Introduction

This book is intended for mental health professionals who are already involved in the care of persons suffering from psychosis and for trainees contemplating a career of this work. I describe an approach to the psychotherapy of psychosis that combines cognitive-behavioral therapy (CBT) for psychosis with psychodynamic psychotherapy for psychosis in a sequence that follows as a logical consequence to the psychology of psychosis. I make no claim to have invented a new therapy. Rather, like fitting two pieces together to solve a puzzle, I fit two existing therapies together.

Psychotherapy for psychosis should be *ambitious*. It should be ambitious in the goals it sets for the recovery of psychotic persons and in the resources it brings to bear to accomplish these goals. Most public mental health systems list "supportive" individual psychotherapy, group therapy, creative arts therapy, and other psychosocial treatments in their program descriptions. The psychotherapy provided to psychotic persons in the public sector is undoubtedly of value, but with few exceptions, it is too vaguely conceived, inadequately staffed, and insufficiently supervised to have a significant enduring impact on patient wellness. Patients and clinicians too often accept stability rather than aim for substantial recovery in work and interpersonal relationships. We should be ambitious in our expectations of the resources for psychotherapy that the public sector should provide. The failure of patients to recover is often attributed to the illness rather than the inadequacy of our clinical approaches. I am a psychiatrist who is convinced of

the value of psychotherapy for psychosis. When I make rounds on a busy pharmacologically oriented inpatient service, I feel like a military medic walking among fallen soldiers wounded in battle, who are succumbing to their wounds for lack of penicillin. Would that ambitious psychotherapy were more available to psychotic persons who have been wounded by life.

Psychotherapy for psychosis should be ambitious in the training expected of psychotherapists doing this work. Because the clinical task demands it, psychotherapists should push themselves beyond the narrow guild identifications in which they trained to embrace a wider, more comprehensive approach to treating psychotic persons. I trained as a psychoanalyst, but 15 years ago I went back to school to learn CBT. This book integrates CBT with a psychodynamic perspective. There are sound reasons to approach the psychotherapy of psychosis in two sequential phases: an initial phase that uses primarily CBT techniques to examine the *literal falsity* of delusional ideas, and a second phase that uses a psychodynamic approach to examine the *figurative truth* (specific personal meaning) contained in psychotic symptoms. In this approach, the heart meets the logical mind in a broad-based, integrated psychotherapy technique that is more comprehensive than CBT or psychodynamic therapy alone. Other approaches, including metacognitive therapy (Lysaker et al., 2011), mindfulness (Pradhan, 2015b), and acceptance and commitment therapy (ACT; Hayes & Smith, 2005), can also be extremely useful additions for therapists doing individual psychotherapy.

I hope CBT clinicians will find something of value in the psychodynamic ideas in this book and that psychodynamic clinicians will incorporate CBT techniques in their practice. Where I refer to psychoanalytic theory, I have attempted to keep jargon to a minimum. I favor the more open-ended concept of *psychosis* over the narrower categorical diagnosis of *schizophrenia*. I find the phrasing "persons with psychosis" or "persons suffering from psychosis" preferable to labeling people "schizophrenics." For the sake of some variety in language, I occasionally refer to a "psychotic patient," a "psychotic person," or a "psychotic individual," knowing well that no one is entirely defined by a psychotic process.

How This Book Is Different

There are any number of good books about the psychotherapy of psychosis. What is different about this one? This book:

1. Draws attention to the need for psychotherapy for psychosis in public-sector psychiatry, where most persons with psychosis receive their care, and offers a blueprint of what would be required to provide needed psychotherapy services in public clinics.
2. Outlines a model of psychosis that extends current models to include biology, the phenomenology of psychosis, and cognitive and psychoanalytic theories, showing how biology and psychology can fit together in theory and treatment.
3. Applies psychoanalytic object relations theory to the phenomenology of psychosis and psychotherapy technique, in a way that views psychosis as an autobiographical play staged in the real world.
4. Assumes that psychotic symptoms are a symbolic expression of the psychotic person's mental life—neutron stars in the firmament of mind that are dense with meaning.
5. Emphasizes the alterations of the subjective experience of consciousness that occur in psychosis that contribute to disability and the formation of delusions.
6. Illustrates the interweaving of CBT and psychodynamic technique in ongoing treatment.

Why is this book, along with other recent books about the psychotherapy of psychosis (Garfield & Steinman, 2015; Lotterman, 2015; Marcus, 2017; Steinman, 2009), relevant at this time? Simply put, *although current pharmacologically oriented treatment-as-usual for psychosis reduces acute psychotic symptoms and helps prevent relapse, it is insufficiently effective to accept its domination of treatment paradigms.* After almost seven decades with biological psychiatry directing care, while other disciplines of medicine have achieved dramatic advances in patient wellness, most chronically psychotic people remain severely disabled throughout their adult lives. Harrow and colleagues monitored outcomes in a cohort of patients diagnosed with schizophrenia for 20 years (Harrow, Jobe, Faull, & Yang, 2017). At the 15-year mark, only 10–20% had a relatively benevolent outcome (recovery), while 25–35% showed chronic psychotic symptoms without remission. The remaining patients showing an intermittent waxing and waning course. Patients not prescribed antipsychotics showed significantly fewer psychotic symptoms and better work histories than those prescribed antipsychotics (Harrow, Jobe, & Faull, 2014). The longitudinal data indicate that in the majority of patients, long-term neuroleptics do not restore premorbid functional capacity (Harrow et al., 2017). See Read and Dillon

for a comprehensive review of functional outcomes for persons with or without medication (Read & Dillon, 2013).

Psychopharmacology currently dominates the treatment of acute psychosis and, for many patients, plays a significant role in preventing psychotic relapse. Discontinuation of neuroleptics has been associated with increased rates of relapse and increased mortality (Tiihonen, Tanskanen, & Taipale, 2018). Because the risk of relapse increased over time, in the Tiihonen study, there appeared to be no minimum period of prescription after which it was safe to discontinue neuroleptics. Because only a small percentage of relapses occurred in less than 6 months, the authors concluded that relapse was likely unrelated to neuroreceptor hypersensitivity. Notably, 30% of patients who discontinued medication early were not rehospitalized, suggesting that some patients can manage without maintenance medication. In my clinical experience, I have been able to help many patients attain significant improvements in quality of life that they were unable to achieve with maintenance medication alone. While I have seen patients manage reductions in medication without relapse, when patients want to stop medication entirely, I have had little success weaning patients off neuroleptics without triggering a resurgence of psychotic symptoms.

Pharmacology dominates treatment despite evidence that some psychotic individuals can recover without medication (Bola & Mosher, 2002, 2003); despite the observation that the majority of first-episode patients who receive intensive psychosocial services can do well with no or reduced medication (Aaltonen, 2011; Cullberg, Levander, Holmqvist, Mattsson, & Wieselgren, 2002); despite the modest response rates of patients taking neuroleptics compared with placebo controls (Leucht, Arbter, Engel, Kissling, & Davis, 2009); despite the toll of side effects these drugs exact; despite the finding that from one-half to two-thirds of patients have significant periods of recovery in the long term, suggesting that psychosis is not an inherently irreversible condition (Ciompi, 1980; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b); and despite the finding that many patients who discontinue medication prosper, suggesting that all patients need not take neuroleptics for a lifetime to do well (Harrow & Jobe, 2007). Surely a 60-year trial of a primarily biological paradigm is sufficient time to conclude we need to intensify our focus on psychological and social treatments.

An Argument for Psychotherapy for Psychosis

The program for ambitious psychotherapy outlined in this book is consonant with the *recovery movement,* a paradigm shift that occurred in

the mid-1970s, that placed patients/mental health consumers/experts-by-experience at the center of their care (American Psychological Association, 2014). Unlike the traditional genetic brain disease model of schizophrenia, whose primary aim was to reduce symptoms in chronic psychosis with medication, the recovery movement set the more ambitious goal that individuals suffering from a psychotic illness should expect to recover significant functional capacity for work and interpersonal relationships and to lead a meaningful life (Deegan, 2003). The civil rights movement, legislation recognizing the needs of disabled persons, and evidence that persons suffering from psychosis could recover (Zipursky, Reilly, & Murray, 2013) lent momentum to this shift.

Recovery is a broad concept that includes not only the aim to reduce psychotic symptoms, but a recognition that individuals who became ill as young adults have lost years of crucial formative life experience that cannot be compensated by medication. The Substance Abuse and Mental Health Services Administration (SAMHSA) defined four dimensions of recovery: ability to overcome or manage one's illness; a stable place to live; meaningful daily activities and the resources to participate in society; and relationships and social networks that provide support, friendship, love, and hope (SAMHSA, 2011). Unlike pharmacology, which is physician-directed, recovery is person-centered, self-directed, and empowering of the affected individual. Recovery is expected to be nonlinear: an ongoing growth process, with occasional setbacks, where a person learns from experience. Ambitious psychotherapy can be an extremely valuable aid in the recovery process.

A pervasive pessimism follows the conviction that "schizophrenia" is fundamentally a chronic brain disease for which we have yet to find the biological cure. In this frame of mind, frontline clinicians may feel that by providing treatment-as-usual they are conducting a palliative holding action until a biological messiah arrives. Waiting for a biological cure provides an endless rationale for therapeutic failure. If we don't really expect patients to recover, we think less about what else we should be doing *now* and content ourselves that we are doing what we can. Because it is a complex biopsychosocial disorder that bears the psychological imprint of adverse life experiences, chronic psychosis will never yield to a singular biological treatment. In my view and in the opinion of many like-minded clinicians, a significant reason for the high mortality, morbidity, and lingering disability in psychosis is psychiatry's failure to include an *ambitious* program of individual psychotherapy in the treatment of psychosis. Karon (2003) described the absence of psychotherapy for psychotic patients as a tragedy. I agree. Psychotherapy cannot substitute for pharmacological treatments, but psychotherapy should be a mainstay of treatment.

To be fair, while successful approaches like Soteria House (a small-scale residential community that provided a supportive safe haven where persons with psychosis could recover without the use of neuroleptics) (Mosher & Boda, 2013) offer viable alternatives to medication, no public health system anywhere in the world has made do without some resort to psychopharmacology. As noted earlier, neuroleptics can reduce acute psychotic symptoms in many patients and help "stabilize" patients in the community, but neuroleptics are far from a panacea. Some patients who are adherent to their medication report that neuroleptics numb their feelings, which may help people tolerate their delusional beliefs without fundamentally changing them (Mizrahi, Bagby, Zipursky, & Kapur, 2005). The widely referenced Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study (Manschreck & Boshes, 2007) that compared the efficacy and side effects of first-generation and second-generation antipsychotics showed that, in general, the newer drugs were not demonstrably more effective than the older, cheaper ones (Leucht, Kissling, & Davis, 2009). In their assessment of what psychiatry learned from the CATIE study, Lieberman and Stroup (2011) opine that looking at the CATIE study results is like seeing the emperor with no clothes. They conclude, "To the extent that antipsychotics differ, it is more in their side effects than therapeutic effects" (p. 772).

Another reason to consider psychotherapy is that neuroleptics damage the brain. A long-term MRI follow-up of brain changes in chronically psychotic patients receiving neuroleptics found that loss of brain tissue over the course of neuroleptic treatment did not correlate with severity of illness or substance abuse, but did correlate with total neuroleptic exposure and length of untreated psychosis (Andreasen, Liu, Ziebell, Vora, & Ho, 2013; Ho, Andreasen, Ziebell, Pierson, & Magnotta, 2011). Considering the structural brain changes associated with total neuroleptic exposure, the authors offer their clinical recommendation.

> By examining the relative balance of effects, that is, relapse duration versus antipsychotic treatment intensity, this study sheds light on a troublesome dilemma that clinicians face. Relapse prevention is important, but it should be sustained using the lowest possible medication dosages that will control symptoms. (p. 609)

Psychosocial treatments, including psychotherapy, can help reduce the patient's cumulative exposure to neuroleptics, as demonstrated in a large, multisite, double-blind controlled trial conducted in community clinics (Kane et al., 2016; Mueser et al., 2015). In this study, patients who were enrolled in the NAVIGATE intervention, which included personalized medication management with less medication being prescribed,

family intervention, resilience-focused individual psychotherapy, and supported employment, did better in terms of quality-of-life outcomes than patients in community treatment-as-usual, which included higher doses of neuroleptics. In other words, patients who received less medication and more psychosocial treatment, including individual psychotherapy, fared better.

When psychiatry places a one-sided bet on medication, it abandons some patients to a life with little hope. A psychotic man once told me in our first outpatient psychotherapy session that when he was told he met the criteria for discharge because he was no longer acutely suicidal, he decided to kill himself after discharge. Although he was not acutely suicidal on the inpatient unit, as he had been on admission, he remained in despair about his future. He assumed that surely the staff knew this because he had told them so many times. He reasoned that if, after 6 weeks of intensive inpatient treatment with medication, the staff was discharging him, they had done their best and they had nothing else to offer. His fiancée and best friend prevailed on him not to give up and encouraged him to try psychotherapy.

Discrediting Myths about Psychotherapy for Psychosis

Every generation of clinicians for the past 100 years has included therapists who have treated psychotic patients in psychotherapy and written about their work (Stone, 1999). Psychoanalysis has produced an extremely valuable body of ideas about psychosis and a number of gifted clinicians, but psychoanalysts have done little to disseminate psychodynamic psychotherapy in public psychiatry (Garrett & Turkington, 2011). Proponents of CBT have done better in this regard, but neither CBT nor psychodynamic therapy has become a standard part of treatment-as-usual. The reasons for this failure are historical, clinical, political, and financial.

1. The biggest obstacle to implementing psychotherapy for psychosis is likely the widespread belief that it is of no value. With the advent of neuroleptics in the 1950s, a number of studies were conducted in the 1970s–1980s to investigate the efficacy of psychotherapy for psychosis compared with medication (Karon & VandenBos, 1972, 1981; May, 1968). The May study, where patients were treated by inexperienced therapists, showed that medication alone was better than psychotherapy alone, but that medication plus psychotherapy was superior to medication alone. In the Karon and VandenBos study (1981), patients were treated either by one of two psychotherapists experienced in the

psychotherapy of psychosis or by inexperienced therapists supervised by these experienced clinicians, with one group of patients receiving psychotherapy plus medication from the inexperienced therapists and another group receiving psychotherapy alone from the inexperienced therapists. Results showed that patients who received psychotherapy spent roughly half as much time in the hospital as the medication treatment-as-usual group. There was also a significant reduction in thought disorder compared to controls who did not receive psychotherapy. At 2-year follow-up, inexperienced therapists treating patients without medication did not reduce overall hospital days, while experienced therapists treating patients with or without medication did reduce hospital days. This study emphasized the importance of the therapist's experience doing psychotherapy for psychosis. It differs from the May study and most other studies in showing that for some patients psychotherapy alone was superior to medication.

The results of these studies and three others are summarized in a report of the Boston Psychotherapy Study, the largest study of psychotherapy for psychosis conducted to date (Gunderson et al., 1984; Stanton et al., 1984). Done at a time when the influence of biological treatment was on the rise while the influence of psychoanalysis was waning, the authors hypothesized that psychodynamic psychotherapy would be more effective than supportive psychotherapy. The study compared exploratory, insight-oriented psychotherapy (EIO), which employed psychodynamic techniques, with reality-adaptive, supportive psychotherapy (RAS), which focused on here-and-now problem solving. It was conducted at three sites and involved 95 patients and 81 experienced therapists, with a 2-year follow-up, albeit with a significant dropout rate. An enormous amount of thought, time, and resources went into this study, an effort not soon to be repeated in the current climate of research funding that favors neuroscience. The most striking and unexpected result was that, while patients improved with psychotherapy, there was no difference between therapy groups on most outcome measures. Consistent with the primary focus of each therapy, RAS showed a clear advantage in reducing recidivist admissions, improving work-role performance, and maintaining household responsibilities, while EIO showed a modest advantage in improved ego functioning and cognition. As was true in the Karon study (1972), a subsequent analysis of the importance of the therapist's skill revealed a significant relationship between skillful dynamic exploration and better outcomes (Glass et al., 1989).

Because it failed to confirm a distinct advantage for psychodynamic therapy, the results of the Boston Psychotherapy Study did not encourage further psychotherapy for psychosis research until CBT investigators

revived this aim in the 1990s. In the 1980s and 1990s, not only was psychotherapy thought to be ineffective, but the idea that psychotherapy might be harmful seeped into the psychiatric literature. Drake and Sederer (1986) published a paper based on one patient they had never seen whose family claimed the patient became delusional and agitated while receiving 5-times-a-week psychotherapy. No specifics of the psychotherapy were described. Nevertheless, the authors opined that psychotherapy can be harmful to patients with schizophrenia. Lotterman (2015) traces this single case report as it may have contributed to the views of other observers who cited this paper that psychotherapy is damaging to psychotic persons (Mueser & Berenbaum, 1990; Scott & Dixon, 1995). What might have been taken as a reasonable caution, that intensive psychotherapy that encourages regression may be ill advised, morphed into a more pervasive cynicism about psychotherapy for psychosis.

The research conducted to date is an inadequate test of the efficacy of psychotherapy for psychosis. The history of chemotherapy provides an instructive contrast. When chemotherapy pioneers noted occasional positive results among frequent failures, instead of throwing in the towel, they took such individual positive results as proof that better results might be achieved in time. They were right. They didn't give up. They conducted more research and refined their treatments, which led to improved efficacy. In this spirit, when a recent study showed that clozapine-resistant patients improved with 9 months of CBT compared with clozapine treatment-as-usual, but the CBT group improvement did not persist at 21 months after CBT was discontinued (Morrison et al., 2018), Schooler suggests that the loss of the CBT effect after the treatment was discontinued may not be so different than the loss of effect when medications are discontinued. The clear additional benefits from CBT in patients already taking the most effective neuroleptic available should prompt researchers to discover how to maintain or increase this positive effect (Schooler, 2018). "Schizophrenia" does not lead to an inevitable mental deterioration. Patients sometimes recover without medication. Many show periods of positive functioning despite their chronic disability. There is good reason to hope that we can help achieve better outcomes for our patients than are currently achieved by refining our methods of psychotherapy. The psychotherapy literature is full of encouraging case reports, but unlike oncologists, who were inspired by early positive results, psychiatrists gave up prematurely, closing the book on research on psychotherapy for psychosis much too early. It is time to circle back and proceed more deliberately.

Despite successes in the work of leading clinicians throughout the 20th century, empirical research demonstrating the effectiveness of

CBT and individual psychodynamic psychotherapy for psychosis, and first-person accounts of recovery from psychosis, a bias against psychotherapy persists.* Psychiatry gave up on psychotherapy research rather than trying to develop more effective techniques. The prejudice against psychotherapy for psychosis is particularly striking considering evidence that CBT can ameliorate symptoms that are resistant to neuroleptics (Rathod, Kingdon, Weiden, & Turkington, 2008) and despite dispiriting reports of a publication bias that suppresses negative neuroleptic trials in favor of publishing studies with positive results. For example, the effect size for unpublished neuroleptic trials was only 0.23, less than half that for the published trials (0.47), a statistically significant difference (Turner, Knoepflmacher, & Shapley, 2012). Suppressing negative neuroleptic trials exaggerates the efficacy of drugs compared with psychotherapy.

In summary, it is fair to say that there is strong evidence for the effectiveness of psychotherapy for psychosis in case reports of successful psychotherapy and some evidence from randomized trials of its value. This should prompt more research to refine psychotherapy techniques rather than lead to a blanket rejection of psychotherapy as a treatment modality.

*Here I am referring to the clinical work of pioneers like Harry Stack Sullivan (Sullivan, 1974), Frieda Fromm-Reichmann (Fromm-Reichmann, 1950), Herbert Rosenfeld (Rosenfeld, 1965), and Silvano Arieti (Arieti, 1974), followed by Hanna Segal (Segal, 1950), Harold Searles (Searles, 1986), Otto Will (Will, 1958), Bertram Karon (Karon & VandenBos, 1981), and, more recently, George Atwood (Atwood, 2012), Michael Eigen (Eigen, 1995), Thomas Ogden (Ogden, 1980), Michael Robbins (Robbins, 1993), Andrew Lotterman (Lotterman, 2015), David Garfield and Ira Steinman (Garfield & Steinman, 2015), Christopher Bollas (Bollas, 2012), and Johannsen, Martindale, and Cullberg (2006). Compelling first-person accounts of recovery from psychosis include those of Joanne Greenberg (Greenberg, 1964), Arnhild Lauveng (Lauveng, 2012), Elyn Saks (2007), and others (Geekie, Randal, Lampshire, & Read, 2011). As for empirical research on psychotherapy for psychosis, some key studies are Wykes, Steel, Everitt, and Tarrier (2008), Gottdiener and Haslam (2002), Mojtabai, Nicholson, and Carpenter (1998), Rosenbaum et al. (2012), Smith, Glass, and Miller (1980), and Summers and Rosenbaum (2013).

The cumulative experience of multiple clinicians over decades noted before tends to be discounted when randomized controlled trials (RCTs) are considered the only evidence of real value. RCTs are well suited for studying the impact of an independent variable (a treatment technique) on a dependent variable (a measurable symptom), if one assumes linear causality. RCTs are in many ways ill-suited for studying the long-term psychotherapy of psychosis, where the dependent variable (the person) is not a passive recipient of the treatment, but an active agent of change who shapes the treatment in unforeseen ways (Carey & Stiles, 2016). If one honors other methods of evidence, such as serial replication, convergence of concepts and results, and the incremental elimination of alternative explanations, one sees substantial support for the psychotherapy of psychosis.

2. According to DMS-5, the same symptom picture might be diagnosed as "brief reactive psychosis" or "schizophrenia," depending solely on length of illness. Defining "schizophrenia" by length of illness rather than pathognomonic symptoms allows some to conclude that a psychotic person who recovers without medication wasn't really "schizophrenic" in the first place. If "schizophrenics" are operationally defined as people who don't get better, by definition, one would expect little role for psychotherapy in their care and little impetus for research in psychotherapy.

3. Understanding the psychology of psychosis requires the clinician to empathize with psychological defenses and levels of anguish not often encountered in everyday life. When clinicians see little connection between ordinary mental life and psychotic symptoms, the utility of talk therapy for psychosis may not be intuitively obvious.

4. The now discredited "schizophrenogenic mother" theory of the etiology of psychosis was in vogue in the 1950s and 1960s. The obvious efficacy of neuroleptics in relieving acute psychotic symptoms undercuts this theory. Unfortunately, discrediting this one psychological hypothesis cast doubt on psychological theories in general, effectively throwing the psychological baby out with the bathwater.

5. Freud did not believe psychotic patients formed an analyzable transference, and so he had no faith in the efficacy of psychoanalysis, at least as he practiced it, as a treatment for psychosis. With some notable exceptions, the psychoanalytic community has mirrored Freud's attitude and has largely abandoned the care of the severely mentally ill. Psychiatric residencies have followed suit, teaching little about the psychotherapy of psychosis in training curriculums (Kimhy et al., 2013).

6. Psychotherapy failed to establish itself not only because it was crowded from the field by biological treatments, but because a classical psychodynamic approach is often ineffective when therapists pay too much attention too early to interpreting the unconscious psychological meanings of psychotic symptoms, and too little attention to the patient's cognitive mechanisms and conscious experience of psychotic symptoms. I hope this book will help to redress this balance.

On a more personal note, when I finished my psychiatric residency some 40 years ago and my psychoanalytic training shortly thereafter, I wanted to work psychotherapeutically with chronically psychotic patients in the public health sector. But I found that the clinical skills I had learned during psychiatric residency were inadequate to the task. Years later, still interested in the psychotherapy of psychosis, I started reading the literature on CBT for psychosis that began emerging in Great

Britain in the early 1990s. Seeing its value, I decided that I needed to put aside the complacency of my psychoanalytic orientation and, approaching middle age, I needed to go back to school. I read papers and textbooks, attended CBT training sessions, went to CBT conferences, and began treating psychotic patients under the supervision of two experienced British CBT therapists, Douglas Turkington, MD, and Alison Brabban, PhD. This training proved invaluable. It allowed me to reclaim my original ambition to do psychotherapy with psychotic persons. Better late than never.

My new training immediately proved useful. The first patient I treated was a woman with a chronic paranoid psychosis who, prior to her psychotherapy, had had multiple inpatient admissions every year for 5 years. Asha's treatment is outlined in Chapter 15. After 4 months of once-a-week psychotherapy, and during 15 years of subsequent follow-up, she has never been readmitted to the hospital. A second patient I treated early in this work was a man with a chronic paranoid delusion who had been confined to a state forensic facility for 15 years after he murdered his parents. Kasper's treatment is also summarized in Chapter 15. After 9 months of once-a-week psychotherapy, he showed sufficient gains to be approved for off-ward passes. He was discharged from the state hospital to a supportive residence the following year. He would certainly have died in the hospital were it not for the work he did in psychotherapy because 15 years of treatment-as-usual had not prepared him for discharge.

Most clinicians attend a conference here and there, and a talk now and then, to log continuing education hours for licensure, but these educational exposures are too brief to develop a confidence in new clinical skills. No one learns to be a CBT therapist or a psychodynamic therapist during an hour-long talk or a weekend retreat. I hope this book will encourage at least a few CBT and psychodynamic clinicians to "go back to school," to spend sufficient time and pay sufficient attention to what colleagues across the conceptual aisle have to offer. I hope that clinicians working in public psychiatry will find this book useful because clinics are where most psychotic patients are treated. I am currently trying to learn more about mindfulness (Pradhan, 2015), meditation, eye movement desensitization and reprocessing (EMDR) (Wilson et al., 2018), acceptance and commitment therapy (Harris, 2009), and other techniques that may make it possible for patients to speak about what would otherwise be unspeakable.

This book is structured in three parts. In Part I, I review current biological and psychological theories of the etiology of psychosis and propose a model that integrates biological and psychological theories. In Part II, I outline an approach to the psychotherapy of psychosis

that follows as a logical consequence of this theoretical model, a technique that integrates CBT and psychodynamic approaches. In Part III, I describe the current realities of the treatment of psychotic persons in the public sector and suggest a template for change.

Throughout this book, I illustrate my recommended approach with relevant clinical material. All examples represent work with real patients, whom I have given pseudonyms and disguised in accordance with contemporary ethical standards of observing confidentiality in professional writing (Clifft, 1986; Gabbard, 2000).

I want to underline that I do not claim to have invented new therapy. I try to avoid giving already established concepts new names. I do not attempt a comprehensive summary of CBTp or psychodynamic ideas (in particular, object relations theory) and certain CBTp techniques, to form an integrated treatment that feels comfortable for me and appears to be useful to my patients.