery that strives to enhance alignment between therapeutic interventions and the individual's psychological state and psychological readiness. It is also in keeping with the *Diagnostic and Statistical Manual* (5<sup>th</sup> ed.) (*DSM-5*) (American Psychiatric Association [APA], 2013) and the latest edition of the International Classification of Diseases (World Health Organization, 2019) for assessing status and progress dimensionally for those with a primary psychotic disorder (Reed et al., 2019). The model is designed for and has been used by professionals across disciplines and across the continuum of care who provide services for psychosis, including psychologists, psychiatrists, social workers, occupational therapists, nurses, and other mental health professionals.

The SEL model conceptualizes psychosis along a continuum of severity based on such factors as the extent of self-definition, interpersonal awareness, distressing hallucinations or delusions, and awareness of thoughts and emotions. The three general phases (surviving, existing, or living) of the model fall along the continuum and reflect different levels of severity. The specificity of the features described for each phase allows for characterizing the immediate psychological state of the person in order to guide effective pacing of therapeutic interventions. In addition, the treatment approach can be quickly modified in response to the rapid changes in psychological status that can occur so as to facilitate attunement between the provider and the individual.

### **Empathic Attunement**

Research has demonstrated the critical role of the therapeutic relationship in treatment outcome across many disorders, accounting for up to 30% of outcome (Ardito & Rabellino, 2011; Martin et al., 2000). An important aspect of the therapeutic relationship is the therapist's presence (Erskine, 2019) and empathic attunement to the client, that is, the clinician's accurate understanding of the client's psychological state and their ability to respond in congruence with the client's state and needs. A psychodynamic conceptualization can assist in this by facilitating an in-depth, comprehensive understanding of the individual, who presents in their particular way based on their past experiences, internal object world and intrapsychic structure, current expectations, and immediate psychological state. The ability of the therapist to flexibly and fluently modify interventions based on attunement with the client is particularly important with individuals experiencing severe psychosis, including those diagnosed with schizophrenia, because of how rapidly their status may change. At one moment the person may speak in a more understandable manner, seem more trusting and engaged with the therapist, and then, suddenly, show disturbances in thinking, talk faster and less coherently, and be less trusting. Increasing congruence between the provider's intervention and the client's need, psychological state, and readiness requires accurate assessment of the phase of psychosis, knowledge of appropriate tasks and goals in each phase, and the ability of the provider to adjust their therapeutic responses to be better aligned with the individual. Knowing what to do when increases the therapist's confidence as well, bolstering their ability to convey to the individual that the therapy can be effective and instilling hope for positive change.

## **The Hallmark of Severe Psychosis**

It is increasingly accepted that the diagnostic category for schizophrenia is too heterogeneous, subsuming individuals with different symptoms and presentations, etiologies, courses, and outcomes in a way that confounds efforts to conceptualize, research, and treat. Therefore, for clarification in the SEL model, severe psychosis is viewed as consistent with the clinical literature, which has long described schizophrenia as a fundamental disorder of the self (e.g., Kraepelin, 1896, as cited in Sass & Parnas, 2003; see also *DSM-3-R*, APA, 1987). For example, Sass and Parnas (2003) described schizophrenia as an “ipseity disturbance,” a fundamental disorder of the self characterized by a diminished awareness of one’s existence. The most severe form of psychosis, then, relates to individuals who, at some point, have experienced a complete loss of awareness of existence of the self (and the accompanying significant disturbances in thinking, behavior, affect, and perception) during an acute episode. Such an episode falls at the farthest, most extreme endpoint on the dimensional scale of psychotic experience and includes many diagnosed with schizophrenia.

## **The SEL Model: Characteristics**

The domains and characteristics of the three phases of the SEL model are presented in Table 1 (Fuller, 2013). In general, in the surviving phase, the person is in an acute state of impairing psychosis. In the existing phase, the individual is emerging from acute psychosis and stabilizing but tends to restrict experiences in order to maintain stability. In the living phase, the person is more fully engaged and better functioning. To determine which phase a person is in, eight domains derived from the clinical and empirical literature and clinical experience are assessed. The eight domains include: self-definition (which refers to the extent to which the person has a defined sense of a core self), interpersonal functioning, threat appraisal, prominence of distressing hallucinations and/or delusions, metacognitive ability (the ability to think about thinking, reflect, imagine, introspect), coherent speech (extent of logical speech/thinking), emotional functioning (identification and adaptive expression of feelings), and goal-directed behavior (level of adaptive functioning). Although no single assessment measure of the eight domains is available, clinician evaluation may be augmented by the diverse measures available, including for assessing hallucinations and delusions, metacognitive ability, and sense of self.

**Table 1**

***Domains of the Three Phases of the SEL Model (Adapted from Fuller, 2013)***

<b>DOMAINS</b>	<b>SURVIVING</b>	<b>EXISTING</b>	<b>LIVING</b>
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<b><i>Self-Definition</i></b>	UNDIFFERENTIATED SELF	EMERGING SENSE OF SELF	DIFFERENTIATED/ INTEGRATED SELF
<b><i>Interpersonal Functioning</i></b>	LIMITED AWARENESS OF OTHERS	GREATER AWARENESS OF OTHERS	INCREASED EMPATHY/AWARENESS OF OTHERS
<b><i>Threat Appraisal</i></b>	CONSTANT SENSE OF THREAT	TENDENCY TO PERCEIVE EVENTS AS THREATENING	MORE ACCURATE APPRAISAL OF THREAT
<b><i>Hallucinations/ Delusions</i></b>	SEVERELY IMPAIRING	MODERATELY IMPAIRING	MINIMALLY IMPAIRING
<b><i>Metacognitive Ability</i></b>	LIMITED AWARENESS OF THOUGHTS	EMERGING METACOGNITIVE ABILITIES	METACOGNITIVE ABILITIES
<b><i>Coherent Speech</i></b>	DISORGANIZED AND/OR INCOHERENT SPEECH	INCREASED ORGANIZED AND COHERENT SPEECH	COHERENT, ORGANIZED SPEECH
<b><i>Emotional Functioning</i></b>	LIMITED AWARENESS OR APPROPRIATE EXPRESSION OF EMOTIONS	EMERGING AWARENESS & APPROPRIATE EXPRESSION OF EMOTIONS	INCREASED AWARENESS & APPROPRIATE EXPRESSION OF EMOTIONS
<b><i>Goal-Directed Behavior</i></b>	LIMITED ADAPTIVE & GOAL- DIRECTED BEHAVIOR	EMERGING ADAPTIVE & GOAL-DIRECTED BEHAVIOR	INCREASED ADAPTIVE & GOAL-DIRECTED BEHAVIOR

The three phases and eight domains are not rigidly defined categories but general divisions and distinctions across a continuum from most impairing, interfering, and/or distressing to the least. This is an alternative to binary categories such as “psychotic or not psychotic” and “sick or well.” Psychosis can be experienced within a range of life experiences and across many different mental

health diagnoses, with different causes, manifestations, levels of impairment, and outcomes. A dimensional perspective is more accurate for conceptualizing the varying forms and degrees of psychosis than trying to place individuals into discrete categories. With such an approach, schizophrenia is distinguished more by severity (including in self-disturbance) from other, less impairing psychotic experiences as well as from other mental health problems. This continuum can provide refinement in assessment and understanding across and within sessions or interactions with a person. This is particularly important for those with a severe psychosis who may regress and progress quickly and abruptly, even within a single therapy session or therapeutic encounter. For example, a man diagnosed with schizophrenia when in the surviving phase had such a severe self-dissolution that he believed he did not have any skin. In the existing phase he began to reconstitute and stated that he wanted to be “comfortable in my own skin,” and in the living phase he had a better defined sense of self and was focused on pursuing his interests and improving his close relationships. This same person presented very differently at various points in therapy (sometimes within single sessions), and this necessitated frequent changes in the therapy approach and interventions in order to maintain attunement and appropriately intervene based on his psychological state.

In the surviving phase, the person is in an acute crisis or decompensated state, most often characterized by prominent impairing hallucinations and/or delusions and problems in organized/coherent thinking. The person constantly feels under threat and readily misperceives internal and external stimuli as threats, resulting in a high arousal state that can go beyond high agitation to numbness. There may be a loss of sense of self to the extent of questioning existence and a regression involving complete dissolution of the self. Individuals generally develop an implicit awareness of existence as a separate individual very early developmentally, but this is lost in a severe regression into psychosis. For example, a woman with acute psychosis on an inpatient unit carried around a hand mirror to frequently check that she still existed. Another patient repeatedly asked to have his vitals checked to ensure that he was still alive. When slightly more constituted in the surviving phase, the individual may feel a threat to their existence, including to bodily or psychological integrity (e.g., beliefs and experiences that people are trying to kill them, their organs are falling out, or some external device is controlling their thoughts).

The loss of self-definition affects the other domains as well. For example, the person in the surviving phase who is struggling with existence and safety in existence is less able to relate self with other (including the clinician); has limited metacognitive ability; and has less ability to identify, verbalize, and manage

emotions. This is because the fundamental awareness of a core self is an essential prerequisite for awareness of thoughts, feelings, and others. In addition, maladaptive behaviors that pose immediate safety concerns likely are prominent in this phase. For example, an individual may experience such a loss of reality testing that they are unable to conduct basic self-care. Other maladaptive behaviors may include being actively, imminently suicidal or homicidal or having an impairing substance use problem.

In the existing phase, the issues of each domain remain a concern but at a more moderate intensity and reduced level of impairment. Characteristic of this phase is that the person is starting to stabilize but remains vulnerable to regression. In an effort to avoid regression, those in the existing phase tend to restrict their experiences emotionally, interpersonally, and behaviorally to avoid becoming overwhelmed. They may want to keep their lives simple and be cautious about exploring their internal and interpersonal experiences or expanding activities. Sometimes care providers, both health care professionals and family, share the person's fears and, consequently, either consciously or unconsciously contribute to the person's avoidance. This perpetuates the individual remaining in the existing phase. There the person has a slightly better developed self-structure—where a core self exists—but split-off, unintegrated aspects to the self remain, such as memories, affects, or distressing voices. The person may start to use more “I” statements, reflecting an increasing sense of a distinct self. There is also an emerging sense of others and of thoughts and feelings, such as the patient who observed that “I can have a thought and have it all day.” Hallucinations and/or delusions may be present but not all consuming. There remains a tendency to misperceive events as threatening and continued hypervigilance and physical arousal but not at an incapacitating level.

In the living phase, individuals are more fully engaged in a range of experiences psychologically, emotionally, and interpersonally. They are developing or regaining an integrated, differentiated, and more stable and consistent sense of self. In this phase they also exhibit increasing relatedness with others, empathy and a capacity for intimacy, a better ability to reflect on emotions and thinking, more adaptive expression of emotions, lower arousal, and a more accurate appraisal of threat. There are minimal impairing or intrusive hallucinations or delusions, and the individual functions more effectively and adaptively. In this phase, individuals are more like other higher-functioning clients, although those with severe psychosis may remain more tenuous in functioning and revert more easily into increased arousal, perceived threat, reduced self-definition, loss of shared reality, and distressing hallucinations or delusions. Currently, fewer individuals with severe psychosis (including those diagnosed with schizophrenia) reach the living phase.

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The objectives of recovery models and models that include psychosocial and psychotherapeutic interventions are to increase the number of individuals with severe psychosis who achieve this higher level of functioning.

### **The SEL Model: Corresponding Interventions**

Once the phase of psychosis is determined, the SEL model can be used as a guide for choosing the types of interventions that are most congruent with the person, their needs, and their psychological capabilities.

The primary goals of the surviving phase are to reestablish awareness of existence as a separate individual, reduce distress, and improve regulation of stressors and emotions enough so the person has less “pull” to escape into an alternate reality or to not exist. The surviving phase is not the time to explore stressors or bring up affectively charged topics, particularly about the past. Rather, the focus needs to be on the present and on containing and fortifying. If the person is regressed to the point of not having an established sense of self, an essential primary intervention is reconstituting the core self. This is achieved through the process of differentiation to increase the individual’s awareness of being a distinct, separate, cohesive person. Differentiation involves increasing awareness of physical and personal attributes that define the self and emphasizing differences between the individual and others to enhance the boundary. This is different from the common therapeutic approach of building rapport by finding similarities and “joining” with clients, which can feel threatening, encroaching, and engulfing to someone in the surviving phase (Laing, 1960). For example, in an initial therapy encounter, a woman diagnosed with schizophrenia nervously pointed out that she and the therapist were both wearing black shoes. The therapist commented, “Yes, but yours are shinier.” The woman sighed with apparent relief and said, “This is what I want to tell you.” She needed to have the boundary between herself and the therapist reinforced in order to feel safe enough to engage without fear of merger. Reconstitution of the self and stabilization also involve interventions that reduce environmental or interpersonal stressors and further enhance trust and safety in the therapy relationship. Such interventions contribute to the individual reestablishing enough of a sense of safety to exist in shared reality.

Other objectives of the surviving phase include maintaining safety, increasing support, reducing distress, and maintaining a present focus. These are common crisis intervention strategies with any individual in acute distress. Unique to those with severe psychosis is the need, once sufficiently reconstituted in self-definition, to conduct basic awareness of thoughts and feelings. This includes identifying

thoughts as their own, as private, and as distinguished from actions and to label and contain emotions. General normalization of thoughts and feelings (Addington et al., 2011) is often more effective in the surviving phase than specific identification of personal thoughts and feelings. For example, stating “I don’t know if it is true for you, but many people would feel a little bit frustrated if someone kept interrupting them” may more likely be acknowledged by an individual in the surviving phase than “It seems that you are feeling frustrated that the person kept interrupting you.” That is because the former statement allows for the option of choosing a feeling that others have as well as to not feel “told” and potentially encroached upon by the therapist. The feeling is also titrated down to a less intense feeling so as to be more manageable for the individual. Family, group, and team interventions focus on the present moment, enhancing self-definition and boundaries with others, reducing emotional intensity in interactions, emphasizing strengths, giving support, and problem solving to reduce or address current stressors.

In the existing phase, fears of reverting back to the surviving phase (i.e., returning to acute crisis, being emotionally overwhelmed, becoming more psychotic, being rehospitalized) reinforce avoidance. Therefore, the primary goal of this phase is to gradually increase tolerance and capacity for expanding experiences within and outside the self. Increasing a sense of safety remains a crucial objective, including improving the ability to accurately assess perceived internal and external threats. Increasing self-definition in the existing phase involves a balance between continued fortifying and differentiating work and starting to connect to unwanted urges, thoughts, feelings, and memories. Self-work also involves an emphasis on gradually increasing awareness of the body and learning to use bodily and physical responses as information and protection rather than viewing the body as separate from the self and as a threat. Having an adequately developed core self allows for expanding self-reflection abilities in the existing phase, including the ability to think about thinking and to identify and explore emotions. Cognitive-behavioral therapy (CBT) for psychosis interventions can be particularly effective starting in the existing phase, including by changing perceptions of hallucinations and delusions (Hagen et al., 2010; Kingdon & Turkington, 2008). Working with the individual to explore and understand the origins and meaning of psychotic experiences (particularly hallucinations and delusions) as emphasized in psychodynamic frameworks (e.g., Karon & Vandenbos, 1981) also occurs. Self-other work concentrates on using the therapy relationship and current other relationships to build social skills and increase healthy, trustworthy relationships. Psychoeducation further normalizes experiences and teaches coping skills, and efforts can be made to begin exploring vocational options. Family and group interventions can also

focus on these objectives, thereby bolstering the individual's coping, increasing focus (to tolerance) on relationships, and identifying and addressing factors contributing to distress. Given the often tenuousness of psychological stability for individuals who experience severe psychosis, providers need to closely monitor the person's status and return to surviving phase approaches whenever there are indications of regression. This may be necessary briefly within a therapy session or for longer periods of time.

In the living phase, the primary goal is to facilitate development of an integrated, differentiated, and stable sense of self and to encourage fuller engagement psychologically, emotionally, behaviorally, and interpersonally. Objectives include enhancing self-reflection, coping skills, and interpersonal relating; further improving reality testing and threat perception; and improving emotional awareness and regulation. Treatment can move between attention to past, present, and future. An individual in the living phase can do more collaborative exploration of how past experiences have contributed to current difficulties, including trauma work, making meaning of hallucinations and delusions, and engaging in deeper levels of emotional and cognitive processing.

However, because those with severe psychosis are more vulnerable to regression, interventions in the living phase must continue to be paced carefully while monitoring the individual's status and responses and adjusting the type of approach accordingly. Although the importance of tailoring the approach is apparent to experienced clinicians, it is not uncommon to think the person experiencing psychosis is ready for particular interventions, to initiate the work, and then to realize the need to revert back to more supportive and strengthening interventions because the individual becomes overwhelmed and begins to regress. Sometimes in such situations the provider may have miscalculated the person's psychological readiness. At other times, the person was ready in that moment but then reacted and regressed. In addition to vulnerabilities to regression in the living phase, the heavy reliance on denial, avoidance, and projection in severe psychosis poses additional challenges to increasing awareness and acceptance of thoughts, feelings, and memories and requires skill and patience by the clinician. Family and group therapies can explore interpersonal and emotional issues more in depth when balanced with continued support and bolstering of the individual's functioning. Supporting the individual in vocational or volunteer pursuits is also an important part of the living phase.

## **Trauma Treatment**

Research indicates high rates of post-traumatic stress disorder (PTSD) in individuals diagnosed with schizophrenia (Dallel et al., 2018). The strong association between trauma and psychosis highlights the necessity of incorporating trauma treatment into therapy for psychosis. However, the vulnerability to regression of many who experience psychosis underscores the importance of timing trauma-specific interventions based on readiness. The SEL model can provide guidance on timing trauma-specific interventions (Fuller, 2009) in addition to general therapeutic interventions. Consistent with many widely used trauma treatment models, trauma work in the surviving phase emphasizes ensuring safety (actual and perceived), stabilizing, and providing support. The existing phase can include psychoeducation about trauma and common trauma responses, teaching coping skills, reducing avoidance, and starting to identify traumatic experiences and potential effects. Psychoeducation can include explaining how psychosis is often a severe stress or trauma response and an effort at self-protection. Specific trauma processing work does not occur until the person is sufficiently stable. Therefore, the deeper cognitive and emotional trauma processing occurs once the individual is in the living phase but with additional caution and reverting to fortifying and support as needed based on fluctuations in the person's psychological status. The goal of the trauma work is to move toward acknowledgment of the effects of past trauma on the person and to reduce effects of the past on the individual's present and future.

## **Limitations**

The SEL model is a conceptual framework that was developed based on clinical experience and the clinical and empirical literature. Although research is needed to empirically validate the benefits of the SEL model for enhancing treatment efficacy, it is hoped that the emphasis on tailoring interventions based on client status and combining therapeutic approaches continues to be a central focus of future clinical endeavors. Development of a diagnostic tool to facilitate assessment of the eight domains would also be useful. In addition, characteristics of a prodromal phase, which is crucial for early intervention, are not included in the SEL model. Increasing attention is being paid to delineating prodromal signs of psychosis in order to improve early detection and intervention. Therefore, the prodromal phase is an important part of the continuum of psychosis severity. Incorporation of a prodromal phase, including distinguishing features and effective treatment interventions, could be an important expansion of the SEL model.

## Conclusions

In summary, innovations in our understanding of and care for individuals suffering from psychosis are infusing treatment approaches with greater effectiveness and increased optimism for recovery. Improving efficacy now necessitates tailoring interventions to client status in order to enhance alignment between therapeutic approach and client readiness and capabilities. The SEL model was described as a method for increasing this congruence and as a means of integrating different therapeutic approaches. Ultimately, the emphasis is on finding ways that every therapeutic encounter can enhance attunement between clinicians and those experiencing psychosis in order to assist the person in moving from merely surviving to more fully living.

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