

Running head: TRAUMA THERAPY IN TREATMENT OF PSYCHOSIS

COMPLEX TRAUMA THERAPY IN THE TREATMENT OF PSYCHOSIS:
TOWARD AN INTEGRATIVE APPROACH

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Abstract

An increasing number of studies have demonstrated that there is a high incidence of childhood trauma and posttraumatic stress disorder (PTSD) in individuals with schizophrenia, yet established treatments for psychosis do not address trauma. Recently, there has been an increasing emphasis on incorporating trauma treatment into care for schizophrenia. Despite heightened awareness of the need, there is little information available detailing an effective treatment strategy specifically tailored to this population. To address this need, a phase-oriented individual psychotherapy model is proposed that integrates Courtois and Ford's (2013) relationship based model, widely recognized as the gold-standard treatment for the treatment of complex trauma, with interpersonal psychodynamic treatment for schizophrenia. The theoretical rationale for the choice of models and their integration are provided along with the historical development leading to the creation of each model. The proposed integrated model is designed for an outpatient population of individuals with psychosis and complex PTSD and is broken down into three general phases. Broadly, Phase I addresses safety, stabilization, and engagement, Phase II focuses on psychosis specific and trauma specific processing, and Phase III involves the consolidation of treatment gains and preparation for treatment termination. Following the outline of the model, a theoretical study is proposed to evaluate the effectiveness of this model in a population of individuals with first episode psychosis and complex PTSD, as compared to two control groups.

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Introduction

Purpose and Rationale

Over the last two decades, evidence has been accumulating showing that schizophrenia is not the chronic, degenerative brain disease it has long had the misfortune of being labeled. The brand of incurability can be traced back to German psychiatrist Emil Kraepelin who, in 1893, observed the characteristics of what he called “dementia praecox”. Kraepelin claimed to have discovered an illness where deterioration begins in adolescence and continues inevitably into permanent dementia. If patients who were initially diagnosed as having “dementia praecox” got better, he questioned the diagnosis, rather than questioning whether what he had observed to be a chronic illness was inevitably degenerative. (Read & Dillon, 2013)

By 1911, Swiss psychiatrist Eugen Bleuler, based on his own studies had refined Kraepelin’s unwieldy diagnosis of dementia praecox into a more manageable, yet still heterogeneous categorization of the “group of schizophrenias”. While Bleuler agreed with Kraepelin that “the schizophrenias” were still fundamentally a physical disease, he was more interested in the mental processes of the disorder than was Kraepelin and was influenced by the work of Freud. Bleuler also differed from Kraepelin in that he observed that the illness was characterized by exacerbations and remissions, rather than a uniform decline, so was somewhat more optimistic than Kraepelin regarding prognosis and treatment. (Read & Dillon, 2013)

A little more than a century later, we are still fascinated and perplexed by the complicated and controversial experience that we call schizophrenia. Philosophy, science, medicine, and psychology have yet to agree on the causes, the trajectory, the biological and social correlates, best treatments, even the validity of the diagnosis itself. However, an increasing amount of evidence has been drawing optimistic attention to fact that schizophrenia is a treatable

disorder. According to Read and Dillon (2013), long-term outcome studies of individuals with schizophrenia have been characterized by three main findings: a) enormous variation in outcome, b) many patients recovering, and c) psychosocial factors as the best predictors of outcome. A 2001 review by Harrison et al. of the WHO International Study for Schizophrenia (ISoS) confirmed that:

...the ISoS findings joins others in relieving patients, carers, and clinicians of the chronicity paradigm which dominated thinking through much of the 20th century. They offer robust reasons for therapeutic optimism and point to a critical ‘window of opportunity’ in the early period of syndromal differentiation. (p. 515)

In addition to psychosocial factors being the best predictors of outcome, there has been a surge in research examining the role of psychosocial factors such as poverty, racism, discrimination, Western culture, isolation, and migration to name a few, in schizophrenia’s etiology (Bourque, Ven, & Malla, 2011; Cantor-Graae & Selten, 2005; Fernando, 2011; Fortney, Xu, & Dong, 2009; G. Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001; Veling et al., 2006; Werner, Malaspina, & Rabinowitz, 2007). Among them is the role of adverse life events, specifically childhood trauma, in the development of psychosis.

It is important to note at this point, the distinction between use of the term *psychosis* and *schizophrenia*, as the literature looks at the whole spectrum of psychosis in relation to childhood trauma. An issue inherent in the literature is that the essential components of this heterogeneous disorder remained debatable, and authors range from using the terms schizophrenia and psychosis interchangeably to having distinct and varying definitions for each. There needs to be better agreement on how we conceptualize the disorder, but a discussion of this is beyond the scope of this dissertation.

Work on the role of childhood trauma and other adverse life events on the development of psychosis, has been pioneered most notably by psychologist John Read (see Read, Agar,

Argyle, & Aderhold, 2003; Read & Bentall, 2012; Read, Bentall, & Fosse, 2009; Read, Fink, Rudegeair, Felitti, & Whitfield, 2008; Read, Hammersley, & Rudegeair, 2007; Read, Perry, Moskowitz, & Connolly, 2001; Read & Ross, 2003; Read, van Os, Morrison, & Ross, 2005).

While it is coming to be accepted by most experts in the field that childhood trauma plays a significant role in psychosis, the translation of this knowledge to clinical practice is still needed.

Fuller (2010) noted:

Because of the high rates of trauma and posttraumatic stress disorder in individuals with psychotic disorders, there has been increasing emphasis on incorporating trauma treatment into comprehensive care for schizophrenia. Yet, despite heightened awareness of the need, limited information has been provided specifying an effective approach tailored to this population. (p. 1)

Read and Dillon (2013) remark in the book *Models of Madness* that the “development of trauma-based interventions for people with psychosis is in its infancy” (p. 331) and requires further development and evaluation. A quote in Courtois and Ford’s (2013) book on treating trauma exemplifies how far the thinking on this matter outside of the psychosis field has yet to come, “On a final but related matter, psychosis does not automatically rule out the occurrence of trauma” (p. 108). That psychosis could *rule out* any history of trauma shows the urgency with which we need to take trauma history into account in treating psychosis.

This study seeks to bridge the gap between theory and practice and will propose an integrative model of psychotherapy for the treatment of schizophrenic individuals with a history of complex trauma. Psychotherapy models exist for both the treatment of complex trauma and the treatment of schizophrenia. Treatment guidelines recently compiled by the Complex Trauma Task Force (Cloitre et al., 2012) outline broadly a three phase approach where the first phase of treatment involves creating and ensuring safety, symptom reduction, and increasing psychosocial competencies. Phase two focuses on processing aspects of the unresolved trauma experience and

phase three centers around consolidating treatment gains and enhancing connection with other aspects of the individual's life.

Within psychodynamic psychotherapy models for the treatment of schizophrenia, the American interpersonal psychoanalytic approach, founded by Harry Stack Sullivan (1931) and further refined by clinicians of the Sullivanian tradition, has a substantial amount of overlap with the current thinking about complex trauma. In particular, the therapeutic approaches outlined by Silvano Arieti (1974), Bertram Karon (1977), and most recently, Andrew Lotterman (1996) discuss the significance of early attachment trauma in the development of the schizophrenic self. While the approaches of each of these practitioners are similar, Arieti, specifically, breaks his model down into four phases of treatment. He describes the first phase as engagement, the establishment of relatedness, and safety; the second phase as identifying psychotic mechanisms and functions, and the third phase as the analytic processing of those experiences. Arieti (1974) also outlines a fourth phase, depending on illness severity and treatment outcome, whereby one actively helps the schizophrenic individual participate in other aspects of his life and maintain a healthy reintegration into society.

While there are similarities between the complex trauma treatment guidelines and the guidelines detailed by the various Sullivanian analysts, including but not limited to a) the phase oriented model; b) the need for an initial establishment of safety and engagement as a key component of therapy; c) the importance of the therapeutic relationship; and d) the significance of childhood trauma; there are also key differences in technique that need to be considered when working with someone with schizophrenia. The proposed model will integrate the similarities of these two approaches and also address key differences.

Literature Review

Trauma

The idea that traumatic events can have a significant impact on individuals and groups is something that is now taken for granted in the mental health field. This was not always the case. Bessel van der Kolk, a distinguished researcher in the trauma field, recounted how in the early 80's the opening line of a grant rejection he received, read, "It has never been shown that PTSD is relevant to the mission of the Veterans Administration" (van der Kolk, 2015). Today, there are over thirty major organizations, both national and international, dedicated wholly or in part to the study of trauma, including the International Society for Traumatic Stress Studies (ISTSS), International Society for the Study of Trauma and Dissociation (ISSTD), National Center for PTSD, Division 56 of the American Psychological Association (APA): Trauma Psychology, Center for the Study of Traumatic Stress (CSTS), and the European Society for Traumatic Stress Studies (ESTSS).

While clinical interest in trauma and PTSD is a relatively recent development in the United States, the concept of trauma had been studied and written about over a century earlier. In 1889, French psychologist Pierre Janet published *L'Automatisme Psychologique*, his first work addressing how the mind processes traumatic experiences (van der Kolk, Brown, & van der Hart, 1989). Janet argued that when a person experiences emotions which overwhelm their ability to cope, the memory of this traumatic experience cannot be properly processed and absorbed: it is split off from the person's consciousness and dissociated (van der Kolk et al., 1989). He felt that this split off memory or aspects of the memory then return later as fragmentary reliving of the trauma, which could manifest as emotional conditions, somatic states, visual images, or behavioral reenactments (van der Kolk et al., 1989).

The concept of posttraumatic stress disorder, or traumatic neuroses as it was initially called, did not come into North American psychology's purview until around 1941 with the publication of Abram Kardiner's *The Traumatic Neuroses of War* (van der Kolk, 2015). As with many concepts in clinical psychology, there are many different perspectives about what defines something as a trauma and how best to treat individuals affected by their histories of traumatic experience. Broadly, a trauma could be defined as an "inescapably stressful event that overwhelms people's existing coping mechanisms" (van der Kolk, 1998). The narrowest definition of trauma may be what is described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) under posttraumatic stress disorder (PTSD). When PTSD was first added to the (DSM-III) in 1980, the controversial diagnostic category was defined by the direct experiencing of a distressing event outside the range of normal human experience; events such as combat, a catastrophic accident, or rape. PTSD was marked by persistent re-experiencing of the event, avoidance of associated stimuli, and persistent symptoms of increased arousal (Friedman, 2016).

Over the various revisions of the DSM, the definition of PTSD has broadened to include exposure to (whether direct or indirect) a traumatic event, the broadening of a traumatic event to include threat to physical integrity, and a greater breadth of possible reactions including cognitive and mood symptoms. While our conceptualization of PTSD has continued to grow and change over the years through research and clinical studies, a movement within the trauma field developed, which grew out of the observations of clinical practitioners that the DSM-III and -IV diagnosis of PTSD did not quite fit many of their patients. The DSM version of PTSD is based on the prototypes of combat, disaster, and rape (Courtois & Ford, 2013; Herman, 1992). The patients for whom the traditional PTSD conceptualization did not fit were those with prolonged,

repeated trauma who exhibited a far more complex clinical picture (Herman, 1992). Fittingly, this alternative concept came to be called complex trauma or complex PTSD.

The diagnostic construct of complex PTSD (also referred to at the time as DESNOS-disorders of extreme stress not otherwise specified) was pioneered by renowned trauma expert Judith Herman and her colleagues (Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). DESNOS was proposed for inclusion as an independent diagnosis in DSM-IV and underwent field-testing by van der Kolk et al. (2005) to establish preliminary validity for its diagnostic criteria. Though the field-test results were favorable and the DSM-IV committee voted to include it as a free-standing diagnosis, it ultimately ended up being listed as an associated feature under the diagnosis of PTSD (Courtois & Ford, 2013). For the fifth revision of the DSM, Herman, Cloitre, and Ford (2009) submitted an updated proposal to the DSM-5 revision committee again advocating for the inclusion of complex PTSD/DESNOS as a separate diagnosis, but were not successful. It was decided that more data was needed to support the validity of DESNOS as a separate construct. Instead, the criteria for PTSD was broadened to incorporate some of the clinical features outlined under DESNOS and a specifier for dissociative symptoms was added (Friedman, Resick, Bryant, & Brewin, 2011; Resick et al., 2012).

Since the publication of the DSM-5 in 2013 more research has emerged supporting the validity of complex PTSD as a separate disorder with a distinct clinical picture (Böttche et al., 2018; Brewin et al., 2017; Marylène Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Marylène Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Rosenfield et al., 2018). While PTSD is a fear-related disorder in which the core symptoms are associated with specific trauma-related stimuli, the symptom picture of complex PTSD (besides the core PTSD categories of intrusion, avoidance, and hyperarousal) refers to the more persistent, long-standing, complex

disturbances in self-organization which are not necessarily linked to trauma-related triggers and present across different settings (Böttche et al., 2018). To summarize, complex PTSD comprises the three core clusters of PTSD (i.e. intrusion, avoidance, hyperarousal), which are directly linked to trauma-related stimuli, and three additional clusters (i.e. difficulties in affect regulation, problems with self-concept, disturbances in interpersonal functioning), which are pervasive and not necessary linked to trauma-related stimuli (Böttche et al., 2018; Maercker et al., 2013).

On a global scale, the construct of complex trauma has already gained recognition and official diagnostic status. In June 2018, the World Health Organization (WHO) released the latest revision of its diagnostic manual, the International Classification of Diseases, 11th Revision (ICD-11), which includes a separate diagnosis for complex posttraumatic stress disorder (WHO, 2018). Though the manual has been released, clinicians will not be required to report diagnoses using the ICD-11 codes until a projected date of January 2022 (WHO, 2018). The ICD-11 describes complex trauma as having the following key components: a) develops following exposure to one or more events of an extremely threatening or horrific nature, commonly prolonged or repeated events from which escape is difficult or impossible; b) characterized by having met the core symptoms of PTSD at some point in the course of the disorder; c) includes additional core symptoms of severe and pervasive problems in affect regulation; persistent beliefs about oneself as diminished, defeated or worthless; deep and pervasive feelings of shame, guilt or failure; and persistent difficulties in sustaining relationships and feeling close to others (WHO, "ICD-11 - Mortality and Morbidity Statistics," 2018).

Complex Trauma

The first distinction that there is a meaningful difference in types of trauma experienced could be credited to psychiatrist Lenore Terr. In 1991, she published a paper in which she

distinguished between what she conceptualized as Type I and Type II childhood trauma (Terr, 1991). Terr (1991) defined Type I as trauma resulting from a sudden, single event and Type II as resulting from repeated or long-standing ordeals. Around the same time, renowned expert on trauma and current Complex Trauma Task Force member, Judith Herman, described complex PTSD as typically resulting from exposure to repeated or prolonged instances or multiple forms of interpersonal trauma, often occurring under circumstances where escape is not possible due to physical, psychological, maturational, family or environmental, or social constraints (Herman, 1992). Herman's work was bolstered by another prominent psychiatrist and fellow task force member Bessel van der Kolk, who in his article on Disorders of Extreme Stress, found that children and adults exposed to chronic interpersonal trauma consistently demonstrated disturbances that are not captured in the posttraumatic stress disorder (PTSD) diagnosis. In the 1994 DSM-IV Field Trial of 400 treatment-seeking traumatized individuals and 128 community residents, researchers found that victims of prolonged interpersonal trauma, particularly trauma early in the life cycle, had a high incidence of problems with regulation of affect and impulses, memory and attention, self-perception, interpersonal relations, somatization, and systems of meaning (van der Kolk et al., 2005).

Cook et al. (2005) confirmed that complex trauma exposure in children (which they defined as emotional abuse and neglect, sexual abuse, and physical abuse, as well as witnessing domestic violence, ethnic cleansing, or war) results in a loss of core capacities for self-regulation and interpersonal relatedness and interferes with the development of a secure attachment. Pearlman and Courtois (2005) also described how developmental difficulties observed in persons with complex trauma adaptations involve alterations in the sense of self, the ability to identify and modulate emotions, alterations in consciousness and self-awareness (often in the form of

dissociation), difficulties maintaining personal safety, somatic and medical concerns, and alterations in personal meaning or spirituality. Courtois and Ford (2009) noted that while research and clinical knowledge on complex traumatic stress disorders will continue to evolve and treatments will change with that growing knowledge, the core problems of affect dysregulation, structural dissociation, somatic dysregulation, impaired self-development, and disorganized attachment are likely to remain issues deserving of clinical attention in treatment.

In November 2012, the ISTSS came out with best practices guidelines to aid clinicians in making decisions about the treatment of individuals with Complex PTSD. Developed by the Complex Trauma Task Force, these guidelines were, in part, a response to the 2008 guidelines that came out regarding best practice guidelines for the treatment of PTSD, which noted that the current PTSD framework did not include salient symptoms and problems of individuals who were exposed to prolonged and repeated interpersonal trauma such as childhood physical or sexual abuse, domestic violence, and political violence. As part of the development of the complex PTSD guidelines, an expert consensus of the definition of complex trauma needed to be established for diagnostic and clinical utility. The resultant definition included the core symptoms of PTSD (re-experiencing, avoidance/numbing, and hyper-arousal) in conjunction with five broad domains of disturbed self-regulatory capacities: a) emotion-regulation difficulties, b) disturbances in relational capacities, c) alterations in attention and consciousness, d) adversely affected belief systems, and e) somatic distress or disorganization.

Treatment of Complex Trauma

While the guidelines for complex PTSD treatment were only just put forth in 2012, the original conceptualization of such a treatment model must again be credited to French psychiatrist Pierre Janet (1925). Janet was one of the first psychologists to create a systematic

therapeutic approach for post-traumatic psychopathology (Hart, Brown, & Kolk, 1989). His psychotherapy model was based on his clinical experience with severely traumatized individuals. The core issue in post-traumatic reactions according to Janet, was an inability to integrate traumatic memories into one's identity and narrative of the self (Hart et al., 1989). "Janet believed that memories could be stored at various levels, as narratives as well as sensory perceptions, visual images (nightmares and hallucinations), and 'visceral' sensations (anxiety reactions and psychosomatic symptoms)." (van der Kolk et al., 1989, p. 369). He created a three-stage psychotherapy for the treatment of what we would now call complex trauma.

Stage models can provide broad therapeutic guidelines, but they must be modified to fit individual cases (Hart et al., 1989). Janet recognized this and in his treatment would vary the sequence and methods according to the stage of the disorder and the status of his patient (Hart et al., 1989). Broadly, the three stages of Janet's model consisted of a) safety and stabilization, b) the "real work", and c) reintegration (Hart et al., 1989). Janet (1925) described the components of the first stage of treatment as ensuring the safety of the patient both in and outside the treatment room, psychological stabilization, symptom-oriented treatment, and establishing rapport throughout this process. Janet (1925) also described the role of the therapist as working to help foster the patient's control over their own life. He viewed this first stage as preparation for the second stage of treatment. Once the patient had been stabilized enough that they could relinquish some of their defenses and develop a working alliance, the work of stage two could begin. At this stage, the patient could start to talk seriously about what was actually troubling them; he called this transition from stage one to two, the "act of adoption" (Janet, 1925, p. 1154).

As Janet viewed the core issue in post-traumatic syndromes as the inability to integrate traumatic memories, the core components of stage two in Janet's (1925) model were the

identification, exploration, modification, and integration of traumatic memories. If a traumatic memory was not readily accessible to his patient, Janet would help them to identify possible traumatic memories through the techniques of hypnosis or automatic writing (Hart et al., 1989). Once identified, Janet worked with his patients toward *neutralization* of traumatic memories. In patients who were psychologically ready, this involved a gradual process of re-experiencing and verbalizing traumatic memories, beginning with the least threatening and working toward integration of the most traumatic aspects (Hart et al., 1987). Consistent with how stage models for complex trauma are structured today, Janet noted that individuals may move back and forth between these stages as needed.

Stage three involved relapse prevention, relief of residual symptoms, and personality reintegration (Hart et al., 1987). Janet worked to help patients broaden their defenses/reactions, so that when faced with another threat, whether physical or psychological, they would be better able to manage it. This was part of his relapse prevention. He noted that dissociation in particular, could make patients vulnerable to future relapses or traumatic event recurrences (Hart et al., 1987). Janet also utilized a technique termed *aesthesiogeny*, which he used to help his patients recover their awareness of physical sensations and restore the mind-body connection, through the placing of magnets on the skin, directed attention to the sensation or body part that was desensitized, and suggestion (Janet, 1898). As his patients began to live their lives again, were open to positive influences, and had less frequent relapses, Janet would begin working toward termination by reducing his therapeutic influence (Hart et al., 1987). Another signal to Janet that his patients were ready for termination included signs of ingratitude as signals of recovery; for example, when patients began to forget appointments with him that meant they

were on the path to recovery and that he should begin increasing the length of time between sessions (Hart et al., 1987).

The symptomology of complex PTSD as we think of it today revolves around the loss of emotional, psychological, social, and cognitive capacities that were either halted and failed to develop properly or deteriorated due to exposure to complex trauma. It follows that the treatment of complex PTSD would involve strengthening these capacities, in addition to the generic therapy goal of reducing psychiatric symptoms and distress. The recommendations put forth by ISTSS nearly a century after Janet's work, include the incorporation of strength-based interventions throughout a three-phase treatment model, where broadly, phase one focuses on establishing safety, phase two focuses on processing unresolved aspects of the individual's memories of the traumatic experience, and phase three involves consolidation of treatment gains. The specifics of such a model are outlined in detail by Courtois and Ford (2013) in their book *Treatment of Complex Trauma: A Sequenced, Relationship-Based Approach* and will be covered more broadly below. A phase-oriented model such as this is currently considered the gold-standard of complex trauma treatment (Briere & Scott, 2012; Chu, 2011; Courtois, 1999; Courtois & Ford, 2009; Ford, Courtois, Steele, Hart, & Nijenhuis, 2005; Herman, 1992; Steele, Hart, & Nijenhuis, 2001; Van der Kolk, 2002).

Goals. The goals of PTSD treatments broadly speaking were consolidated and outlined below by Marmar, Foy, Kagan, and Pynoos (1994, p.27). They include:

1. Increased capacity to respond to threat with a realistic appraisal rather than exaggerated or minimized responses.
2. Ability to maintain normal levels of arousal rather than hypervigilance or psychic numbing.

3. A return to normal development, adaptive coping, and improved functioning.
4. Restored personal integrity and normalization of traumatic stress response.
5. Minimization of the threat of retraumatization by having fostered an atmosphere of safety and security.
6. Regulation of the level of intensity of traumatic aspects to facilitate cognitive reappraisal.
7. Increased capacity to differentiate remembering from reliving of past traumas.
8. Regained perspective of the trauma and control over life experiences rather than eradicating memories of the trauma or avoiding and overreacting to reminders.
9. Attention paid to biological and social learning risk factors that shaped the trauma response.
10. Intervention addressed at secondary adversities and prevention of future complications.
11. Facilitation of a transformation in self-concept from a victim to an individual with a sense of constructive engagement in daily life and future goals.
12. Enhanced personal courage in approaching memories and reminders of the trauma.

Additional goals, specific to the treatment of Complex Traumatic Stress Disorders as per Courtois and Ford (2013, p. 89-90) include to:

13. Face, rather than avoid, the trauma memory and its associated thoughts, feelings, beliefs, and schema about self and others.
14. Experience the relational safety and attunement in the therapeutic relationship as a “secure base” from which to develop or regain secure inner working models.

15. Develop and/or restore emotion regulation; i.e. the ability to access and identify emotions and increase the capacity for and tolerance of emotional expression as a means of self-development.
16. Shift the self-concept from helpless to autonomous self-determination.
17. Acquire or regain capacities for bodily self-awareness and arousal regulation that have been split off or compartmentalized in the form of somatoform dissociation.
18. Develop or regain self-regulatory capacities to recognize and reduce the severity and frequency of dissociation, addiction, self-harm, impulsivity, compulsion, and aggression toward self and others.
19. Identify reenactments of traumatic events and develop self-protection and self-enhancement skills to prevent re-victimization and re-traumatization.

Assessment. As with any psychotherapy, prior to beginning treatment it is important to do an intake or assessment to determine the nature of what the client is coming in with, what symptoms are most troubling and disruptive to them, and to inform the phase and focus of treatment. Also, as with any psychotherapy, assessment never truly ends as the therapist should be continually updating their treatment and hypotheses as new information is gained, and evaluating progress. The following section will address the initial assessment phase.

In this phase, specific issues may arise in the assessment of clients with complex trauma histories, which may not be an issue with other kinds of clients. Clients with complex trauma histories may be difficult to engage due to their learned mistrust and suspicion of others, inclination toward automatic self-protection and preservation, desire to avoid discussion of painful reminders of what they have experienced, generalized fear, and fear of loss of control (Courtois & Ford, 2013). Actual loss of control and decompensation are potential issues in

assessment with these individuals. These are additional reasons for Courtois and Ford's (2013) recommendation that assessment be an ongoing process that occurs over time, rather than just all at one time in the initial stage of treatment.

In addition to the typical areas addressed in an intake, it is important for this population that areas such as personal strengths and resources, support network, and ego and self- capacities be given attention as well (Courtois & Ford, 2013). Consistent with a strengths-based approach the therapist should capitalize on these personal resources from the start of treatment. The stance of therapist in the assessment phase should be one of "supportive neutrality", a calm and respectful demeanor that is encouraging, but not pressuring and involves direct, yet sensitive questioning. This is because victims of trauma have experienced intrusion and damage at the hands of others and so are naturally suspicious of others motives including that of the therapist. Being asked to discuss personal experiences and reactions can feel like an intrusion even if delivered in a supportive and non-judgmental manner, but the therapist should do their best to support honest disclosure and phrase questions in a direct and open-ended way (Courtois & Ford, 2013).

From the beginning, the therapist should strive to create an atmosphere of safety and encourage the development of rapport. This means explaining the assessment stage, what the client can expect, and being open to questions. The therapist should be explicit that there are no right or wrong answers, they are not expecting particular responses, and that the client may feel upset or uncomfortable as painful topics are inquired about and that this is normal. It is also important to emphasize that the client is encouraged to maintain as much control as possible given the nature of trauma as experienced as intrusive and out of the individual's control. The client should be encouraged to communicate if they begin to feel overwhelmed or numb, to ask

for clarification, to choose whether or not and how to answer questions, and to ask for breaks if needed. The idea here is to set the expectation from the start that this is a collaborative process that the individual has some control over. It is important to stay within the client's window of tolerance (Siegel, 1999) as no therapeutic work can be done if the client is in a state of either hyper- or hypo- arousal. (Courtois & Ford, 2013)

Another important area to assess with this client population, given the relational nature of their trauma is attachment style. Daniel Brown (2009) in his chapter titled "Assessment of attachment and abuse history, and adult attachment style" described how early attachment predicted a significant portion of variance in adult psychopathology. Courtois and Ford (2013) suggest using Main et al.'s (2002) Adult Attachment Interview to assess attachment style, the extent of unresolved trauma, and capacity for mentalization. Assessment of symptoms is of course another arena that should be addressed, both for trauma-specific and more general symptomology. Numerous measures are available for use and can be found listed and categorized by symptom domain in Courtois and Ford (2013, p. 109-111).

A final, yet equally important consideration during the assessment phase is evaluating any indicators of the client's potential prognosis. This means considering the client's strengths, resources, individual circumstances, and other factors in determining their capacity to make use of treatment and have a positive outcome (Courtois & Ford, 2013). Early research on complex dissociative forms of PTSD treatment outcome by Richard Kluft (1994) illuminated various treatment trajectories; categorized as high, middle, and low trajectory. Low trajectory clients were associated with poor prognosis for recovery and tended to have backgrounds of chronic trauma and mental illness, chaotic lives, unstable families, multiple crises, self-injury, suicidality, addiction, and limited support (Kluft, 1994). Middle trajectory clients tended to have more

resources and stability in their lives, were able to develop a therapeutic alliance over time, but still required years of treatment to develop a stable recovery (Kluft, 1994). The focus of treatment with these clients revolved around emotion regulation. High trajectory clients had the most strengths, stability, and resources to utilize, and took the least amount of time to achieve stable recovery (Kluft, 1994). Baars et al. (2011) built upon the work of Kluft and furthered the research on treatment prognosis by developing a model that contains 51 factors divided into eight categories that effect the likelihood of successful treatment outcome in clients with complex PTSD (Courtois & Ford, 2013). The eight categories were degree of motivation, healthy relationships, healthy therapeutic relationships, internal and external resources, Axis I comorbidity, serious Axis II comorbidity, attachment, and self-destruction (Baars et al., 2011). Baars et al. (2011) recommended that the model be used as a kind of checklist, by which clinicians could assess client strengths and weaknesses and then focus the therapeutic work accordingly to achieve a realistic positive outcome.

Phase I. After enough assessment has been done to move forward with treatment, the focus can shift into Phase I work. Phase I begins with safety and safety planning. If the client is still in any kind of actual danger, trauma treatment cannot begin as the client still needs to use their survival defenses (Courtois & Ford, 2013). If the client is a danger to themselves that also needs to be addressed with safety planning (Courtois & Ford, 2013). While establishing safety and building the therapeutic alliance, the therapist should also begin providing psychoeducation about trauma and posttraumatic reactions (Courtois & Ford, 2013). Phase I also encompasses some skills building. It is important for success in later treatment stages that the client learn and develop skills of emotion identification and emotion regulation (Courtois & Ford, 2013). Once some degree of safety and self-regulation have been established, the therapist can begin building

on the client's available strengths and resilience to develop other skills such as stress management, self-care, daily living skills, and addressing treatment of any medical conditions, which the client may have been avoiding (Courtois & Ford, 2013). It is important to note that some clients may be satisfied with any gains made in this stage of treatment and never move beyond Phase I (Courtois & Ford, 2013). Additionally, completion of Phase I and preparation for Phase II work is measured not by time, but by the acquisition of the needed skills (Courtois & Ford, 2013).

Phase II. Once the foundation of safety has been laid and the client has learned to identify and regulate their emotions, they can begin the work of Phase II. Phase II involves facing and processing the trauma and the associated emotions, beliefs, and cognitions (Courtois & Ford, 2013). At this stage, the focus shifts to helping the client change the way they relate to the memories and their associated emotional states. The client should be reminded to apply the emotion identification and regulation skills learned in Phase I to the work throughout Phase II (Courtois & Ford, 2013). The focus of this stage is on the trauma directly and treating any existent PTSD symptoms of intrusive memories, hypervigilance, and avoidance (Courtois & Ford, 2013). This can be achieved through a variety of trauma-focused techniques, while continuing to further expand and strengthen emotion tolerance and regulation capacity (Courtois & Ford, 2013). Any therapeutic work must take place within the client's window of tolerance, at client's pace and emotional capacity. If pushed beyond their level of tolerance, the client may return to utilizing previous coping skills and defenses (Courtois & Ford, 2013). The therapist then would need to return the work of Phase I and encourage the client to utilize the skills they learned to regulate emotions, while reestablishing a foundation of safety (Courtois & Ford, 2013).

The work of processing the trauma means facing and accepting that one has been a victim, that it was something that happened *to* them not because of them, and that it has impacted them and their life (Courtois & Ford, 2013). If the processing and resolution of past trauma is successful, the client should gain a sense of control over their reactions and empowerment and hope, as opposed to feelings of helplessness and hopelessness (Courtois & Ford, 2013). At this stage, work can revolve around helping the client to change or piece together their life narrative and increase self-understanding, which can lead to improved self-compassion, self-esteem, and self-determination (Courtois & Ford, 2013).

Phase III. This final phase of treatment involves consolidating the therapeutic gains made in Phases I and II (Courtois & Ford, 2013). This means applying the emotion regulation skills, communication skills, self-understanding, and self-confidence that has been achieved in therapy out in the real world (Courtois & Ford, 2013). The client's new "earned secure" attachment style is applied as appropriate in current and future relationships with the support of the therapist (Courtois & Ford, 2013).

Complex Trauma in Psychosis

As often occurs in separate areas of research and scientific inquiry, similar ideas gain traction in tandem. Around the same time that a portion of the trauma field was investigating complex trauma, specifically childhood trauma involving ongoing emotional, physical, and/or sexual abuse or neglect, a portion of the psychosis field was investigating the role of childhood trauma in relation to psychosis and schizophrenia. As mentioned previously, a complication in this literature is that studies vary on whether they are investigating psychosis, schizophrenia, schizophrenia spectrum disorders, or all the above. The studies that look at psychosis can be further broken down based on various operational definitions, with psychosis sometimes

meaning the individual symptoms of hallucinations and delusions and sometimes meaning more broadly any disorder with psychotic symptomology (i.e. depression with psychotic symptoms). This brings up the yet unsettled philosophical and diagnostic questions about the heterogeneity of what we call schizophrenia, but a critical, comprehensive review of this is beyond the scope of this paper.

Correlational studies. A review article by (Brown, 2009) looked at studies done over the past forty years investigating the link between child abuse (emotional/neglect, physical, and sexual) and psychosis (hallucinations and delusions) and found overall that symptoms indicative of psychosis and schizophrenia, particularly hallucinations, are related to having a history of childhood abuse and neglect.

Husted, Ahmed, Chow, Brzustowicz, and Bassett (2010) found that childhood trauma was independently associated with schizophrenia even when looking at familial and genetic risk. They investigated 184 members of 24 Canadian families with a history of pre-psychosis childhood trauma, in which multiple and multigenerational members had schizophrenia previously shown to be associated with a functional allele in the NOS1AP gene. Childhood trauma was more prevalent in those with narrowly defined schizophrenia than in their unaffected family members (OR of 4.17), even after adjusting for the NOS1AP risk phenotype, and for parental history of schizophrenia.

A study by Hardy et al. (2005) looking at the content of hallucinations in adults with non-affective psychosis reported that 45% of patients who had experienced trauma, had hallucinations with similar themes to their trauma. Traumas rated as intrusive were associated with intrusive hallucinations, and sexual abuse and bullying were most likely to be associated with hallucinations. Corroborating their findings, a study by Kilcommons & Morrison (2005),

showed there was a salient relationship between the content of the trauma previously experienced and the themes of delusions and hallucinations described by the subjects. Other studies have shown that psychotic symptoms with sexual content are related to history of previous sexual trauma (Thompson et al., 2010).

A study looking at cognition and psychosis, showed more severe deficits in cognitive performance in patients with first-episode-psychosis who also experienced childhood trauma (Aas et al., 2012). Linking this finding to biology, the authors hypothesized that changes affected by stress through the hypothalamic-pituitary-adrenal (HPA) axis lead to structural changes in the brain that explain this finding. Using magnetic resonance imaging (MRI) to examine the association between childhood trauma, cognitive function, and amygdala and hippocampus volumes in 83 patients with first-episode-psychosis (45% schizophrenia, 55% other psychosis) and 63 healthy controls (HCs), the authors found that mean amygdala volume was significantly smaller in patients compared with HCs, especially in those who experienced more significant childhood maltreatment. A history of childhood trauma was associated with both worse cognitive performance and smaller amygdala volume.

Freeman and Fowler (2009) conducted a study with adults showing that severe childhood sexual abuse was significantly associated with an increased risk for developing persecutory delusions and verbal hallucinations. However, a major meta-analysis by Varese et al. (2012) found no evidence that any specific type of childhood trauma is a stronger predictor of psychosis than any other. Of note, is the suggestion by Varese et al. (2012) that psychosocial interventions, which have been used for patients working through trauma, be among the treatment options for patients with psychosis.

Longitudinal studies. Longitudinal studies allow for the inference of some level of causality. Several recent population-based studies suggest that childhood trauma could be at least one causal factor for psychosis (Janssen et al., 2004; Spauwen, Krabbendam, Lieb, Wittchen, & Os, 2006; Shevlin, Dorahy, & Adamson, 2007). A longitudinal, prospective study published in the *American Journal of Psychiatry* in 2013 found childhood trauma (defined here as physical abuse and bullying) to be predictive of psychotic experience (defined as hallucinations per the Adolescent Psychotic Symptom Screener) in a study of 1,112 adolescents age 13-16. A dose-response relationship was observed between severity of bullying and risk for psychotic experiences. Moreover, cessation of trauma predicted cessation of psychotic experiences, with the incidence of psychotic experiences decreasing significantly in individuals whose exposure to trauma ceased over the course of the study. (Kelleher et al., 2013)

One landmark, large-scale population study of 17,337 Californians investigated the contribution of multiple adverse childhood experiences (ACE's) to the likelihood of reporting hallucinations. They found that child abuse was a causal factor for psychosis and more specifically, for voices commenting and command hallucinations, in a dose-response fashion whereby the more types of adverse childhood events experienced the greater the odds of experiencing hallucinations. (Whitfield, Dube, Felitti, & Anda, 2005)

A prospective study by Dvir, Denietolis, and Frazier (2013) found that childhood adversity and trauma increase the risk of psychosis with an odds ratio (OR) of 2.8, and that patients with psychosis were 2.72 times more likely to have been exposed to childhood adversity than controls. Assuming causality, if childhood adversities were removed from the population as risk factors, the number of people with psychosis would be reduced by a third (Dvir, Denietolis, & Frazier, 2013).

Supporting the theory that roughly a third of psychotic patients suffered childhood trauma, a chart review of 658 patients with first-episode psychosis showed that 34% had been exposed to sexual and physical abuse, and that these patients were more likely to have had PTSD and/or substance use disorders before psychosis onset, to have more history of suicide attempts, and poorer premorbid functioning (Conus, Cotton, Schimmelmann, McGorry, & Lambert, 2010).

Arseneault et al. (2011) followed 2,232 twin children looking at traumatic experiences and psychotic symptoms between the ages of five and twelve years old. Children who experienced maltreatment by an adult or bullying by peers were more likely than those who were not exposed to such events, to report psychotic symptoms by age 12, regardless of when these events occurred. This risk remained significant when controlling for prior internalizing or externalizing disorders, family adversity, socioeconomic status, IQ, and genetics, which was calculated for each pair of twins.

Meta-analyses. A meta-analysis of 36 patient-control, prospective (longitudinal), and cross-sectional cohort studies by Varese et al. published in *Schizophrenia Bulletin* (2012), reported strong evidence that childhood adversity (defined as sexual abuse, physical abuse, emotional/psychological abuse, neglect, parental death, and bullying) is associated with increased risk for psychosis in adulthood. Matheson, Shepherd, Pinchbeck, Laurens, and Carr (2013) found in their meta-analysis that individuals diagnosed with schizophrenia specifically, were 3.6 times more likely than the general population to have suffered childhood trauma ($p < .0001$). The authors found that compared to other mental disorders, only dissociative disorders and PTSD had a stronger association than schizophrenia to childhood trauma.

It is important to note that the reliability of retrospective reports of childhood abuse in patients with psychosis has been shown to be stable over a long period of time (Read et al., 2005;

Thompson et al., 2010; Read & Dillon, 2013). It seems that severity of psychotic symptomatology at the time of report does not influence the likelihood of reporting childhood abuse, and that rates of childhood trauma are similar when obtained by different assessment instruments as well as by clinical notes (Fisher et al., 2011). Also of note is the finding that patients with a history of early childhood trauma respond poorly to pharmacotherapy alone and better to a combination of psychotherapy and medication, which was found to be only marginally superior to psychotherapy alone (Nemeroff et al., 2003).

An article by Read and Ross (2003) summarized that overwhelmingly the research literature has shown a high prevalence of psychological trauma, including childhood sexual and physical abuse, among people diagnosed psychotic in general and schizophrenic in particular. In some of the studies, causality can be inferred showing that childhood trauma is at least one of the variables that can be related to the development of psychotic symptomatology later in life. Notably, the authors point out that “regardless of whether clinicians view the relationship as causal, contributory, co-morbid, or coincidental is irrelevant to the fact that the high prevalence dictates that all people diagnosed schizophrenic receive a proper trauma assessment and, where appropriate, be offered psychological treatments to address the sequelae of the trauma or abuse” (p. 1).

The statement above highlights the inspiration to create an integrated model of treatment for psychosis, which incorporates a trauma assessment and trauma-specific treatment as appropriate. Obviously not everyone who has experienced childhood abuse goes on to develop schizophrenia, but the accumulating evidence shows that having experienced childhood abuse is one of many variables that increase the risk of developing psychosis; a variable that until recently has largely been ignored by the scientific and psychological community.

Psychotherapy for Psychosis

A number of psychosocial treatments for schizophrenia have been developed, including family therapies, group therapies, case management teams, and skills training (Alanen, Chávez, Silver, & Martindale, 2009; Read & Dillon, 2013). This brief review will focus on a subset of individual psychotherapies, specifically psychodynamic therapy for schizophrenia. Unlike many other forms of therapy, psychodynamic therapy with schizophrenic individuals seeks to try to understand the personal meaning of psychosis or psychotic symptoms in the context of the individual's life and to help that individual make meaning out of their experience, in addition to the general therapeutic goal of symptom reduction (Read & Dillon, 2013).

Psychodynamic treatment. The psychoanalytic treatment of individuals diagnosed as psychotic or schizophrenic has a long history that is often unacknowledged by the mainstream scientific community, dating back to the birth of psychotherapy itself with Freud. Freud likened psychotic states to that of dreams, both involving the phenomena of distorted time, hallucinations, and delusions and serving in one manner or another as distorted wish-fulfillment fantasies related to internal drives (Karlsson, 2016). Carl Jung would later agree with Freud's comparison of psychosis and dream states and wrote, "Let the dreamer walk about and act as though he were awake and we have at once the clinical picture of dementia praecox" (Jung, 1909/2015). Freud viewed psychotic individuals as outwardly expressing the same psychological states that neurotic individuals are able to repress, and suggested that all individuals have the potential to develop a psychotic state if their more advanced defense mechanisms break down during times of crisis or severe stress (Karlsson, 2016). One could argue that Freud had a more humanizing view of psychosis than is often held in modern Western medicine. In Freud's (1958a) analysis of the Schreber Case, where a man presented with bizarre

psychotic delusions and hallucinations, Freud made sense of the psychotic symptoms as distorted versions of some traumatic experience that resulted in the man's psychotic break (Karlsson, 2016). This is a key and distinguishing feature of psychodynamic treatment of psychosis; that there is some historical fragment of the individual's reality in their psychotic delusions and/or hallucinations.

From a technique perspective, Freud thought that it was pointless for psychotherapists to try and convince psychotic individuals of the inaccuracy of their delusions, as he saw delusions as the way they made sense of the suffering they were experiencing (Karlsson, 2016). He saw the treatment as similar to what one might do with a neurotic patient in "liberating the fragments of historical truth from its distortions and its attachments to the actual present day and in leading it back to the point in the past to which it belongs" (Freud, 1964, p. 268). While Freud held these views theoretically, he had limited experience working with psychotic individuals and ultimately concluded that traditional psychoanalytic technique could not be used with schizophrenic patients (Freud, 1964). He felt they were not capable of establishing the transference relationship essential in psychanalytic work. "They reject the doctor, not with hostility but with indifference" (Freud, 1916-1917).

Other early analysts such as Carl Jung (1909/2015), Sandor Ferenczi (Ferenczi & Rickman, 1950), Karl Abraham (Good, 1995), and Paul Federn (1947) among others, worked with psychosis and asserted that psychoanalytic approaches were very relevant in the treatment of this population (John Read & Dillon, 2013). Jung (1909/2015) worked closely with Bleuler and pioneered the analysis of symbolism in psychosis. Jung developed the theory of universal archetypes stemming from his idea of the collective unconscious, archetypes which could appear and therefore be analyzed in psychotic hallucinations and delusions. Jung also thought that the

psychological disturbance of psychosis produced a kind of metabolism or toxin that injures the brain, more akin to a stress hormone, and believed that the psychotic mechanisms caused the brain correlates, rather than vice versa as is often thought today (Arieti, 1974). In this way, his theory is more akin to that of trauma where we know that in response to a distressing psychological event, a cascade of stress hormones and neurotransmitters are released, which impact the body and brain and can cause long-term damage. Another important contribution of Jung's was his concept of the introvert personality, which he used to describe the personality organization of psychotic individuals (Arieti, 1974). Whereas an extrovert personality is one with exaggerated emotivity and psychic energy directed outward toward the environment, the introvert personality is one where psychic energy is directed centripetally, away from the environment and toward the self, with decreased emotivity (Arieti, 1974).

Abraham (1955) was interested in the link between childhood sexual trauma and psychosis. He described multiple case examples from his clinical work where patients diagnosed with "dementia praecox" experience hallucinations and delusions directly related to sexual abuse experienced in childhood (Abraham, 1955). Abraham (1955) noted that in his clinical experience many cases of psychosis have a history of childhood sexual trauma, but that childhood sexual abuse does not necessarily cause the psychosis, as there are examples of non-psychotic individuals who have a history of childhood sexual abuse and vice versa.

Federn (1947) was known for creating the concept of the "ego boundary", a fundamental idea in the psychoanalytic theory of psychosis. Federn believed that the main problem in patients with schizophrenia was that the mental ego boundary that normally separates internal thoughts and feelings from perceptions is faulty, allowing the content of the unconscious to spill into consciousness where it is perceived as reality (Garrett, 2014). From a treatment perspective,

Federn advised not to encourage the emergence of unconscious material, but rather to compensate for the patient's defective ego boundary by supportive reality testing. This view contradicts that of later analysts following in the Kleinian tradition (further described below), who felt that unconscious material should be elicited and interpreted to promote healing.

Ferenczi had a notably different approach to psychoanalysis than Freud (Rudnytsky, Bokay, & Giampieri-Deutsch, 2000). He used a more active, collaborative, two-person approach to psychotherapy which he found worked with psychotic patients. His approach was one of the first interpersonal or intersubjective approaches to psychotherapy, which is consistent with current interpersonal technique in schizophrenia treatment. As will be elaborated upon later in Harry Stack Sullivan's interpersonal approach, he valued honesty and authenticity in therapeutic relationship (Rudnytsky et al., 2000). Notably, Ferenczi's later work revolved around an interest in trauma, particularly childhood trauma.

Melanie Klein (1993), who was a student of Abraham and Ferenczi, branched off of her predecessors' work to create what is now commonly called the European Kleinian School or Kleinian object-relations. She viewed adult psychotic patients as becoming regressed to the paranoid-schizoid position of childhood. Klein, like Freud, focused on internal conflicts and fantasies, but also paid attention to the significance of others or "objects" in a person's life. Through her work with children, Klein observed that individuals oscillate between two developmental psychological states which she labeled, the paranoid-schizoid position and the depressive position (Klein, 1993). Klein (1993) viewed the paranoid-schizoid position as the first stage of development in object relations and more primitive than the depressive position. She characterized the paranoid-schizoid position as involving paranoid anxieties about physical and emotional attack, projected and introjected aggression, the self as split into fragments, and part

object relations (part objects viewed as all good or all bad). The core internal drive associated with this position was fear; specifically fear of annihilation described as “death or the fear of falling into pieces” (Karlsson, 2016, p. 160). Klein (1993) posited that this internal fear was too much for someone to tolerate and so individuals in this position project their fear into an external object and then perceive said object as persecutory and respond to them as such.

Another defense these individuals employ is what Klein labeled splitting, meaning viewing others as either idealized and all good, or devalued, persecutory, and all bad (Karlsson, 2016). In delusions of grandeur, psychotic individuals may experience omnipotence, as the boundaries between the self and the idealized good object are dissolved (Karlsson, 2016). In psychosis, Klein (1993) viewed the boundaries between the internal self and external object as blurred if at all existent, possibly because of what she termed projective identification. Projective identification is an unconscious process in which parts of the self are projected into an external object to take control or possess the object and correspondingly, the external object receives the subtle projections or behavioral cues, identifies with them, and feels the projected part is part of the object’s self (Karlsson, 2016). Projective identification is not a process limited to psychotic individuals however. As an example, projective identification may be at play when a therapist who is not normally sadistic, finds themselves feeling sadistic toward a client who has experienced abuse or on a more benign level, when a therapist empathizes with a client’s experience.

With improved functioning, the psychotic individual could move into the more mature depressive position, in which the objects they have split, viewed as an oscillating all good (love) or all bad (hate), can be viewed from a more integrated perspective of a single person (or whole object) with both “good” and “bad” qualities (Karlsson, 2016). Klein suggested that the

convergence of love and hate toward the same object will result in a more reality-based perception of an internal object, that more realistically represents the actual external object (Karlsson, 2016). Later proponents of Kleinian theory who did work with schizophrenic patients including Hanna Segal, Wilfred Bion, and Herbert Rosenfeld have found Klein's theoretical contributions of the paranoid-schizoid position, schizophrenic symptoms as a defense against annihilation anxiety, and the link between internal fantasy projected into reality crucial to their work (Read & Dillon, 2013).

Segal (1952) emphasized the role of splitting and denial, introjection, and projection in her work with psychotic patients. She noted that unlike in neurosis, a great deal of primitive fantasy is conscious in psychosis, but it is the link between fantasy and reality that is repressed (Segal, 1952). She also talks about the loss of symbol use in language of schizophrenic individuals and felt that it was important to interpret unconscious material at the level of greatest anxiety, most often in the form of primitive body-related fantasies. Segal (1981b) asserted that the failure to make the distinction between fantasy and reality is due to a failure of symbolization and results in a type of concrete thinking in which individuals equate the experience of a symbolic or imagined object as identical with the original, real object and have no awareness of themselves as an interpreter of the experience. Instead, individuals in the paranoid-schizoid position experience themselves as a passive object that "things happen to" and feel that they are the eternal subject of victimization.

Rosenfeld (1971) highlighted the use of projective identification in individuals with schizophrenia. He identified various ways projective identification can be used in the therapy relationship including as a distortion or intensification of the normal nonverbal infantile communication, as ridding the self of unwanted parts, as a means of controlling the therapist's

body and mind, or as a way of dealing with aggressive impulses like envy (Rosenfeld, 1971). He also emphasized the use of countertransference as a guide to the patient's inner state, given the schizophrenic individual's use of projective identification over verbal symbols and described how work with psychotic patients often activates the therapists own psychotic anxieties and the fear that the patient will drive one mad (Read & Dillon, 2013).

Bion (1954) also highlighted the importance of attention to the countertransference when working with psychosis. He described two cores in any personality structure, a neurotic core and a psychotic core (based off of Klein's depressive position and paranoid-schizoid position) and that these cores are at odds with one another (Bion, 1956). The psychotic core fears the reality based responsibilities, emotional connections, and object relationships of the neurotic core and the neurotic core fears the psychotic core's tendency to break through the defense of repression and overtake the whole personality thereby losing control and agency (Bion, 1956). In a psychotic state, sensory, somatic, and affective experiences feel overwhelming, uncontainable, and fill the individual with fear. Bion felt the psychotherapist's role was to help the psychotic individual contain an inner "nameless dread" by helping them to think and to be the containing object that can tolerate anxiety and still think and process connections, becoming the containing object that the individual's parent or caregiver could not be (Karlsson, 2016). Part of the containing function is maintaining a clear and consistent therapeutic frame (Bion, 1959/2013, Karlsson, 2016). The therapeutic frame includes things like payment, where sessions are held, how often, how long they last, and how the sessions start and end.

Pediatrician and psychoanalyst Donald W. Winnicott, while influenced by Klein, moved away from her theory to emphasize actual environmental influences, rather than just the child's internalized representation of them. He focused on the role of the caregiving environment and

most often this meant the mother and her interaction with her infant. Winnicott (1974) theorized that if experiences triggered distress, discomfort, and negative emotions too frequently or for too prolonged periods, the infant will begin to split off such experiences internally and begin a process of self-fragmentation. The infant's resultant sense of self will be highly vulnerable to anxieties and "fear of going to pieces" (Winnicott, 1974). In looking at physical handling of the infant, if the touch is incongruent or insensitive, again the infant will split off the distressing sensory and body experience from mental life. Winnicott (1974) conceptualized infants as being completely vulnerable and constantly on the brink of unthinkable anxiety, annihilation anxiety, but held together by a "good enough" environment. When too many disintegrating experiences are suffered early in development, aspects of a child's psychological development cease. A "false self" that is shown to the world develops, but as demands of life increase, the false self can experience failures and at a certain subjective point, the fragmented psychotic self comes through (Winnicott, 1974).

More recent clinicians who currently work with clients with psychosis and practice in the Kleinian psychoanalytic tradition include Michael Eigen (2018), Thomas Ogden (2018), Christopher Bollas (2012), and Danielle Knafo (2016). All have written about their work doing more traditional psychoanalysis with psychotic clients, in which, consistent with the Kleinian school, the goal is to promote healing through the interpretation of unconscious material and object-related fantasies through the use of projective identification, joining with the client's psychotic transference, and analyzing their countertransference (Garrett, 2014).

Harry Stack Sullivan (1940, 1953) is widely held as the founder of another branch of thought in the psychodynamic world, that of the American interpersonal school. Counter to the Freudian school of thought, Sullivan felt that schizophrenic individuals absolutely can and do

establish a transference relationship, but noted it can be intense and unstable. He viewed symptoms of schizophrenia as defenses resulting from the patient's fleeing anxiety and need for security. Sullivan emphasized the need to first and foremost establish contact with schizophrenic patients, meaning form a relationship and establish a sense of safety, before any further work can go on. He stressed the need to approach the often frightened and traumatized patient with respect, tolerance, and acceptance. He described how an extreme sensitivity often underlies whatever disguise the patient uses and that part of the healing process begins with treating the patient as a fellow human (Arieti, 1974). Differing from the Kleinian object-relations school, Sullivan (1953) advocated against analytic neutrality and took a more- what today we would call relational- stance where the therapist is "participant observer"; a stance that was originally put forth by Ferenczi (Ferenczi & Rickman, 1950). He also noted that with a schizophrenia patient it is essential to be honest, as the patient will be acutely aware of the therapist's nonverbals and unconscious feelings. Sullivan advocated for a therapeutic approach that was direct and involved reconstructing the chronological development of the psychosis and helping them to understand that whatever they were experiencing was related to their life experiences (Arieti, 1974). Notably, this approach resembles a trauma-informed approach as it views the development of psychotic symptoms as defenses or adaptations of the patient to cope in their environment and broader life context. Prominent followers of the Sullivanian tradition include Frieda Fromm-Reichmann, Harold F. Searles, and Silvano Arieti.

Fromm-Reichmann followed in the Sullivanian interpersonal approach with its emphasis on the therapeutic relationship. She conceptualized schizophrenic individuals as on a continuum from normal or neurotic to psychotic and viewed psychotic symptoms as defensive escapes from pain, conflict, and unbearable anxiety. Unlike the previous clinicians described who thought an

important piece of therapy for psychosis was engaging in the psychosis transference, Fromm-Reichmann thought that it was the role of the therapist to remain grounded in reality when working with psychotic clients and to convey warmth, humility, and therapeutic acceptance. She held on to the capacity however small of the psychotic individual to relate interpersonally to another human being, while also emphasizing the difficulty this population has in trusting anyone, even the therapist. She emphasized the very real loneliness of schizophrenia. An assumption in her theory and work is that the schizophrenic individual wants to resume interpersonal relationships, but does not want to be hurt again as in the original trauma, which caused the solitary path and withdrawal from the world to begin with. Regarding the process, she described how if the therapist disappoints in any way, (which they inevitably will) it is likely to be taken by the client as a repetition of earlier traumas and anger and hostility can result and need to be worked through. Fromm-Reichmann was also more cautious about the use of interpretations than her predecessors. She viewed the goal of treatment as having the schizophrenic individual gain insight into how their psychotic symptoms are defenses that came about because of or in order to cope with their thwarted past or present interpersonal relationships, especially early formative ones; that they become aware of the losses sustained in early life on a reality-based level, and accept that they cannot be made up for, while also holding that they are fully capable of becoming integrated and joining the real interpersonal world. She described the importance of the schizophrenic individual recognizing their fear of closeness and of their own hostility. Another technique utilized by Fromm-Reichmann was addressing the “adult” part of the client’s personality regardless of the level of disturbance. (Arieti, 1974)

In addition to what was emphasized by Sullivan and Fromm-Reichmann, Searles (2012) emphasized the importance of honesty and use of countertransference reactions to understand

what the patient may be feeling, but unable to communicate verbally. He also stressed conveying the mutual impact of the work on therapist and patient, conveying respect, and being with another human being regardless of their “diagnosis” and all it comes with. He noted the strength of the schizophrenic patient’s attachment to their pathology as it functions to foster connection in some way and also their struggle against dependence on the therapist or anyone. A rather unique contribution of Searles (2010) was his attention to the therapeutic environment and perspective that a transference can develop there as well as with human object-relations. Process-wise, Searles (2012) thought it important to pay attention to the human experience of multiple selves and multiple self-states and that working to accept these is part of accepting the whole self and moving towards integration. (Aron & Lieberman, 2017)

More recently, clinicians who engage in psychodynamic psychotherapy with schizophrenic individuals and have organized their ideas and techniques in what comes closest to a treatment manual include Bertram Karon, Silvan Arieti, Andrew Lotterman, and Michael Garrett. The former three follow in the Sullivanian interpersonal tradition, with Michael Garrett branching off of that and utilizing more of a combined CBTp and psychodynamic integrated treatment; the psychodynamic portion of which aligns with the Sullivanian interpersonal approach and draws from Kleinian object-relations (Garrett, 2019).

Karon and VandenBos (1977) described schizophrenia as a “chronic terror” syndrome. They described the symptoms of schizophrenia as attempts to deal with a long-standing terror and specifically use the word “terror” rather than anxiety, to emphasize the intensity of the affective experience the schizophrenic individuals are guarding against. The psychotic defenses (as with most defenses) serve to reduce the immediate fear or anxiety, but then are maladaptive in the long run and actually make their problems worse (Karon & VandenBos, 1977). For

example, withdrawing from interaction with people to reduce the fear of people, also makes it harder to then overcome the fear of people by having a corrective experience with others. The other common symptoms of schizophrenia, also make it difficult to relate to other people and vice versa and so the symptoms are maintained and become a source of safety for client. The symptoms of schizophrenia also are often frightening for other people and their fearful reactions and desire to avoid the psychotic person serves to confirm the schizophrenic individuals' beliefs about themselves as bad or destructive.

Karon also firmly believed that any human has the potential to become psychotic if placed under the right conditions and exposed to certain levels and types of stress. He viewed schizophrenia as on a continuum and stated that, "every case we have treated, the individual had lived a life that we could not conceive of living without developing his symptoms" (Karon & VandenBos, 1977, p. 40). This belief likely informed his desire and ability to understand the subjective experience of his clients and his use of countertransference as essential information in their treatment- key components of Karon's work. He described his clients as frightened, confused, lonely, and often angry (Karon & VandenBos, 1977). He also described common themes that arise in the content of what the schizophrenic client is discussing; themes of feeling "drained" often presented as a literal fear of having their insides drained and often disguised by sexual content; splitting in the Kleinian sense of all good vs. all bad; conflict and shame around normal sexual behaviors, for example masturbation; and anger (felt as destructive, murderous rage) as the most problematic affect for the schizophrenic client. Another point of emphasis in Karon's theory was that the symptoms of schizophrenia, however bizarre, are meaningful and relate in some way to the individual's life. The work of the therapist is to help the client understand and make meaning of them in the context of their life history.

In the families of schizophrenic clients, Karon and VandenBos (1977) noted a common pathogenic theme, which was the repeated predominance of parental needs over the child's needs. These needs can vary widely, as can the dynamics between parent and child, but the overarching theme is the degree to which the parent acts in terms of their own needs over their child's needs when the two conflict. This is not to say a parent cannot have their own needs or they must always prioritize the child's needs over their own, this would not be healthy either, but there must be a balance and a responsibility taken by the parent for their part in the relationship dynamic. Ruptures and imperfection in relationships are normal and important for the child's healthy development, if there are also repairs, rather than the child internalizing that they are "the bad one". Think of Winnicott's "good enough" parent and the importance of mentalization by the parent of the child's experience. Karon and VandenBos (1977) described how often, the family discourages any relationships outside of the family; relationships which could have served as protective factors and corrective experiences for the client. Sometimes the schizophrenic person may hold a special place within the family and their role is often in some way serving the needs of the parents or one of the parents. With the confusion of needs and whose are being attended to, the boundary between self and other is often blurred in the pre-schizophrenic child. In families of schizophrenic individuals there are often distorted views of the world and of "normal" family life.

A common pattern according to Karon and VandenBos (1977) is the unconscious need of the mother to maintain control of (most often) her son, such that he never becomes fully independent of her. The normal process of separation and individuation is somehow unconsciously thwarted by her own need to keep him around. A common pattern in the role of the father with a schizophrenic son is not related to separation, but to competition with the son in

areas he himself feels inadequate. Here the role of the son is to lose such a competition in order to reassure the father of his own worth. Another pattern in the fathers of schizophrenic children of either gender is emotional absence. Karon and VandenBos, (1977) have been unable to identify any clear cut parental patterns for female schizophrenic children, but described a sometimes occurring pattern of the fathers acting unconsciously (or consciously) seductive towards their daughters or more frequently emotionally withdrawing entirely for fear of their own sexuality.

Karon and VandenBos (1977) are also aware of the perception that they are blaming and demonizing the parents of schizophrenic clients and make it a point to emphasize that the needs of the parent(s) are often out of their own conscious awareness; the parents are often doing the best they can given their own family histories, and that they are not purposefully trying to be destructive. Karon and VandenBos (1977) also empathize with the struggle, confusion, helplessness, and often painful experience of the parents in living with and providing for a sick, puzzling, and difficult child.

Consistent with interpersonal psychodynamic theorists Karon felt that in treatment the therapeutic relationship is of primary importance; the patient must know and feel that you are there to help them and that you believe you can help them. He emphasized honesty and use of countertransference to help the clinician understand what affects the client may be feeling, but unable to verbalize. By honesty, Karon means the therapist acting authentically like themselves and a willingness to be "off the mark" and make mistakes, rather than portraying a psychoanalytic neutrality and need to be "right". Waiting to be "right" and give a brilliant interpretation is more about the therapist's needs than the client and so likely a repetition of the parental dynamics. Making mistakes and owning those mistakes models for the client that authority figures can both be good and fallible. He also addressed the patience and persistence

required to work with schizophrenic clients, as therapy can take a long time and often the client does not provide any direct feedback to the therapist about whether they are helping or accurate in their interventions.

Another obstacle in therapy unique to work with schizophrenic clients, is what Karon and VandenBos (1977) described as the client's resistance. Whereas a client on the neurotic spectrum may exhibit resistance through various defenses and become anxious when those defenses are challenged or made conscious, there is a general cooperation and understanding by the client that the therapist is there to help and that it is worth tolerating the anxiety to ultimately alleviate their distress in the long run. With schizophrenic clients, the experience of having their psychotic defenses challenged is not just anxiety-provoking, it is terrifying, as the client may literally believe they cannot live without their symptoms (Karon & VandenBos, 1977). The therapist attempting to interfere with the client's psychotic defenses is the therapist raising the threat of death; if the client cooperates it is probably to get the therapist to leave them alone or because they want help with the source of their terror, not with the psychotic symptoms or any desire to live in the world without their symptoms. In this sense, the work of therapy with a psychotic client is akin to working with someone who has been mandated to do therapy, an unwilling participant in the process until the relationship has been established long enough to build a semblance of trust.

Following this, Karon and VandenBos (1977) noted that the first goal of therapy is to provide enough safety, protection, and gratification to overcome the conscious resistance of the client. If the client can begin to face what had previously been a source of terror, they fight the process of therapy less. Karon and VandenBos (1977) describe the importance of being more direct and gratifying than one may be with a neurotic client because with the psychotic client's

often chaotic, undependable childhood they will fill in any ambiguities about what is said or unsaid with destructive or malevolent information. A second goal as a working relationship is forming, is to utilize the transference that arises to gain insight into the client's past and help them put words to their past. A third goal is to provide a model of relating, for the client to identify with and begin to internalize; to begin internalizing a "good enough" parent, so the client can begin letting go of old patterns of relating. Karon noted that "the real tragedy of schizophrenia is not the severity of the symptoms and the suffering that results for patients and for their families, but that we know psychotherapies that work and we are not using them." (Karon, 2003, p. 90)

Psychiatrist Andrew Lotterman (1996), identifies himself as also following in the Sullivanian tradition with his emphasis on importance of the patient-therapist relationship, treating the patient as a respected colleague in the work, the need to acknowledge primitive and painful affects, and the importance of being honest and candid about one's thoughts and feelings with the patient. Regarding the latter point, Lotterman (1996, p. 49) states that "not to reveal aspects of oneself at certain moments may confirm the patient's fear that such feelings are too painful to bear and frightening to talk about." He describes treatment (once the therapeutic relationship is established) as helping the patient to identify and verbalize inner states. The identification and verbalization of emotions is consistent with the therapy for complex trauma, as well.

Lotterman (1996) notes that contrary to other theorists (such as Arlow and Brenner (1964), Fromm-Reichmann (1954), and Karon and VandenBos (1977)), he does not view neurosis and schizophrenia on a continuum. For him, the psychological structure of schizophrenia is fundamentally different from neurosis in important ways that affect how one

conducts therapy with this population (Lotterman, 1996). He outlines five key areas requiring technique adjustment unique to the pathology and psychological structure of schizophrenia as compared to neurosis and borderline conditions: a) disturbance in the capacity for emotional attachment, b) disturbance in affect awareness and regulation, c) disturbance in the development and preservation of psychological boundaries, d) disturbance in symbol use, e) disturbance in the testing of reality (Lotterman, 1996).

Regarding a schizophrenic individual's capacity for emotional attachment, Lotterman (1996) highlights the fragility and vulnerability of their object attachments describing how cautiously they make human connection and how tenuous that connection can be. Unlike in neurotic and borderline individuals, schizophrenic attachments do not at least at first have the staying power to withstand disappointment, loss, or rage and can quickly shift from having a positive emotional tone to a paranoid one (Sullivan (1962) terms this pattern a malignant transformation) resulting in the ending of the attachment relationship (Lotterman, 1996).

Lotterman (1996) describes the schizophrenic individual's awareness and regulation of affect as more disturbed than that of neurotic or borderline individuals. He notes specific difficulty containing, toning down, and integrating impulses, especially aggressive impulses, which may either a) break through the ego unmodified resulting in behavior that is verbally abusive, physically threatening, or provocative, b) be avoided all-together through the individual becoming excessively passive, emotionally withdrawn, or even in a stupor, or c) be projected onto others (Lotterman, 1996).

Regarding the schizophrenic disturbance of boundaries, Lotterman (1996) points out porous or non-existent boundaries exist not only between the id and ego, but also the internal world of the patient and the external world. Unique to patients with schizophrenia is the

profound difficulty they experience in discriminating what is inside and what is outside or what is self and what is other (Lotterman, 1996). He states that this “sense of boundary” (Lotterman, 1996, p. 73) is what allows a person to differentiate between feelings, memories, perception, and fantasy and so is a key component of the ability to reality test. Lotterman (1996) notes that is unclear how this disturbance arises and hypothesizes that it could be a disturbance in a normal developmental process or a product of pathological process. Clinically, the lack of boundary leads schizophrenic patients to feel “helplessly at the mercy of affects stirred up by another person” (Lotterman, 1996, p.74). They may feel that their inner life is being controlled or manipulated by the other, and contributes to their sense of vulnerability to pain initiated by the outer world (Lotterman, 1996).

One of the more profound disturbances unique to schizophrenia is disturbed symbol use. This can present in the form of the loss of the capacity for concept formation or abstraction, which consequently affects the ability to perceive, derive, and express meaning and the affects that accompany this process (Lotterman, 1996). This can also present as conceptual vagueness or obfuscation as in when a patient presents with “word salad” or speaks in loose associations or neologisms. This is one of the primary disturbances, which Lotterman (1996) says must improve in order for any meaningful therapy, which relies on shared language and symbolic meaning, to take place. He notes that from a technique perspective, the use of the therapist’s countertransference is essential in navigating what the client may be feeling, but unable to verbalize in session. Lotterman has observed in his own work that there is an inverse relationship between the client’s ability to identify and verbally communicate inner emotional states and their use of non-verbal “emotional induction” to communicate (Lotterman, 1997, p.88).

The breakdown in the capacity for reality testing is generally agreed upon to be one of the defining features of schizophrenia (Lotterman, 1996). Reality testing is defined by Lotterman (1996) as the capacity to discriminate internal sources of perception from external, self from object, the ability to empathize with the social criteria of the external world, and the ability of the ego to hold all of this in the form of meaningfully, shared concepts and symbols. Lotterman (1996) conceptualizes intact symbol use as inherent in the ability to reality test and therefore essential in any kind of therapy for schizophrenia.

In addition to the five areas outlined above, Lotterman (1996) discusses general technique variations that he uses in treating schizophrenic individuals that differ from the psychodynamic treatment of people who are neurotic or borderline in their psychological structure. In discussing the nature of transference, Lotterman (1996) describes how with the schizophrenic patient there is often and especially in the initial phases of treatment, more explicit reviewing, examining, and explaining of the therapist's view of an interaction that may be occurring in the room. The schizophrenic client brings his past object experiences to bear in the present, but unlike with the neurotically structured client, the psychotic client is often not initially able to take a step back and see that they are imagining the therapist is, for example, untrustworthy, uncaring, malicious, or controlling, while holding the possibility that in fact the reality is that the therapist is not these things. With the psychotic client, the therapist is definitely the attributes they are projecting onto the therapist and will not be convinced otherwise.

Lotterman (1996) does not see any use in trying to analyze the transference until much later on in treatment, once trust has been established, and finds it more useful to focus on the present, here-and-now interactions and feelings that come up in the room. He has the clients detail what about the present interaction is leading the patient to perceive the interactions as they

are and shares his feelings and perceptions in the moment as well. In this way, Lotterman is beginning to help the patient with reality-testing and providing immediate feedback about interactions occurring in reality. Regarding reality testing, Lotterman (1997) agrees with his fellow Sullivanian's that it is important for the therapist to remain grounded in reality and to point out for example, that the patient is being obscure in their communication when they are or that the therapist is not understanding the client's language. Also consistent with the interpersonal psychodynamic theorists, Lotterman (1997) emphasizes the use of the therapist's countertransference as a window into what the client may be feeling and trying to convey, noting that sometimes this may be the only guide to what is occurring with the client.

He notes there is more activity and self-disclosure on the part of therapist about their honest feelings in the here and now than occurs in traditional psychodynamic work with non-psychotically organized individuals. The later therapy work of client self-disclosure and introspection that is characteristic of psychodynamic therapy will never occur if the client does not first have some basic belief in the therapist's honesty, dependability, and self-control (Lotterman, 1997).

Silvano Arieti has a similar approach to Karon and VandenBos. I will not go into too much detail here about his work, as much of his thinking about treatment will be described, used and integrated in my proposed integrated treatment model detailed in the *Methods* section. Arieti (1974) broke down his actual treatment into the most detail, and administered it in outpatient settings (as opposed to purely hospital settings), and, as such forms much of the basis for my own proposed treatment model.

Another disciple of Sullivan, Arieti (1974) noted the importance of engaging and connecting with patient with schizophrenia. He broke down his psychotherapy model into four

phases: a) establishment of relatedness; b) specific treatment of psychotic mechanisms; c) psychodynamic analysis; and d) general participation in the patient's life. In the initial phase of treatment; establishing safety and a connection is of prime importance. The therapist's role is to engage, connect, and build trust with the patient. Once that phase of work is accomplished and the patient is stabilized, they move on to phase two, where together patient and therapist learn how psychotic mechanisms are defenses to disguise true thoughts and feelings, and eventually building up enough ego strength (developing new coping skills) to render them unnecessary (Arieti, 1974). Much of this phase involves helping the client to identify and name their emotions, identify cognitive errors or faulty assumptions and connect this to the psychotic defenses, which he describes as symbolic representations of the patient's inner struggle. This phase of the work actually aligns with the cognitive-behavioral therapy for psychosis (CBTp) work described by Garrett (2019). When the patient could begin to let go of their psychotic defenses, Arieti (1974) moved into the third phase of the work and did what began to look like general interpersonal psychodynamic work of examining the origins and development of the patient's psychosis with them, family history, exploring the therapeutic relationship in the here-and-now, and helping the patient gain insight into their dynamics (Arieti, 1974). Through this, he helped the patient construct a personal narrative. In the fourth phase, he outlined recommended engagement with external therapeutic resources such as social workers, case managers, psychiatrists, vocational specialists, nurses, which help promote and maintain recovery. Arieti (1974) noted that while he breaks up his treatment into phases, they often do not occur in a strictly linear fashion, especially regarding his fourth phase, which often is occurring outside of therapy, while the therapy is going on.

One of the most recent publications in the arena of psychodynamic psychotherapy for psychosis is Michael Garrett's (2019) *Psychotherapy for Psychosis: Integrating Cognitive-Behavioral and Psychodynamic Treatment*. Garrett (2019) identifies himself as both a psychoanalyst and trained cognitive-behavioral therapist and thus utilizes a therapy combining psychodynamic theory and cognitive-behavioral therapy for psychosis (CBTp) technique. In the psychodynamic part of his work, he describes the utility of Kleinian object-relations theory in working with psychosis, but also draws from many different psychodynamic theories and theorists including Winnicott, Sullivan, Lotterman, Arieti, Searles, and Bion. Consistent with the Sullivanian interpersonal approach, Garrett (2019) describes the importance of the therapeutic relationship and of being honest, authentic, and open with psychotic clients, rather than the traditional psychoanalytic "blank slate". He also emphasizes the importance of connecting to the essential humanity in clients with psychosis and treating them as a respected colleague in the work together. In his integrated treatment, Garrett (2019) describes his general approach as first engaging the patient and establishing rapport, eliciting the patients story and helping them to begin constructing a narrative or timeline, then building coping strategies and utilizing CBTp techniques to decrease psychotic symptoms, and then when the severity of psychotic symptoms is decreased or manageable, moving into the psychodynamic work of interpreting the origin and function of the psychotic symptoms and helping the client make meaning.

Cognitive Behavioral Therapy for psychosis (CBTp). Though not the focus of this proposal, it is important to briefly touch upon what has been the traditionally recommended psychotherapy modality for the treatment of schizophrenia by large mental health organizations and sites such as the National Alliance on Mental Illness (NAMI) and Schizophrenia.com (schizophrenia.com, 2006; NAMI, 2017). This is in part due to CBT having a larger research

base, as opposed to reliant on case studies and the expertise of clinicians, as CBT is pragmatically oriented and utilizes operationalized techniques. Cognitive-behavior theories have gone through “waves” of development, with the first wave being behavioral therapy developed in the 1950’s, the second wave being Aaron Beck’s cognitive revolution with traditional CBT developed in the 1960’s, and a third wave developed in the 80’s/90’s in which researchers responded to some of the shortcomings of CBT by adding components of eastern philosophy such as acceptance, mindfulness, duality, and focusing on the context and function of psychological phenomena. CBT for psychosis (CBTp) was developed during the third wave era, but is fundamentally based on Beck’s cognitive-behavioral theory (Garrett & Turkington, 2011). CBTp focuses on reducing the distress caused by the positive symptoms of schizophrenia with an emphasis on cognition, challenging and reformulating beliefs, and ideally integrating them into a new narrative. This often involves setting out to examine cognitive biases in psychosis and using the A-B-C model of CBT, where A is an activating event, B are the beliefs about the event, and C are the consequences of said sequence.

Since the zenith of CBT in the 70’s and 80’s, more research has emerged showing that in general, other types of therapies such as psychodynamic and interpersonal psychotherapy are as effective as CBT and in some cases more effective when tracked longitudinally (Gottdiener, 2006; Leichsenring & Rabung, 2011; Luborsky, Singer, & Luborsky, 1975; Wampold et al., 1997) . Additionally, there has been some critique of the underlying theory and an assertion that CBT ignores important aspects of human experience, such as the role of emotion, in its attempts to distill the complexity of human experience down to simplistic operationalized constructs. A set of critiques that are particularly relevant and which psychodynamic models do address, comes from the field of phenomenology. A paper by Skodlar, Henriksen, Sass, Nelson, and

Parnas (2013) presented a critical evaluation of CBT for schizophrenia from a clinical-phenomenological perspective. Among the arguments they made are that CBT for schizophrenia ignores the meanings or interconnectedness of symptoms and by “stripping symptoms of their contexts and embeddedness in the patients’ experiential world, the essence of the symptoms in question can hardly be captured” ((Skodlar et al., 2013, p. 253). Psychodynamic theories of schizophrenia do see symptoms as meaningful and connected to the patient’s life and experiential world. Skodlar et al. (2013) also described how CBT for schizophrenia focuses primarily on the positive symptoms- the improvement of which many not necessarily result in a satisfactory clinical outcome, and that it does not give adequate consideration to the affective dimension of the patient’s life (Skodlar et al., 2013). They note regarding the latter point that attention is beginning to be given to the affective dimension in clinical work with third wave CBT therapies like ACT and mindfulness-based approaches. Interpersonal psychodynamic approaches to the treatment of schizophrenia have always made the affective experience of the schizophrenic client an area of focus.

Another paper by Nelson, Sass, and Skodlar (2009) examined implications for psychological interventions in the prodromal population and concluded that CBT for schizophrenia may not be suitable and even may be counterproductive for the high risk prodromal population as CBT’s emphasis on cognitive reflection, examining and challenging beliefs, and “thinking about thinking” may serve to exacerbate an already occurring pathological process of hyperreflexivity or exaggerated self-consciousness (hyperreflexivity will be discussed further in the *Symptomology* section). The authors suggest that therapies that provide an intersubjective space where clients can evolve the first-person perspective of themselves, the second-person perspective, and have the experience of trustworthy relationships when

encountering others could be more beneficial for clients at high risk of becoming psychotic. Additionally, they remark that “empathic attunement afforded by the phenomenological approach’s sensitivity to psychotic experience and strategies that encourage a form of immersion or absorption in present activity, including mindfulness” is recommended (Nelson, Sass, & Skodlar, 2009, p. 290). Interpersonal psychodynamic psychotherapies encompass all of these recommendations and will be further addressed in the presently proposed integrated model.

While I will not go into further detail regarding the CBT theory and general mode of therapy, it is worth noting that many of the cognitive biases noted in CBTp overlap with dynamic ideas, but have different terms. For example, a defensive behavior in dynamic terms might be called a safety behavior in CBTp and the A-B-C model, though not labeled as such, is recommended by Arieti (1974) when he describes identifying what lead up to an event, what feelings occurred prior and during the event, and what that led the patient to then do and feel (Garrett & Turkington, 2011). There are also some key differences between CBTp and psychodynamic approaches. For example, CBTp emphasizes cognition and challenging beliefs, whereas psychodynamic therapy for psychosis emphasizes emotion and does not see challenging beliefs or delusions as beneficial, but rather would seek to understand the meaning and function of them.

Garrett and Turkington (2011) have proposed an integrated model of CBTp within a psychoanalytic frame, which makes use of the benefits of both approaches. Garrett details this approach in his book *Psychotherapy for Psychosis: Integrating Cognitive-Behavioral and Psychodynamic Treatment* just released in 2019. Stated in simplified form, CBTp can help patients manage, cope, and live with their symptoms, but psychodynamic therapy for psychosis can further help the patient make sense of their symptoms, find meaning, create a narrative, and

integrate their story into the broader context of their life; consistent with the goals of a complex trauma model. For further review, see Garrett and Turkington (2011), Garrett (2019) and Chapters 16 and 22 in *Models of Madness* (2013).

PTSD treatment and psychosis. The scientific literature exploring the efficacy of trauma-focused interventions for individuals with co-occurring PTSD and psychosis is nascent (Dvir et al., 2013). Although the relationship between trauma and psychosis has strong scientific support, the development of treatments to address this complex relationship are only recently being explored. A handful of studies were found that have attempted to begin tackling this issue.

O'Driscoll, Mason, Brady, Smith, & Steel (2016) conducted a study on trauma-focused CBT (TF-CBT) for schizophrenia and found that the participants appeared to be able to engage in the emotional processing aspect of trauma treatment, but not to the required level for successful cognitive restructuring. Another study undertaken to address clinicians' concerns about using exposure treatments with schizophrenic patients, evaluated a 16-session cognitive restructuring program, without direct exposure, for the treatment of post-traumatic stress symptoms specifically within individuals diagnosed with schizophrenia. Both the treatment group (who received cognitive restructuring through CBT) and control group (clinical services as usual) experienced a significant decrease in PTSD symptoms over time, but there was no effect of the addition of CBT on PTSD or psychotic symptoms, suggesting that cognitive restructuring without emotional processing of traumatic memories (i.e. direct exposure) is not useful in patients with schizophrenia. The authors note that a sub-diagnostic severity level of PTSD in the majority of their sample and a small sample size were limitations of their study. (Steel et al., 2017)

Four studies out of the Netherlands, found more promising results. One study looked at the efficacy and safety of two psychological approaches to posttraumatic stress disorder (PTSD) in 10 patients with a co-morbid psychotic disorder. Patients were randomly assigned to either prolonged exposure (PE) or eye movement desensitization and reprocessing (EMDR) therapy. The PTSD treatment protocols of PE and EMDR both significantly reduced PTSD symptom severity, with PE and EMDR appearing equally effective and safe. No serious adverse events occurred, nor did patients show any worsening of hallucinations, delusions, psychosis proneness, general psychopathology, or social functioning. The results suggest that PTSD patients with comorbid psychotic disorders benefit from trauma-focused treatment approaches such as PE and EMDR, for their PTSD symptoms specifically. (de Bont, van Minnen, & de Jongh, 2013)

While important to know that psychotic symptoms did not worsen as a result of the PTSD treatments, they also did not improve as a result of the PTSD treatments in that particular study. A pilot study by van den Berg and van der Gaag (2012) investigated the use of only 6 sessions of EMDR therapy for 27 adult patients with a psychotic disorder and co-morbid PTSD. Symptoms were assessed at baseline and the end of treatment. The authors found that PTSD symptoms, auditory verbal hallucinations, delusions, anxiety, depression, and self-esteem all improved significantly. Paranoid ideation and feelings of hopelessness did not significantly improve, but treatment did not lead to symptom exacerbation in any patients.

van den Berg et al. (2015) then followed up on their pilot study with a full single-blind, randomized control trial examining the efficacy of 8 sessions of PE and EMDR as compared to a waitlist (WL) control group in 155 patients with chronic, severe psychotic disorders and comorbid PTSD. Most of the participants experienced complex PTSD, with only five percent experiencing a single-event trauma in adulthood. The authors found participants in the PE and

EMDR conditions showed a greater reduction of PTSD symptoms than those in the WL condition. Participants in the PE condition or the EMDR condition were significantly more likely to achieve loss of PTSD diagnosis during treatment than those in the WL condition with participants in the PE condition only being more likely to gain full remission. Treatment effects were maintained at the 6-month follow-up in PE and EMDR. As in their previous pilot study, treatment did not lead to symptom exacerbation in any patients. Treatment effect on psychotic symptoms were not analyzed in this study, but were analyzed in a follow-up to this study, by the same authors (van den Berg et al., 2016).

In the follow-up study which utilized data from the same population as the previous RCT, the authors examined paranoia, depression, hallucinations, dissociation, and suicidality in addition to symptoms of PTSD (van den Berg et al., 2016). The authors found a decrease in PTSD symptoms and paranoia during treatment, with hallucinations, dissociation, and suicidality remaining mostly unchanged throughout the 8 sessions of treatment. These studies all addressed a common and unfounded fear among clinicians that the symptoms of psychotic individuals could be exacerbated by treating their trauma.

While more research is needed, taken together these studies suggest that a) emotional processing or direct exposure to trauma memories are important for the resolution of PTSD symptoms; b) individuals with psychosis can successfully engage in the emotional processing components of trauma treatment leading to the resolution of trauma symptoms; and c) symptoms of psychosis are not exacerbated in trauma specific protocols like PE or EMDR.

Complex Trauma Therapy in the Treatment of Schizophrenia

As Winnicott (1974) wrote, “we fear breakdown to the extent that we experienced it before we had words, and thus before we could hold these experiences in verbalized memory.

We hold them in our bodies; and these body memories hold our fear of death and psychosis.”

Such a message sounds strikingly similar to what has become a catchphrase in the trauma world, “the body keeps the score” (van der Kolk, 2014). There is much overlap between the world of complex trauma and the world of schizophrenia, but also some key differences. When looking at the theory of psychopathology suggested by the psychodynamic theorists for schizophrenia, particularly within the Sullivanian interpersonal psychodynamic tradition, one could argue that it is essentially a theory that posits that childhood relational “trauma” is a major causal variable in the development of schizophrenia. It is important to highlight here that childhood relational *trauma* in the psychodynamic sense has a broader spectrum than what the complex trauma community would likely consider *trauma*. A widely accepted definition of trauma is an inescapably stressful event that overwhelms an individual’s existing coping mechanisms (Van der Kolk, 2015). Trauma therefor is arguably a subjective experience with a different threshold for an event being considered traumatic for a given person depending on their coping mechanisms. However, a dive into the phenomenology and complexities of what is considered trauma is beyond the scope of the present work. For the purposes of the proposed integrated model, I will make a distinction between childhood relational *ruptures* as the psychodynamic definition of trauma and childhood complex trauma as encompassing what is traditionally thought of as traumatic and includes prolonged and repeated emotional, physical, and sexual abuse and/or neglect.

This study seeks to outline the similarities and differences in theory and suggested treatment models between complex trauma and the interpersonal psychodynamic theory of schizophrenia. The treatment models will be integrated based on similarities of structure (i.e. relationship-based, phase oriented models), overall goals, and phase specific objectives. Where

differences arise, guidelines will be provided as to how the integrated model will approach the diverging theories with rationale in support of the suggested guideline.

Methods

The purpose of the proposed study is to develop an integrative model of therapy that pulls from the literature on complex trauma and psychodynamic therapy for schizophrenia. The proposed model will adapt aspects of the ISTSS and ISSTD recommended treatment guidelines for complex trauma and integrate these standards with aspects of the treatments outlined by Arieti (1974), Karon and VandenBos (1977), and Lotterman (1996) for schizophrenia. The model will then be incorporated into a theoretical study, designed to gauge the effectiveness of the intervention as compared to two control groups; clinical management (CM) defined as medication management and supportive therapy, and cognitive-behavioral therapy for psychosis (CBTp). A secondary aim of this study would be to add to the evidence base for psychodynamic treatments.

Process

The construction of treatment guidelines. The proposed model will be developed based on the theoretical work, clinical experience, and existing treatment guidelines of clinical experts in their respective fields of trauma and schizophrenia. Courtois and Ford (2013) detail their three phase, sequenced, relationship-based approach for the treatment of complex trauma in their book; outlining theory, research, clinical implications, and the three phases of treatment along with technique.

I will refer to the group of experts doing psychodynamic psychotherapy with schizophrenia as the modern-Sullivanians, as all identify themselves as strongly influenced by the interpersonal psychodynamic tradition of Harry Stack Sullivan, and have similar styles and technique. Each of them detail different aspects of the psychotherapy of schizophrenia. For example, Lotterman (1996) details many specific techniques and focuses on the structure of

treatment and more technical aspects, whereas Karon and Vandebos (1977) while outlining technique, take a broader philosophical view that incorporates theory to a greater extent. Arieti's (1974) book is the most extensive of the three, as he also outlines phases of the treatment model in an organized fashion. Taken together, one can get a comprehensive guide of interpersonal psychodynamic psychotherapy for schizophrenia (IPPS) through the work of these three scholars.

It so happens that the treatment approaches for complex trauma and for schizophrenia overlap a great deal, each broken down into phases that can be integrated and align nicely as far as goals in each phase, with the IPPS model based on the idea that childhood relational ruptures and often more significant trauma play a key role in the development of later psychosis. While psychodynamic theorists had the clinical insights about the role of childhood trauma in psychopathology for decades now, scientific evidence is now accumulating to support their theories. Despite their uncanny similarities in approach, special considerations need to be taken into account when working with schizophrenic individuals that would not need to be taken into account in the more "general" complex trauma approach of Courtois and Ford.

In constructing the treatment guidelines, Courtois and Ford's (2013) "gold-standard" therapy model will be used as the frame, on which to map the IPPS model and show how the IPPS model incorporates much of what is outlined by complex trauma model. Though Arieti (1974) describes his model as having four phases, for the purposes of my integrated model I have combined his phases two and three (psychotic specific mechanisms and psychodynamic analysis) into one phase, which then align with Courtois and Ford's (2013) "processing" phase. Where the models diverge due to the nature of working with schizophrenic individuals, treatment recommendations and rationale will be provided. The result of this process will be a

comprehensive psychotherapy model that systematically integrates what is known to be an effective treatment for complex trauma with what is clinically accepted in the world of psychodynamic psychotherapy to be an effective treatment for schizophrenia. Limitations of the model will be discussed as well.

Overview of proposed integrated treatment model. The integrated model will align structurally with the model for complex trauma outlined by Courtois and Ford (2013), as it is considered the “gold-standard” treatment for complex trauma. It will be phase-oriented and relationship-based, consistent with Arieti’s (1974) model for the treatment of schizophrenia. The phases of treatment, while outlined linearly, will not necessarily follow a linear path. More realistically, individuals, in line with the “exacerbations and remissions” of the disorder (whether trauma or schizophrenia), will move back and forth between the phases. There is no set time limit, nor is there a session limit, as individuals will vary in the amount of treatment needed. (A session limit will be proposed for the evaluation of the model later, but that is for experimental design purposes). As Karon (1977) notes, individuals with schizophrenia need to be met where they are at and flexibly. The determination of whether to move forward in the phases is determined collaboratively and based on the achievement of the objectives in the current phase. Individuals may choose not to go further in the process, if they are satisfied with the gains made at that time.

Phase I. The goal of Phase I is the establishment of safety, engagement, and “making contact” as Arieti (1974) puts it. It is noted in both Courtois and Ford (2013) and by the modern-Sullivanians that this phase of treatment may often be the longest and most essential aspect of treatment, as it sets the frame for further work if it is to be attempted in the later phases. In some more severely distressed individuals, treatment may remain entirely in this phase. The modern-

Sullivanians all note that the therapeutic attitude in working with schizophrenic individuals must be one of honesty, authenticity, and genuine warmth, optimism, and desire to help. The once classical attitude of therapeutic neutrality and the “blank slate” is noted to be particularly detrimental in the treatment of schizophrenia.

Objectives. Briefly, the objectives here include stabilization, safety and safety planning around harm to self or others, establishing safety of the individual’s environment, the establishment of a therapeutic relationship with the therapist as (in attachment terms) a secure-base or providing a Winnicottian “good-enough” environment, reestablishing threads of trust in the world and themselves, psychoeducation about trauma and its relationship to psychotic symptoms, learning new emotion regulation skills, beginning to name emotions and emotional states that could be nonverbal and unacknowledged at this point, and building the clients resources and strengths.

Phase II. The goal of Phase II is the decreased reliance on psychotic symptoms or defenses, the processing of the traumatic memories and their attendant emotions and cognitions, and linking of these to the individual’s particular psychotic dynamics.

Objectives. Objectives here can include helping the individual become aware of the ways in which they can transform psychodynamic conflict into psychotic symptoms (Arieti, 1974) (i.e. understanding defenses) substituting new coping and self-regulation skills for old psychotic defenses, continued naming and verbalization of emotions, and processing through an established PTSD treatment the traumatic experiences endured. It is important that the processing of the trauma should be agreed upon collaboratively. The client’s capacity to emotionally tolerate such processes and motivation to continue, must be carefully assessed and monitored here, so as not to overwhelm them and trigger a return to previously relied upon

psychotic or other defenses. Throughout this phase the individual may require additional support of the therapist. If the individual can integrate their sense of self, take in the therapist as a “good object” or secure base, increase self-compassion, and piece together a more coherent narrative of their life and self, they have the possibility of improved self-esteem, a sense of agency, and a sense of greater personal control.

Phase III. The goal of Phase III is the solidifying of therapeutic gains, incorporating new knowledge, skills, sense of self, and into daily life, and bolstering support and relationships with others. This last goal could involve the incorporation of family therapy or supportive group therapies to build the individual’s support network, as well as ensuring that additional resources are in place if needed (ex. case managers, psychiatrists, vocational supports, etc).

Objectives. Objectives in this phase include applying treatment gains to daily living and moving toward a realistic understanding and living of their life based on who they are and what they want, acknowledging, processing, and overcoming a fear of improvement (Arieti, 1955; Karon and VandenBos, 1977), reversing post-traumatic decline, furthering developmental phases that were stunted, fostering a realistic sense of independence (which may vary from individual to individual), and promoting a path of recovery.

Again, it important to note that this model of treatment is fluid and adaptable to the individual client.

The Integrated Model

The proposed model of therapy assumes a basic understanding of general psychodynamic theory and treatment including those outlined in Shedler’s (2010) article on psychodynamic psychotherapy. While his paper focused more broadly on the efficacy of psychodynamic psychotherapy, it elaborated on seven distinctive features of psychodynamic technique including

focus on affect and expression of emotion, exploration of attempts to avoid distressing thoughts or feelings (i.e. defenses and resistance), identification of recurring themes and patterns, discussion of past experience, a focus on interpersonal relations, focus on the therapy relationship, and exploration of fantasy life (Shedler, 2010). An important distinction in the therapeutic stance should be mentioned here, that diverges from the classical psychoanalytic stance of neutrality or “the blank slate”. The stance recommended both in the complex trauma literature and the psychodynamic psychosis literature is one of greater activity, warmth, respect, authenticity, honesty, and very much a two-person “participant-observer” standpoint (Arieti, 1974; Courtois & Ford, 2013; Sullivan, 1931). This therapeutic stance will be covered in more detail under the *Treatment Preparation* section below.

Symptomology. The potential symptoms resulting from exposure to complex trauma are vast and as outlined earlier include five broad domains of disturbed self-regulatory capacities: a) emotion-regulation difficulties, b) disturbances in relational capacities, c) alterations in attention and consciousness, d) adversely affected belief systems, and e) somatic distress or disorganization. One might argue that these symptom domains encompass what we currently classify as psychosis or schizophrenia and indeed Courtois and Ford (2013) list psychosis, hallucinations, disturbances in self experience, paranoia, detachment, and other psychotic-like experiences in their extensive list of potential sequelae of exposure to complex trauma. Others (Sass, 2014; Sass & Parnas, 2003; Sass, Pienkos, Nelson, & Medford, 2013) might argue there is a distinct, phenomenological quality of schizophrenia that distinguishes it from other “psychotic-like” experiences or alterations in consciousness. Regardless of whether these constructs are distinct or overlapping and what construct can be attributed more to the experience of trauma vs.

psychosis, the contribution of this treatment model is that it is designed to address all of the above regardless of origin.

According to the DMS-5, a diagnosis of schizophrenia is classified by two or more of delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms present for a significant portion of a one-month period, with continuous signs of disturbance for at least a six-month period and causing impairment in level of functioning (American Psychiatric Association, 2013). Psychosis or psychotic symptoms more generally can be any of the above and can occur in the presence of any other psychological disorder. Sass and Parnas (2003), describe the heterogeneous disorder of schizophrenia through the lens of phenomenology and argue that what underlies and unites the various and sometimes disparate symptom presentations is the alteration in consciousness; specifically, alterations in the individual's sense of self. They describe schizophrenia as fundamentally a self-disorder or *ipseity* disturbance characterized by two distinctive alterations in self-consciousness: hyperreflexivity and diminished self-affection (Sass & Parnas, 2003). Hyperreflexivity refers to an exaggerated or increased focus on aspects of oneself or turning inward, such that the aspects being attended to begin to be experienced as external objects or alienated from their usual inhabited, tacit experience. Diminished self-affection refers to a decreased fundamental sense of existing in the world as a vital presence capable of action and awareness, a weakened in-the-moment sense of existence and corresponding sense of existence of the world. Sass, Pienkos, Nelson, and Medford (2013) suggest that interventions aimed at reducing these experiences in any schizophrenia spectrum disorder could be useful and advocate for therapeutic techniques that may enhance the minimal sense of self, foster a stronger orientation outward toward the world, and increase the

client's experience of emotional involvement, all of which are advocated for in the proposed integrated model.

Psychosis symptoms. The following is a list of symptoms which may arise in the context of treating a client with psychosis along with recommended treatment techniques as described by the Modern Sullivanians (Arieti, 1974; Karon & VandenBos, 1977; Lotterman, 1996). These symptoms can occur in the context of trauma, may be caused by trauma, or may be distinct, but occur in addition to trauma symptomology depending on the individual.

Hallucinations. Auditory hallucinations are the most common type of hallucination and also appear to be correlated with a history of childhood sexual abuse. Following auditory, visual hallucinations are next most common, especially in acute cases of psychosis. Of other sensory hallucinations which tend to be rarer, olfactory is the most common, especially olfactory hallucinations related to one's body. Hallucinations tend to be reflections of the client's inner emotions. They experience feelings not as arising from within themselves, but as distorted perceptions of the outside world. Hallucinations when they arise should be explored, feelings named, and enlarged. "Enlarged" is a term used by Lotterman (1996), to describe a process of clarification and directed associating. Many patients have trouble putting their feelings and thoughts into words and when asked may respond concretely or with somatic imagery, for example, after stating that their mind is blank, a patient may elaborate with statements such as "my body is changed", "there is a lump in my throat", "my heart is being buried", "heat is protruding from my chest", all of which are somatic and more concrete ways of representing underlying emotion. It is the therapist's job to help the client name their emotions. The elaborations or enlargement of the feelings involve getting the client to say what the feelings are related to or associated with as a way of returning the feelings back to the client's inner life and

connecting them to the outer world and story of the client's life. Lotterman (1996) gives an example of a client who kept evading a repeated question from her therapist about what led her hospitalization. After repeated asking and evading the client reported seeing an object "which looked like sandpaper" near her therapist. The therapist asked the client to describe it and what comes to mind as she describes it. The client described the object as rough and abrasive, "like the appearance of someone who is irritating and pushy" (Lotterman, 1996, p. 134), which led to a conversation about the client's dislike of the therapists persistent questioning.

Delusions. Lotterman (1996) describes a delusion as a belief, not consensually validated, and maintained with certainty. Delusions are a complex interaction of the client's wishes with their perceptions and concepts about what is real. Delusion formation is likened to the process of forming and telling a lie. A lie, which is an altered form of reality, is developed for other people because it serves our own emotional interest. If there is any doubt about the certainty of the belief, it is not classified as a delusion. The technique for approaching delusions is to understand the emotions connected to the delusion and the function the delusion is serving for the client. It is noted that to confront the delusion with logic and rationality is not useful, but that it can be useful for the therapist to acknowledge explicitly that the client and therapist have two different views of reality and that this is okay and should not hinder the therapeutic work and relationship.

Ideas of Reference. This symptom reflects the client's sense of safety, boundary, and self-esteem. Client's may believe that they are being mocked, ridiculed, or betrayed and there is exaggerated meaning and connection in the environment. Nothing can be coincidental or having meaning of its own, but everything is connected back to the client in some form. Ideas of reference usually reflect the client's sense of felt worthlessness, smallness, oddness, or badness. Clients may confront other's regarding their actions to either confirm what the client had

suspected or gain reassurance. The underlying issue here can be the inability to tolerate an anxiety. The defense enacted here is usually projection.

Paranoia. When working with paranoia, the techniques recommended include patience, boundary setting, and giving voice to the interpersonal interactions occurring in the here and now of the session. The level of paranoia can vary greatly depending on the client, with some clients feeling paranoid only toward the therapist and therapy setting, while others may be hostile and suspicious toward everyone they encounter. Lotterman (1996) notes that these clients tend to be filled with rage and exhibit devaluation, contempt, and hostile withdrawal making it difficult to build a corrective relationship with anyone else. Their lack of emotional nourishment from others can then serve to reinforce their sense of deprivation and isolation and only further fuels their anger and envy of others. The interpretation of this cycle and of the use of defenses like devaluation, projective identification, splitting, denial, and omnipotent control can be helpful to the client, but can also cause them to feel more enraged and paranoid.

Communication Disturbance. Communication disturbance in psychosis can take on many forms including pressured speech, loose associations, word salad, perseveration, or neologisms. With clients who exhibit communication disturbances, it is often helpful to interrupt and explain the reality of the situation; that you are interrupting because you take what the client is saying seriously, and the client is speaking too quickly or jumping too fast for you to follow or using terms unfamiliar to you. The client is recommended to slow down, take one idea at a time, and explain the use of the language being used. Some clients will respond to that while others will take more redirecting. Other clients may be motivated to speak incoherently in order to avoid talking about their emotions and to avoid being understood. Clients may fear being understood as it poses a threat to their use of psychotic defenses. A conversation might then be had about why

the client does not want to be understood. Alternatively, the therapist may be able to listen with a trained ear for as Lotterman (1996) states the “background music” of ideas and affects and themes emerging from what the client is saying.

Disorganized/disruptive/inappropriate behavior. Behaviors that interfere with treatment require limits and boundary setting. Often clients translate feelings into action because they do not yet have the words. Parameters and limits on disruptive behavior serve to protect the therapist, the client, and therapy frame. Limits preserve the client’s safety-without safety psychotherapy cannot take place, allow the therapist to feel calm and safe, so that the work of therapy can occur, prevent the client from destroying conditions necessary for successful therapy via behaviors such as self-mutilating, manipulative suicidality, or attending sessions intoxicated, and encourage the use of verbal working through of conflicts, issues, and affects rather than acting them out. Clients may also try to engage in behaviors such as yelling, touching the therapist, and taking or damaging personal property. The specific technique recommendations for setting limits (which will be covered in more detail in the *Treatment Preparation* section) include saying no, expressing feelings and reactions to the client honestly, encouraging the use of verbalizing thoughts and affects, and having realistic and consistent consequences for actions, including ending sessions or hospitalization.

Experience of emptiness or numbness. A feeling of emptiness, numbness, deadness, or something missing is common in clients with psychosis. While the therapist may be pulled to reassure, soothe, or encourage and while this may be temporarily comforting (for both therapist and client), often the more difficult and most needed technique is listening. Truly listening and comprehending the client’s inner experience is often a painful and difficult task for the therapist and requires the therapist’s ability to tolerate the stirring up of such painful affects in themselves

and a willingness to go through it with the client. As Lotterman (1996, p. 127) states, “it is not easy to sit with someone, encourage him to take off his emotional shirt, and then stare at his gaping affective wounds.” It requires the therapist making space within themselves to tolerate that painful experience with the client and stand by them in their pain. If the therapist can go through this with the client and the client can sense the therapist’s willingness, they may feel less isolated, alien, alone, and detached from the world.

Trauma symptoms. The potential symptoms or difficulties experienced resulting from exposure to complex trauma can vary and can be inclusive of psychosis symptoms. The extent and degree to which each of these symptoms occur will vary depending on the individual and may vary over time and circumstances within an individual.

Emotion-regulation difficulties. Complex trauma survivors can be described as “prisoners of their emotions” (Courtois & Ford, 2013, p.4). They often vacillate between physiological hyperarousal and hypoarousal, between feeling overwhelmed and flooded by emotion and then feeling detached and numb. They may fear emotions emerging that would be so intense and out of control that they it would result in hurting others, themselves, or “going crazy” (Courtois & Ford, 2013, p.32). Indeed, it seems that if complex trauma is in fact one possible causal factor of psychosis, that this fear is well founded. The parallels between the complex trauma literature and psychodynamic psychosis literature are remarkable. For example, the complex trauma survivor’s fear of “going crazy” and the almost ineffable way this is held and experienced by the individual sounds much like the psychotic individual’s “annihilation anxiety” or fear of going to pieces. In this way, it could be argued that both core processes are dealing with a fear of physical or psychogenic death.

Common anxiety-related manifestations of complex trauma experienced by individuals include hypervigilance, panic attacks, sleep disturbance, nightmares, fear, terror, constant apprehension, and phobias (Courtois & Ford, 2013). Depressive reactions can include deeply held sadness, hopelessness, despair, guilt, shame, anhedonia, avolition, detachment, and numbness. Another parallel with the psychodynamic psychosis literature is the complex trauma literature's description of the trauma survivor's sense of self-estrangement, deadness, emptiness, badness, isolation, loneliness, and like a "black hole" or "yearning void" (Courtois & Ford, 2013, p. 32). Yet another parallel includes the trauma survivor's struggle with intense feelings of anger and rage, the same emotions mentioned by Karon and VandenBos (1977) as the emotions with which the psychotic individual has most difficulty.

Trauma survivors frequently have difficulty coping with their emotional distress. They can experience intense and distressing emotional reactions to seemingly minor daily life events and even positive or celebratory situations. Something about these events often triggers or serves as a reminder of whatever their past trauma was, whether consciously or outside of their awareness. Because the emotional reactions are related to the trauma and because often these individuals never learned how to successfully cope with emotions, they tend to exceed the individual's ability to regulate them successfully and result in all-or-nothing reactions of full-on, unmodulated emotion or shut-down avoidance, withdraw, and numbing. The trauma survivor will utilize whatever defense they have available or have learned in the context of surviving to cope, which could look like repression, dissociation, compulsions (including excessive or impulsive eating, working, sex, hoarding, exercise, shopping), substance abuse, directing anger outward through yelling, abuse, or violence, or directing anger at the self through self-injury, parasuicidality, or suicidality among others.

Disturbances in relational capacities. By definition complex trauma involves the perpetration of trauma by other people, often a person or people the individual should have been able to trust to care for or protect them. The experience of relational trauma will alter the individual's ability to trust and have healthy relationships with other people. Trauma survivors tend to have little concept of physical and emotional boundaries with self and others; an area that is described as disrupted in the psychosis literature as well, but perhaps to a more fundamental degree. Trauma survivors often experience and exhibit either extreme dependence, enmeshed relationships, and a preoccupation with others (an anxious attachment style) or are too rigid, portray extreme self-sufficiency with little to no need of others, and are detached (an avoidant or dismissive attachment style) (Courtois & Ford, 2013). They may also vacillate between these two types of attachment styles in an inconsistent and unpredictable way, in what has been termed a disorganized attachment style.

Trauma survivors with an insecure and disorganized attachment style can be particularly vulnerable to and at-risk of re-victimization in their current and future relationships without intervention. Torn between their avoidance of the dangers of closeness with others and their underlying need and longing for connection, they may be isolated, yet desire connection and attach quickly. People tend to seek out relationships that are familiar to them; unfortunately for the complex trauma survivor, what they have known are abusive relationships. Additionally, because of the trauma survivor's compromised emotions, the incoming data and defenses against it can interfere with the client's ability to protect themselves. For example, someone who learned to dissociate as a way to survive their abuse as a child and now overly relies on that defense when any kind of anxiety or threat is registered, may be at risk of re-victimization when they

freeze and dissociate in a threatening situation where a more adaptive response might be fighting back or fleeing.

The tremendous emotional needs of complex trauma survivors may be expressed outwardly and so may appear obvious or they can be camouflaged by self-sufficiency, a dismissive or avoidant style, taking on the parentified or caretaking role in the family, or exhibiting superficially compliant behaviors and passivity (Courtois & Ford, 2013). The apparently self-sufficient trauma survivor may appear highly functional and high achieving, never letting on externally about the suffering they have endured. On the surface these individuals may appear to have it all together, perfect even, but the façade of flawlessness is a defense against intense feelings that they are hiding from others as well as, and more importantly themselves (Courtois & Ford, 2013). Often the façade is only discovered after a certain threshold of stress or exhaustion is reached and the individual has developed coping strategies with more outwardly negative consequences like infidelity, overspending, hoarding, or addiction or they reach the point of a breakdown (Courtois & Ford, 2013). Children and adolescents in chaotic, traumatic family situations can also learn to cope by caretaking and/or controlling other people (Courtois & Ford, 2013; Herman, 1992). The caretakers keep the peace in the family and attend to the needs of everyone else over their own. Compulsively caring for others was how they protected themselves in an abusive family and gained acceptance from others (Courtois & Ford, 2013). In later relationships, the caretakers may find themselves continuing this pattern through enabling and rescuing others, rather than holding boundaries and often have no idea what their own needs are. By adopting these roles, these individuals develop some semblance of self-worth, but it is fragile and under constant threat because it is based on *what* they do as opposed to their value coming from *who* they are (Courtois & Ford, 2013).

The controllers establish order by taking charge, exhibiting dominance, and sometimes controlling through aggression, coercion, defiance, or hostility (Courtois & Ford, 2013). These feelings and behaviors may be directed toward the perpetrator of the abuse or displaced onto others and can be expressed directly or in passive-aggressive ways (Courtois & Ford, 2013). Controllers may also direct their unspoken rage and hostility toward the self in the form of self-injury, suicidality, risk taking, self-disregard, and self-defeating behaviors (Courtois & Ford, 2013). They may end up reenacting abusive strategies in later relationships to avoid anticipated hurt, rejection, or abandonment by others.

Survivors of complex trauma often have a profound distrust of others and their motives, sometimes verging on paranoia. This distrust is one of the many ways they protect themselves after having learned what other people can be capable of. They have a difficult time believing that other people can be caring and benign, which can also lead to an inability to feel connected and intimate with those they may like to feel connected to. These individuals may cope by withdrawing from any kind of social contact and at the extreme become isolated loners (Courtois & Ford, 2013).

Along with general relational and connection issues, clients who are the survivors of childhood sexual abuse can experience and display a wide range of sexual problems with sexual compulsivity at one end of the spectrum and sexual aversion at another end (Courtois & Ford, 2013). This could be in the form of relating to other children in primarily sexual ways having been eroticized themselves by their abuser, compulsive masturbation, engaging in sexual behavior at a young age, often with older partners, sex addiction, and as adults may find themselves in sexually exploitive situations such as prostitution, pornography, or sex trafficking (Courtois & Ford, 2013; Herman, 1992). As adults, these survivors of sexual abuse may also find

themselves in repeated relationships with victimizers. At the other end of the spectrum, childhood sexual abuse survivors may have sexual aversions and phobias and view sex and sexual organs and characteristics as repulsive, dirty, ugly, or terrifying. With these individuals, any sexual feeling, thought, or behavior may bring up extreme emotional distress such as rage or anger, fear, guilt, shame, despair and elicit coping strategies such as avoidance, emotional numbing, and dissociation (Courtois & Ford, 2013). It is also important to note that many survivors of childhood sexual abuse do not demonstrate disturbed sexual behaviors or attitudes, whether through their own innate resilience or reparative relationships and experiences. Additionally, because someone may display disturbed sexual behaviors or attitudes does not necessarily mean they have been victimized themselves.

Alterations in attention and consciousness. Attention deficits are common in survivors of complex trauma and can manifest at home, school, or work as difficulty focusing or a failure to complete or perform key tasks even when the cognitive ability is present. Another way this can manifest is through almost the opposite reaction of actually performing very well and being a high achiever, but feeling deep down like an imposter or fraud who does not deserve the achievement or recognition (Courtois & Ford, 2013).

Alterations in consciousness can manifest as extreme psychological withdrawal, dissociation, depersonalization, derealization, loss of personal continuity and awareness, and split off and fragmented identities or self-states. Trauma survivors can experience amnesia about the trauma or amnesia about whole time periods in their life. Posttraumatic dissociation is described as the psychophysiologically based segregation or fragmentation of consciousness or awareness of different emotions, physical sensations, memories, behaviors, and knowledge that occurs in response to psychodynamic triggers (*Putnam, 1989*). This is a self-protective process

that occurs in some individuals that allows for the compartmentalization of awareness or memory of distressing and otherwise overwhelming trauma-related thoughts and emotions (Courtois & Ford, 2013). Dissociative experiences exist on a continuum and happens for most of us to some degree in our everyday lives; for example, when driving a car and becoming lost in our thoughts and then suddenly coming back to the present moment with the startling awareness that we have been driving for a time without full awareness of the process and our behavior. Some might see every day dissociative experiences as on the same continuum as posttraumatic dissociation with similar psychological mechanisms differing only in degree or severity, while others see the experiences as fundamentally different. Van der Hart, Nijenhuis, and Steele (2006) suggest posttraumatic dissociation is structurally different than the psychological defense of dissociation. These authors suggest that the trauma-related sequelae are split off into divisions of the individual's personality and functioning, such that an "apparently normal personality" develops as well as an "emotional personality". The apparently normal personality holds little or no knowledge of the trauma related experiences and allows the individual to function well in an apparently normal way, while the emotional personality contains the split-off memories and emotion. Their description sounds similar to the concept of dissociative identity disorder, but they would argue that in most cases the structurally dissociated parts of the self are different states of mind within the same self rather than distinct identities or selves (Courtois & Ford, 2013).

Another common alteration in consciousness is depersonalization, which is described as the experiences of unreality, detachment, or feeling as an outside observer of one's thoughts, feelings, sensations, body, or actions (American Psychiatric Association, 2013). This includes perceptual alterations, distorted sense of time, unreal or absent self, and emotional and/or

physical numbing. Some survivors of complex trauma, and in particular childhood sexual abuse, feel betrayed and disgusted by their bodies and learn to dissociate from their lived experience so completely they experience self-anesthesia and analgesia. Some individuals can become so body-alienated that they do not experience basic needs to eat, rest, sleep or register pain or temperature change (Courtois & Ford, 2013). Derealization is described as the experience of unreality or detachment with respect to external surroundings (American Psychiatric Association, 2013). Subjectively, this experience has been described as individuals or objects seeming unreal, dreamlike, foggy, life less, or distorted. Depersonalization in this sense could be thought of as the experience of the unreality of the self, while derealization is the experience of the unreality of the world.

Alterations in consciousness are also talked about in the schizophrenia literature, but are often described as alterations of perhaps a more fundamental, basic, profound, or continuous nature, though this is debatable and deserves further attention. An article by Sass, Pienkos, Nelson, and Medford (2013) compare the subjective experience of severe depersonalization with schizophrenia and find a considerable amount of overlap with some potentially distinctive features unique to the schizophrenia spectrum such as self-world or self-other confusion. It would be interesting to compare the experience of derealization with schizophrenia to see if the self-world distinction still surfaces as a unique factor. While a discussion and comparison of the phenomenology of various alterations in consciousness is beyond the scope of this work, it is interesting to note potential overlap in symptoms in this arena.

Courtois and Ford (2013) also note that psychotic like experiences and outright psychosis can happen as a result of experiencing complex trauma. Most common are auditory command hallucinations and intrusive negative voices, especially in the case of childhood sexual abuse.

Additional psychotic experiences mentioned in the trauma literature include intrusive images or hallucinations that threaten, denigrate, or urge self-harm or harm of others.

Adversely affected belief systems. Many trauma survivors blame themselves for somehow bringing the abusive treatment on themselves, even if just by their existing in the world. This could be because of directly hearing this message from their abuser. It could be from another adult's unintentional disparaging of the child as lazy, stupid, oppositional, or irresponsible when they do not understand the child's behavior (Courtois & Ford, 2013). It could also be because humans are meaning making creatures and it is more palatable for us to find some reason that terrible things are happening to us, even if that reason is an awful one, than accept that we are in a helpless, powerless situation and being hurt by those we should be able to trust. The way a child survives in the world, is by attachment to their caregiver(s) and that attachment must be preserved at any cost, even if the cost is the child internalizing "I am bad" and therefore deserving of mistreatment (Courtois & Ford, 2013). With trauma, the priority is surviving the situation.

Trauma survivors often have existential questions as well, such as "Why did this happen to me?"; "How could someone who is supposed to love me do this to me?"; "Why did God allow this to happen to me?" (Courtois & Ford, 2013). In the absence of any evidence to the contrary, the conclusion is often that they were born bad, marked for abuse, are damaged, or deserve it; that something about them that they can never change is a signal to others that they deserve abuse (Courtois & Ford, 2013). Trauma survivors may or may not be consciously aware of their negative beliefs and the impact they have. They may only be aware of the inexplicable rage or depression they feel, which they again blame themselves for feeling.

Not only do trauma survivors have negative core beliefs about themselves, they also have them about the world. Their belief in a just world is shattered, as are their beliefs that other

people can be trusted, other people can be safe, that they have any control over their life, and even that they have or can find a sense of purpose. The difficulty in working to change these core beliefs is that they are all based on data and the client's early, formative experience and so will take time and many corrective experiences to begin to change and for the client to be able to feel a sense of hope.

Somatic distress or disorganization. Though long overdue there has been increasing attention in the medical field being given to the mind-body connection, as we realize that we have created a false dichotomy and that the mind and body are inextricably linked (Gok Metin et al., 2018; Grassi, Wise, Cockburn, Caruso, & Riba, 2019; Taylor, Goehler, Galper, Innes, & Bourguignon, 2010). Emotions have a physiological basis and they are there to relay information. When individuals have learned one way or another to avoid emotions, push them down, or never learned how to name, tolerate, and express them, feeling states are held in the body and can be manifested through physical symptoms. This can be in the form of psychodynamic conversion symptoms or hypochondriacal preoccupations such as chronic pain, headache, insomnia, gastrointestinal distress, joint pain, and chronic fatigue syndrome. These clients may seek ongoing medical treatment for their symptoms, for which doctors can never find a physical cause and become "professional patients" (Courtois & Ford, 2013). They may also develop medical conditions, which do not respond to treatment such as autoimmune disorders, where the body, perhaps in a manifestation of the afore mentioned negative self-beliefs, is attacking itself.

As mentioned previously, some trauma survivors can be so alienated from their body that they do not experience basic needs such as the desire to eat. Interestingly, somatic complaints, often related to basic needs, are what bring prodromal individuals into treatment (Karon &

VandenBos, 1977). Additionally, many delusions and hallucinations in schizophrenia are about the body and its functioning (Karon & VandenBos, 1977). There have even been cases of organ failure happening related to body areas that were violated or exploited in childhood abuse (Courtois & Ford, 2013).

Chronic stress and in particular chronic abuse has a cascade of physiological effects on the body with stress hormones such as cortisol pulsing through the body impacting the functioning of every major bodily system (Felitti et al., 2019; Sapolsky, 2004; van der Kolk, 2015). The large, ongoing, longitudinal Adverse Childhood Experiences (ACE) study shows that a history of adverse childhood experiences such as emotional, physical, and sexual abuse or witnessing domestic violence is related to an increased risk in adulthood of a myriad of medical illnesses including cardiovascular, pulmonary, immune, gastrointestinal, endocrine, diabetes, cancer, and obesity with the risk increasing with increased exposure to adverse experiences (Felitti et al., 2019). Research such as this highlights the importance of acknowledging the wide-ranging effects of childhood trauma, adequately treating it, and some of the hidden costs associated with it.

Symptoms Summary. Any of the above complex trauma symptomology can be found and should be addressed in psychotic clients and currently it is not. It is hoped that using the structure and techniques proposed in this integrated model, will address this need, as it is the current gold-standard model of treatment recommended for non-psychotic individuals with complex trauma. Part of this model, not yet addressed, is doing specific trauma processing for PTSD. This will be discussed further under Phase II. Additional psychosis-specific symptomology was discussed along with specific technique recommendations, which were not addressed in the complex

trauma literature. The degree to which any of this symptomology may be present will vary from client to client, as well as within a client, over time.

Treatment preparation.

Setting the frame. The treatment of both complex trauma and psychosis is challenging. It goes without saying that this integrated treatment for complex trauma in psychosis will be equally if not more challenging. This should realistically be considered a longer-term treatment, but will vary widely depending on the individual and their goals, level of functioning, willingness to engage, amount of support, innate resilience, and available resources. Some clients may be helped in 15-20 sessions (for example prodromal or first episode patients or clients who fit a good prognostic trajectory), while other clients may be in treatment for years, decades, or a lifetime. The frequency of sessions may ebb and flow over time as well. The typical once-a-week individual therapy is recommended, with more frequent sessions advised during times of increased stress, crisis, or after a recent inpatient or partial hospitalization stay. A reminder about boundaries is important to note here. Too frequent sessions, especially if out of the desire to rescue the client or process trauma without adequate grounding and skills building could cause emotional flooding and destabilization (Courtois & Ford, 2013). Too frequent sessions and perceived unlimited availability of the therapist could also convey unrealistic dependence expectations and the message that the client is not responsible for their own behavior and recovery (Courtois & Ford, 2013).

Part of the treatment frame includes the client's responsibilities, which should be discussed in the treatment contract and initial meeting. These include attending scheduled therapy sessions or providing proper notice of cancellation, ensuring payment for sessions (whether through self or a third party), respecting the privacy of other clients at the office or

agency, respecting the therapist's boundaries and property, being honest, putting forth a good faith effort to engage in therapy, working toward trust, and to verbalize feelings rather than act them out (Courtois & Ford, 2013; Lotterman, 1996).

Informed consent. Informed consent is an essential component of the treatment frame and ongoing treatment. The client has the right to know what will be required of them in therapy and also what they can expect from therapy. This includes the role of the therapist, boundaries, availability outside of sessions for crises, conditions that may necessitate hospitalization, process during times of unavailability, and use of email and other technology for communication (Courtois & Ford, 2013). This also includes the above-mentioned rights and responsibilities of both parties and the ground rules for treatment. Clients should be informed about confidentiality and the limits of confidentiality, as well as advised that they have the right to accept or refuse aspects of treatment, to question its course or effectiveness, and to end treatment without penalty (Courtois & Ford, 2013).

Additionally, clients should be informed about what significant problematic behaviors could bring about the end of therapy including threatening behavior toward the therapist that becomes unmanageable or a matter of safety, stalking, engaging in dual therapies without letting the therapist know and refusing to choose one or the other, excessive cancellations or no-shows, or the client not disclosing information about impending lawsuits that significantly interfere with treatment (Courtois & Ford, 2013). As is the standard best practice, this should all be clearly written out in a contract that both parties sign if treatment is to move forward. The therapist should also go through the contract verbally with the client, to ensure that the client understands what they are signing up for and consent is truly informed. Having stipulated all-of-the-above ground rules, a certain amount of clinical judgement will come into play if and when any of these

issues arise in the course of treatment. It will be up to the therapist to determine whether they can be worked through and how much they interfere with therapy.

A certain level of mistrust, resistance, testing, and acting out is to be expected, especially from this population of clients who have likely learned that authority figures are untrustworthy at best. A therapist who is clear about their own limits and maintains clear and consistent boundaries with the client, will set a frame that encourages structure, safety, and a therapeutic environment for the client. Additionally, the informed consent portion and application of setting limits should be delivered in a matter-of-fact way, rather than what the client may interpret (accurately or otherwise) as punitive, harsh, or judgmental (Courtois & Ford, 2013). Treatment planning should be collaborative and the process of informed consent helps to make the process more transparent. The client should feel they have a choice in the process rather than that something is “being done to” them (Courtois & Ford, 2013).

Setting limits. As mentioned previously, clients often translate feelings into action because they do not yet have the words to verbally express what they are feeling and needing. If they do have the words, they may not yet trust that they will be heard or that their words won't be used against them. One of the goals of psychotherapy for individuals with schizophrenia, in addition to reducing symptoms, is to have them express their mental life in words (Garrett, 2018; Lotterman, 1996). This requires setting limits on behaviors other than verbal expression, which may interfere with treatment. Such behaviors can include self-mutilating, repetitive suicide attempts or parasuicidal behavior, attending sessions intoxicated, yelling at the therapist, touching the therapist, and taking or damaging personal property. In instances where behaviors such as the ones mentioned above interfere with the ability to engage in productive outpatient

psychotherapy, referral to a higher level of care, up to and including hospitalization, may be necessary.

Lotterman (1996) outlines several requirements that must be in place in order for therapy to take place with a client with schizophrenia: a) the client must be able to attend therapy, b) they must wish to tell their story to someone who will listen, c) they must be able to put their ideas and feelings into words, d) they must find someone willing to make sense of what is conveyed, e) they must have financial resources or the support of those who do to pay for sessions, and f) they must refrain from attacking the physical setting or the composure of the therapist. Anything that interferes with these conditions should be addressed by the therapist. Setting limits in therapy could take the form of saying no or conveying that a specific behavior is not acceptable and will not be tolerated by the therapist; expressing feelings and reactions to the client honestly, so that the client can learn the impact of their behavior on another; encouraging the verbalization of thoughts and affects, rather than acting them out; and making sure to have realistic and consistent consequences for actions, including ending sessions or hospitalization. Setting limits may also require some creativity or directness on the part of the therapist around behaviors, which may not occur in other client populations. For example, Lotterman (1996) describes a case where a client needed to be redirected to sit in a chair facing the therapist rather than with her back to the therapist and to be told that it was not okay to put on the therapist's overcoat during session.

Therapeutic stance. The therapeutic stance is the attitude and approach of the therapist. As mentioned previously, clients with complex trauma histories and psychosis may be difficult to engage due to their learned mistrust and suspicion of others, inclination toward automatic self-protection and preservation, desire to avoid discussion of painful reminders of what they have

experienced, generalized fear, and fear of loss of control or annihilation of the self (Arieti, 1974; Courtois & Ford, 2013). Consistent with both the complex trauma literature, the modern-Sullivanian's, and more recent practitioners of psychotherapy for psychosis such as Michael Garrett (2019) the therapeutic relationship is seen as the vehicle of change and the therapist's stance recommended to be one of authenticity, warmth, openness, curiosity, honesty, and activity. Karon and VandenBos (1977) in particular discuss the importance of the therapist being authentically themselves with clients with psychosis and embracing and owning their own imperfections. Garrett (2019) talks about the importance of warmth and connecting to the essential humanity of clients.

The traditional psychoanalytic "therapist as blank slate" is contraindicated for this population and likely may feel so destabilizing, unsafe, anxiety-provoking, and ripe for all kinds of malicious projections that they may never return to treatment. While there are still modern analysts who work primarily with psychosis such as Christopher Bollas and Michael Eigen who claim success using traditional psychoanalysis, a discussion of their work is beyond the scope of this dissertation). Using attachment language, the therapist should strive to become the secure base for the client or the Winnicottian "good enough" surrogate parent, ideally helping to move the psychotic and traumatized client from the Kleinian paranoid-schizoid position, where objects are split into all good vs. all bad, into the depressive position, where objects are seen as more whole, holding both "good" and "bad" qualities.

It is important for the therapist to have, hold, and convey realistic hope for what the client can achieve (Garrett, 2019; Karon & VandenBos, 1977). While any therapist should be empathic, respectful, and emotionally regulated with defined boundaries, these qualities are especially important in working with clients with psychosis and a complex trauma history. From

the modern-Sullivanian perspective, it is also important for the therapist to remain grounded and connected to reality in navigating the work with psychosis. For the therapist to embody the role of being trauma-informed means that the client's experience of trauma is never viewed as irrelevant to understanding and treating the client's issues (Courtois & Ford, 2013). Additionally, it means viewing symptoms as once-adaptive ways to cope.

Regarding therapeutic stance, it also cannot be emphasized enough that the therapist working with this population needs to a) know themselves well given the increased use of countertransference to guide what the client may be feeling, but unable to verbalize and the psychotic individual's ability to elicit the therapist's own unconscious dynamics and b) take care of themselves. The therapist working with this population will be hearing and engaging with some of the most painful, horrific, and terrifying experiences a human can tolerate. To be able to continue engaging with this type of work and not immediately burn out or become jaded, depressed, and suffer repeated vicarious traumatization, the therapist needs to balance that with nurturing, caring, life-sustaining activities and relationships. What this looks like will be different for each individual, hence the importance of knowing oneself. It may look like the therapist attending to their own physical and mental health through getting their own personal therapy, engaging with colleagues, connecting with friends and family, engaging in hobbies, exercising, and eating healthy. It may look like knowing one's limits, knowing when to take a break, and destressing. On the flip side, this work can also be extremely rewarding, meaningful, and invigorating when clients do make changes and do improve. It is important for the therapist to also celebrate clients' resiliency, capacity to grow and change, and acknowledge the impact we can have.

Hospitalization. While the proposed integrated therapy model is meant to be practiced on an outpatient basis, it is important to briefly touch upon the topic of hospitalization and when it is necessary. Arieti (1974) outlined several situations that would indicate a potential need for hospitalization. One, which is standard in any therapy practice, being if the client is a danger to themselves or others. Specific to the psychotic population, a client may decompensate becoming so acutely delusional, irrational, or bizarre that they pose a danger to themselves or others and require hospitalization in an attempt to prevent any action from being taken in either direction. Another situation that might call for hospitalization is to provide a treatment that cannot be given on an outpatient basis such as drug administration that needs to be closely monitored or a treatment such as electroconvulsive therapy (ECT) or transcranial magnetic stimulation (TMS) (though in the latter stages, these treatments are given on an outpatient basis, while still usually located within a hospital). Additionally, clients may benefit from a therapeutic community beyond or in addition to outpatient such as a day program or partial hospitalization, where they may have access to vocational training, group therapy, art therapy, or residential options. Another situation outlined by Arieti (1974) that could necessitate hospitalization is behavior by the client that is so bizarre that it could have potential negative societal or legal consequences like getting arrested. Hospitalization may be called for to remove the client from a dangerous, demanding, or traumatic environment, which could worsen symptoms or lead to a crisis. The therapist should consider however, whether the act of hospitalization or the particular hospital environment available to the client would be equally or more traumatic for a given client. Lastly, the client may desire or benefit from the structure and safety of a hospital.

In treating this population, it is also important to note that the mere presence of hallucinations, delusions, paranoia, ideas of reference, or other odd behavior is not sufficient to

warrant hospitalization. Only if these symptoms or experiences bring about the scenarios outlined above, should hospitalization be considered. The conditions that may bring about the need for hospitalization, why, and what that process may look like should be discussed with the client as part of informed consent at the beginning of treatment. Additionally, after a hospitalization, if the client returns to outpatient treatment, the hospitalization, client's experience, and relationship between the therapist and client should be processed. The client may feel any number of ways along a continuum from supported and cared for to betrayed and outraged.

Goals. An extensive list of the goals of trauma treatment was previously outlined. The list that follows is an integrated listing of consolidated goals for treatment of trauma combined with goals for psychosis treatment.

1. The establishment of trust in the therapeutic relationship.
2. An increased capacity to respond to threat with a realistic appraisal.
3. The ability to maintain normal levels of arousal rather than hypervigilance or psychic numbing.
4. Restored personal integrity and normalization of traumatic stress response.
5. Increased capacity to differentiate remembering from reliving of past traumas.
6. Regained perspective of the trauma and control over life experiences rather than eradicating memories of the trauma or avoiding and overreacting to reminders.
7. Attention paid to biological and social learning risk factors that shaped the trauma and psychotic response.

8. Enhanced personal courage in approaching and facing memories and reminders of the trauma and its associated thoughts, feelings, beliefs, and schema about self and others.
9. Increased ability to experience the relational safety and attunement in the therapeutic relationship as a “secure base” from which to develop or regain secure inner working models.
10. Development and/or restoration of the capacity for emotion-regulation and bodily self-awareness.
11. A return to normal development, adaptive coping, and improved functioning.
12. Recognition and prevention of reenactments of traumatic events or psychotic deterioration and development of self-protection and self-enhancement skills to prevent re-victimization, re-traumatization, and regression.
13. Facilitation of a transformation in self-concept from helpless or a victim to an autonomous individual with a sense of self-determination and constructive engagement in daily life and future goals.
14. Relinquishing psychotic defenses for other defenses while maintaining connection to reality- this may mean moving into a state of depression
15. Increased ability to care for self, engage in activities of daily living, and form relationships with others.

Assessment. As mentioned previously, from the first interaction on, the therapist should strive to create an atmosphere of safety, collaboration, and encourage the development of rapport or the therapeutic alliance. Without some level of safety, transparency, and trust the rest of the work will not occur. As Garrett (2019, p.110) states, a “strong positive therapeutic relationship

isn't just the facilitator of technique; it is a primary agent of change." Regarding assessment specifically, this means explaining the assessment stage of treatment, what the client can expect, and being open to questions. The therapist should be explicit that there are no right or wrong answers, they are not expecting particular responses, and that the client may feel upset or uncomfortable as painful topics are inquired about and that this is normal. Again, it is important to emphasize that the client maintain as much control as possible given the nature of trauma as experienced as intrusive and out of the individual's control. Victims of trauma have experienced damage at the hands of others and so are naturally suspicious of others motives including that of the therapist. The client should be encouraged to communicate if they begin to feel overwhelmed or numb, to ask for clarification, to choose whether and how to answer questions, and to ask for breaks if needed. The idea here is to set the expectation from the start that this is a collaborative process that the individual has some control over.

In addition to the typical areas addressed in an intake (presenting concerns, how the client came to find or be referred to therapy, psychological and medical history, family history, social history, trauma history, and risk assessment), it is important for this population that areas such as personal strengths and resources, support network, and ego and self- capacities be given attention as well (Courtois & Ford, 2013). Consistent with a strengths-based approach the therapist should capitalize on these personal resources from the start of treatment and be sure to highlight them for the client.

Assessing metacognition. Not every client will be able to benefit from this type of outpatient individual therapy, so assessment prior to and during the early stages of treatment is important to ensure both client and therapist have a realistic view of what can be achieved. Lysaker et al. (2011) discuss the importance of metacognition, the awareness and ability to

understand one's own thought processes, in clients with psychosis who can achieve successful outcomes in insight oriented therapy. They adapted a 9-step hierarchy of metacognitive reflection ability, originally created by Semerari et al., (2003), to be used as a guide for assessment and choice of psychotherapy technique in clients with psychosis. The hierarchy can be used a clinical guideline with which the therapist can adjust their approach and technique as necessary. For example, if a client cannot identify and differentiate between emotions, the therapist asking "how do you feel about _____?" is not likely to be a successful intervention.

Each level or step of the hierarchy builds on the previous step in reflective awareness and complexity with the lowest, step 0S, being that the client is unaware they have internal mental experiences and the highest, step 9S, being that they can synthesize multiple life experiences, cognitions, and emotions into a coherent and complex integrated narrative. Based on the steps outlined by Lysaker et al. (2011) and consistent with other individual, outpatient therapies for psychosis (Garrett, 2019), clients falling anywhere at or above step 3S (ability to distinguish between different mental operations such as remembering versus imagining versus desiring), would likely be able to receive some benefit from the proposed treatment model. Lysaker et al., (2011) recommends that step 4S (ability to identify and differentiate emotional states) be the initial gauge of level of metacognitive ability, catering technique more specifically depending on whether the client's ability falls above or below that level.

An additional important note about metacognitive ability using this hierarchy as a guide, is that it is dynamic and ever-changing, even over the course of a single session and depends on the client's abilities at that given moment and with the particular content being discussed (Lysaker et al., 2011). Clinically, it may be useful to get a general average baseline of where the

client is at and what therapy techniques may be most useful for them, if the therapist is feeling stuck or notices their interventions do not appear to be having the desired impact.

What information can be gained in the assessment phase will vary based on the specific client, the severity and type of psychotic symptoms, and severity and type of trauma experienced. For lower functioning clients in Lysaker et al.'s (2011) OS-2S range, the therapist may need to rely more on reports from external sources such as family, other doctors, nurses, psychiatrists, social workers, etc. to help inform their clinical assessment. Assuming metacognitive functioning in the 3S or higher range, assessment information can likely be gathered primarily from the client.

Assessing attachment. Another important area to assess with this client population, given the relational nature of their trauma and its relevance to the therapeutic relationship, is attachment style. Courtois and Ford (2013) suggest using George, Kaplan, and Main's (1996) Adult Attachment Interview to assess attachment style, the extent of unresolved trauma, as well as capacity for mentalization. Assessment of symptoms is of course another arena that should be addressed, both for trauma-specific, psychosis-specific, and more general symptomology. Though I will not list them all here, numerous measures are available for use and can be found listed and categorized by symptom domain for complex trauma in Courtois and Ford (2013, p. 109-111).

Assessing psychotic symptoms. Regarding symptom domains of psychosis, there is a much smaller pool of valid and reliable measures to choose from. The Examination of Anomalous Self-Experience (EASE) scale (Parnas et al., 2005) is the most time intensive, but qualitatively rich measure for assessing subjective experience characteristic of and across the schizophrenia spectrum and likely the most useful measure is assessing subthreshold and

prodromal stages of psychosis. The Positive and Negative Syndrome Scale (PANSS) (Kay, Fiszbein, and Opfer, 1987), Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1982), and Scale for the Assessment of Positive Symptoms (SAPS) (Andreasen, 1984) are older measures, but still widely considered the gold-standard of symptom assessment in schizophrenia (Kumari, Malik, Florival, Manalai, & Sonje, 2017). The Clinical Assessment Interview for Negative Symptoms (CAINS) (Kring, Gur, Blanchard, Horan, & Reise, 2013), is a newer and more comprehensive measure, but focuses only the negative symptom domain in schizophrenia.

Prognosis. A final, yet equally important consideration during the assessment phase is evaluating any indicators of the client's potential prognosis. This means considering the client's strengths, resources, individual circumstances, and other factors in determining their capacity to make use of treatment and have a positive outcome (Courtois & Ford, 2013). See the work previously mentioned of Richard Kluft (1994) and Baars et al. (2011) on treatment prognosis in complex PTSD and specific measures that can be used in treatment assessment. As Karon and VandenBos (1977) state, it is important to meet the client where they are at. Regarding the proposed integrated model, some clients may never get past Phase I of treatment and that may be okay for them. Other clients may be able to make full recoveries and live rich, meaningful lives. The majority of clients will fall somewhere in the middle of that recovery range.

Arieti (1974) details multiple variables that indicate a favorable prognosis in clients with psychosis. One favorable prognostic variable is an acute onset, especially onset precipitated by specific stressors like the loss of a job, childbirth, or a break-up. Another is the client's experience of conscious anxiety and general connection with affective experience, as this indicates that the client is still engaged with reality to some degree, the psychotic symptoms have

not eliminated the presence of emotions, even if they are distressing, and the client may be more motivated to examine their experience and behavior and be more willing to make changes. Consistent with Lysaker et al.'s (2011) hierarchy of metacognition, Arieti (1974) discusses the client's level of insight as an indicator of prognosis. A client who is aware that they have internal mental processes, that are fallible and may or may not align with reality, and who takes some level of responsibility for their own behavior has a better prognosis. This is as opposed to clients who project everything onto others and out into the world, completely exonerating themselves of any responsibility and ability to change. Clients who can trust the therapist and process enough to attend sessions, follow-through, and maintain some level of compliance have a better prognosis. Lastly, a client's demonstration of some level of hope and belief that things can change for them also indicates a favorable prognosis.

Client self-disclosure. A client with psychosis and complex trauma history, may or may not disclose to the therapist about their trauma or abuse history, even when the therapist asks about it directly and with sensitivity. The therapist working with this population needs to be patient, attuned, and not assume the meaning behind a lack of disclosure. The client may not yet trust the therapist enough to disclose such information or they may not be aware of any past experiences of abuse to report even if it is suspected. They may be aware of their past abuse, but have learned never to talk about it for fear of repercussions for themselves or their abuser or they may be too overwhelming to acknowledge and talk about.

If the client does disclose a history of abuse, the therapist should attempt to ask in a direct, yet sensitive manner, about the objective factors (who, what, when, where, actions taken or not) and the subjective thoughts, beliefs, and feelings about the occurrence of the abuse (Courtois & Ford, 2013). Additionally, as Briere (2004) details, the therapist assessing a history

of trauma needs to stay attuned to the toll such questioning may take on a client and adjust the pace of questions accordingly or stop the process altogether if needed. Some clients may be dissociated enough from their emotions that they can report details of abuse without much discomfort, while for others the experience of remembering can be overwhelming and coping skills may need to be learned or enhanced before assessment can continue.

Phase I. Phase I of the proposed integrated model centers around the establishment of safety, stabilization, and engagement or “making contact” with the client. As mentioned previously, both Courtois and Ford (2013) and the modern-Sullivanians note that this phase of treatment may be the longest and most essential aspect of treatment, as it sets the frame for further work if it is to be attempted in the later phases. In some severely distressed or disturbed individuals, treatment may remain entirely in this phase. Again, while each of the goals in Phase I will be laid out here separately and linearly for organizational purposes, in practice, the therapist will likely be working on all the goals in tandem or flowing back and forth between them depending on what the client is needing.

Safety. The work of psychotherapy cannot take place if the client (or the therapist) are worried about safety. The effects of trauma cannot be treated if the client is still in danger and still in need of their survival defenses. This stage of the work may involve safety planning around harm to self or others and establishing safety of the individual’s environment. Clients who have experienced trauma and experience psychosis are at increased risk of attempting to take their own lives, especially if they feel hopeless, isolated, are impulsive, use substances, and have a lack of protective factors in their lives. A careful risk assessment should be completed during the intake and monitored throughout treatment with development and use of safety planning as necessary. Treatment can also begin to look at the function the client’s risky

behavior may be serving, whether as an escape from or attempt to control emotional pain and new coping skills can be introduced. At times, hospitalization may be necessary to ensure the client's safety. See the section on hospitalization above under Setting the frame, for further details. (Courtois & Ford, 2013)

Safety concerns can be born of the individual's external environment as well. In some cases, the environment may be readily changed to increase safety and in other cases it may not be a realistic possibility. In situations where a safer physical environment is not realistically possible, the role of the therapist can be to help the client assess for external safety issues, become aware of resources available to them in the community, provide psychoeducation about and increase awareness of threats or potential for re-victimization, inform them of their rights, and collaboratively develop a realistic plan for dealing with threats to safety (Courtois & Ford, 2013).

Individuals who have been traumatized, have been made to feel unsafe. Once objective levels of safety have been established, psychological safety and subjective appraisals and perceptions can begin to be addressed at this stage. For individuals who have been traumatized and whose boundaries have been impinged upon, everything can be viewed as a threat, including the therapist. This can be particularly true for client's who are paranoid, experience ideas of reference, and/or have delusions. In these cases, it is important for the therapist to remain grounded in reality and assess what the client may be needing to feel safe. As engagement occurs and trust begins to be established in the therapeutic relationship, the therapist can work to help the client come to understand themselves, how they have survived and coped until now, and new ways they can begin to cope to increase their felt sense of safety.

Therapists working with clients who have psychosis and/or a history of trauma, whose life circumstances seem overwhelming and unsafe, often feel pulled to want to rescue their clients, especially if the client's transference includes a wish to be saved or protected (Arieti, 1974; Courtois & Ford, 2013). From a developmental and strengths-based perspective however, safety is most likely to be attained not when the therapist rescues, but when they help the client to develop a realistic awareness and appraisal of potential dangers, a sense of what options are available to them for maintaining personal safety, and a sense of responsibility in taking care of themselves (Courtois & Ford, 2013).

Stabilization. Helping the client to cope and build the foundation of emotion-regulation skills needed for daily functioning and later phases of treatment is the focus of this stage. This will likely be revisited time and time again throughout treatment as stressors and challenges arise, so a strong foundation here is important for future work. A thorough assessment of where the client is at informs where this piece of the work needs to go. The client may need help with basic life skills such as decision-making, home organization, assertiveness, expectations around personal hygiene, and basic vocational skills or professionalization. It may be helpful to connect the client with a case manager or social worker if the client is lower functioning.

As this stage revolves around the learning of new skills and techniques, it may likely look and feel more like therapies such as cognitive behavioral therapy for psychosis (CBTp, (Kingdon & Turkington, 1994), dialectical behavior therapy (DBT; Linehan, 2014), or acceptance and commitment therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). It is important to build on whatever strengths and resources the client may already have and utilize to help them expand their repertoire of emotion-regulation skills and distress tolerance techniques. Courtois and Ford (2013, p. 127-130) describe and cite various emotion regulation techniques, as well as

whole approaches that can be taught during this stage such as distress tolerance, grounding, mindfulness, mental focusing, body scanning, sensorimotor approaches, progressive muscle relaxation, breathing exercises, visualization/imagery, relaxation techniques, and identifying cognitive distortions.

In addition to the latter skills, the therapist will want to help the client begin to name and differentiate emotions and emotional states that could be nonverbal and unacknowledged for the client (Arieti, 1974; Lotterman, 1996; Karon & Vandenbos, 1977). For this piece of the work, the therapist may need to rely on their countertransference to begin to help clients through this process until that ability is more developed and the client has a vocabulary for their emotional states (Arieti, 1974, Lotterman, 1996, Karon & Vandenbos, 1977). Lotterman (1996) details specific techniques for navigating psychosis symptoms such as reality testing, object definition (the process of the therapist remaining grounded in reality, with consistent boundaries, authentic, and discussing interpersonal interactions occurring in the room with the client), naming (i.e. identifying and naming emotions occurring in the present), and enlargement (once the client can name their emotions, having them expand and clarify associations in a focused way). The therapist may also need use their creativity and engage in alternative methods of communication if they are not getting anywhere verbally by pulling from other therapy approaches such as art or play therapy. If the client remains dysregulated, disordered, or outside their window of tolerance, the therapist should consider the use of medications to help the client stabilize and have a discussion with the client about the potential pros and cons of medication.

Another component of the process of stabilization is psychoeducation around both trauma and psychosis. The therapist should assess the client's understanding of themselves, what they have experienced, stigma they have encountered, and messages they have received about

themselves from the larger society and from any past mental health professionals they have seen. Psychoeducation about what clients often have no vocabulary for, but are experiencing can often feel relieving, stabilizing, and normalizing. Regarding trauma and traumatic reactions, describing what the clients are experiencing in the present as normal responses to extreme and abnormal circumstances can help the client begin to understand themselves, how they have coped until now, and begin to develop some compassion for themselves and what they have been through. Regarding psychosis, the client has likely encountered stigma and messages about it as chronic, progressive, unchangeable, unmanageable and perhaps received the labels of “schizophrenia”, “mental illness”, “bipolar disorder”, “crazy”, or a “chemical imbalance” (Garrett, 2019; Karon & Vandenbos, 1977). It is important for the therapist to understand the meaning the client takes from any past labels or experiences and how they have come to understand what they experience. The therapist should also provide psychoeducation about trauma and its relationship to the development of psychosis and the role of psychotic symptoms as defenses that may hold meaning in the context of the client’s life. At this stage, it is important for the therapist to instill a realistic hope for what the client can achieve and begin to work on altering any misconceptions that can impede the therapy.

Engagement. What can be considered the core of this integrated model and the piece that most brings about healing, without which all other processes and techniques cannot happen, is a strong therapeutic relationship. Its importance as the foundation for all other therapeutic work cannot be overstated. Engagement starts from the very first contact with the client and should be assessed, monitored, and processed throughout the rest of the work. Much of the work of Phase I, implicitly and explicitly involves the establishment of a therapeutic relationship, building trust, creating a collaborative working alliance, and creating connection. In attachment terms, the goal

is to become a secure-base for the client. However, with this population that has suffered unfathomable pain and betrayal from the actions of others, who have had their basic trust in others and the world shattered, to whom the idea of connecting to other people brings about fear, suspicion, rage, confusion, or hopelessness- this is not an easy task. Arieti (1974) describes how even the “sickest” client with psychosis who may retain only paranoid ties to the world still retains a desire, however slight, to rejoin the human community. It is the therapist’s job to help the client begin to reestablish threads of trust in the world and themselves.

Engaging with the client means meeting them where they are at and as they are and conveying an attitude of acceptance, benevolence, and sincerity in the effort to reach them. The therapist should strive to provide corrective emotional experiences for the client, knowing and welcoming that there will be ruptures and ideally repairs. The client may reject or devalue the therapist entirely, try to drive them away, drive them crazy, or idealize them completely, and the role of therapist is to own their shortcomings and mistakes and efforts, and process the relationship and interpersonal interaction with the client, again striving to be the Winnicottian “good-enough” parent. This also means have clear and consistent boundaries, setting limits around behaviors that are not acceptable, helping the client to become aware of adaptive as well as maladaptive characteristics, and helping them to navigate the line between acceptance and change.

Phase II. Phase II is all about processing. Processing in order to decrease reliance on psychotic defenses, processing the traumatic memories and their attendant emotions and cognitions, and then the linking of these to the individual’s particular psychotic dynamics. Before moving into Phase II work, it is important to have a solid foundation of coping skills, emotion regulation capacity, and a good therapeutic alliance. A study by Cloitre et al. (2010)

found that there were fifty percent fewer dropouts during a trauma-processing component of therapy in a study of women with childhood abuse histories and PTSD, when the processing component was preceded by skills training in emotion regulation and interpersonal effectiveness. These coping and regulation skills are important as processing involves facing and experientially working through (at a tolerable level) painful emotional memories and experiences that up until now, the client has been developing all manner of defenses and distractions (some adaptive, some not) to avoid.

Throughout Phase II, it is likely and in fact recommended that therapist and client together revisit the work of Phase I. As with any new skill, to have it become more natural and accessible takes practice. It is important that the processing of trauma component of this phase be agreed upon collaboratively. The client's capacity to emotionally tolerate such processes and motivation to continue, must be carefully assessed and monitored here, so as not to overwhelm them and trigger a return to previously relied upon psychotic defenses.

Psychosis specific processing. In interpersonal psychodynamic psychotherapy for schizophrenia (IPPS) psychotic symptoms are viewed as defenses against a core, unbearable emotion or idea. Unlike neurotic defenses, which all humans use and need to one extent or another, psychotic defenses are both more symbolic and more concretized than traditional neurotic defenses. Arieti (1974, p.572) gives the following example of a client with olfactory hallucinations to illustrate what is meant by both more symbolic and concretized, as well as the process by which an anxiety provoking feeling or thought manifests as a psychotic symptom:

...the symptom stands for a great deal more, actually for what it wants to eliminate but cannot. The symptom is a symbolic barricade around the core of anxiety; it does not permit us to touch the genuine anxiety...A patient has an olfactory hallucination; he smells a bad odor emanating from his body. In this symptom a great deal of pathology is encapsulated. The patient feels he has a rotten personality, he stinks as a person. A schizophrenic process of concretization takes place and an olfactory hallucination results.

This olfactory hallucination stands for, or summarizes, the whole life history, the whole evaluation of the self, the whole tragedy of the patient. We usually say that the hallucination symbolizes what the patient feels about himself. This is correct, provided we understand that the symbol is a symbol for us, not for the patient. The patient, by virtue of the symptom, stops worrying about his personality and worries only about his stinking body. What we call a symbol actually has a realistic, not a symbolic, value for the patient. It tends to replace the reality that it wants to substitute... Whatever cannot be sustained at an abstract level, because it is too anxiety provoking, is reduced to, or translated into, concrete representations.

Much of processing with clients with psychosis, involves bringing their awareness to this process and the ways in which they transform psychodynamic conflict into psychotic symptoms. The therapist then helps them to begin substituting new ways of coping, emotionally regulating, communicating, and navigating interpersonal interactions for old psychotic defenses. One may wonder what could possibly push a client to relinquish a symptom that protects them from so much mental pain and instead adopt strategies, which require them to join the realm of reality and face painful emotions. That is part of the difficulty of this work, but there are a few possible answers. One is that often the symptoms themselves are not pleasant experiences, but rather also scary, anxiety provoking, or shame inducing and the client often wants to be rid of the symptoms. Another goes back to the core work of Phase I, which is engagement and human relatedness. Ideally, if an atmosphere of basic trust and threads of connection have been developed, which is rewarding enough for the client to want more connection, than they will be willing to experiment with new ways of coping and relating to the world (Arieti, 1974). The new symptoms (like the recognition of being concerned about one's personality, not body) may be more difficult to bear, but can be more easily shared with the therapist and hopefully, eventually other people.

Working with psychotic symptoms. In general, the modern-Sullivanian's all tend to work with specific psychotic symptoms such as hallucinations, delusions, ideas of reference, paranoia,

etc. by finding the meaning that they hold for the particular client and connecting that back to emotions the client is experiencing, but having difficulty tolerating or verbalizing. It may be a current emotion, related to a current interaction or it could be tied to a past emotion, or past recurring, dynamic conflict. The key is connecting with and understanding the client enough to figure out their particular dynamics and finding what Freud labeled the fragment of historical truth embedded in the symptoms. Within this process, Arieti (1974) describes helping clients to identify and become aware of what he terms the listening attitude or referential attitude. He describes how very often, at least in cases of psychosis where the client is still generally functioning in their day-to-day lives, but still having active symptoms, they tend to hear voices or see things when they expect to see or hear them and that this usually tied to feelings of increased stress and a specific mood, which they are having difficulty tolerating. He describes helping the clients to examine and become aware of what they were feeling just before the experience of the psychotic symptom and how they then transformed whatever feeling that was, into a more palatable form for themselves. Exploring how this transformation occurs for the client, also involves identifying faulty thinking patterns and helping the client to see when they are making connections, which involve some form of common cognitive distortion, like jumping to conclusions.

As previously mentioned, part of how the modern-Sullivanians view the role of the therapist is to remain grounded in reality. This differs from other more traditional psychoanalytic techniques with schizophrenia, where it is suggested that the therapist join with the client in a “transference psychosis” and collude, for lack of a better word, with their delusional thinking or hallucinations in order to connect, interpret, and then bring them out of the psychosis. The modern-Sullivanians, consistent with other current forms of psychotherapy for psychosis like

CBTp and Garrett (2019)'s integrated CBTp-psychodynamic model, do not see that as helpful. When a client is talking about a hallucination or delusion they are experiencing, remaining grounded in reality would mean that the therapist conveys to the client in a non-judgmental manner, that they are not having the same experience or interpretation of events as the client. Challenging and confronting a delusion directly is also not seen as helpful, as the client will likely experience it as an attack. Rather, the therapist should gently offer up alternative perceptions/explanations and state their own perception.

Psychodynamic therapy. When enough trust has been established, there is a strong working alliance, the client is not in a state of crisis and has been fairly stable and has learned to substitute some additional coping and emotion regulation skills for psychotic defenses, then the work of therapy begins to look like any interpersonal psychodynamic psychotherapy. Arieti (1974) refers to this stage as "psychodynamic analysis", wherein broader dynamics, family and other significant relationships are explored in order for the client to better understand themselves, gain insight into the origin and development of the psychological components of psychosis, and have self-compassion. This is also consistent with Courtois and Ford's (2013) objective of helping the client piece together their life narrative and gain increased self-understanding. Part of this work often involves helping the client tolerate anger, hurt, and disappointment about their childhood and parent's involvement in their psychology and helping them to shift from seeing their parents as "all good" or "all bad" to flawed human beings with their own limitations and psychologies, moving from Klein's paranoid-schizoid position to the depressive position (Arieti, 1974). Additionally, part of this stage of therapy involves helping the client to take responsibility for the course of their lives going forward and begin living a life that they want and can realistically lead. Consistent with general psychodynamic therapy, part of the work throughout

remains helping the client to identify, name, and express emotions. The relationship with the therapist should also be explored and processed throughout, as well as the client's view of themselves. If the client can integrate their sense of self, take in the therapist as a "good-enough object" or secure base, increase self-compassion, and piece together a more coherent narrative of their life and self, they have the possibility of improved self-esteem, a sense of agency, improved relationships, and a sense of greater personal control.

Trauma specific processing. The trauma processing component of Phase II involves purposefully developing awareness of and gaining control over trauma memories and the extreme emotional distress and physiological symptoms they evoke (Courtois & Ford, 2013). The trauma memories focused on could be earlier childhood traumas, more recent interpersonal traumas, or even PTSD around having an acute psychotic episode. Depending on the client and what they are wanting and needing the work could look more like trauma processing in the context of psychosis or it could be trauma processing of the experience of psychosis itself. This is accomplished through a structured process designed to safely facilitate not only remembering, but also the client's vivid experiencing of trauma-related emotions, physical sensations, and associated thoughts, beliefs, and appraisals in the immediate moment of therapy session (Courtois & Ford, 2013). As previously outlined, posttraumatic stress disorders are defined generally by avoidance of memories and related reminders of traumatic events and the experience of extreme physical, mental, and emotional distress expressed through hyperarousal (ex. panic, rage, agitation, terror, vigilance, acute dysregulation, sleep problems, physical tension, pain, impulsive behavior) and/or hypoarousal (ex. numbing, dissociation, depression, catatonia). Memories and related emotions often occur intrusively in a manner that feels out of the client's control. Safely experiencing emotions and the states of hyper- and hypo- arousal in

the presence of and with a supportive therapist helps the client learn how to co-regulate, gain control, and expand their ability to tolerate distressing affect (Courtois & Ford, 2013).

Again, success in this phase of the work relies on having a solid foundation in Phase I of a strong working alliance and a wide array of coping and emotion-regulation skills. Successful therapeutic processing happens within a client's emotional "window of tolerance" (Siegel, 1999) or at an optimized emotional intensity. As the client engages with the memory of the trauma, if they become emotionally overwhelmed to the point of returning to their old emotion-regulation methods or reaching the extreme of hyperarousal, then too much emotional stimulation has occurred, over-shooting the window of tolerance. If too little emotional stimulation occurs, then the client and therapist are under-shooting the window, leaving the client essentially unchanged. In trauma therapy and trauma processing, one of the goals is working to expand the client's emotional tolerance in a gradual way, that the client feels in control of, in a safe space, with a safe and trusted other. Another important piece incorporated into the processing of trauma is understanding the impact that it has had on the individual; beliefs about the self and others, beliefs about the world, and how that individual relates to others and the world.

Before trauma processing. Prior to diving into specific evidence-based, trauma-processing techniques a few things need to be considered. One is that client should be in a relatively stable place in their life, be able to engage in taking care of themselves, and have (as should have been laid down in Phase I) a solid foundation of emotion-regulation and coping skills. The client needs to have the capacity to acknowledge that the traumatic experience had an impact on them. They need to be on board about the purpose of processing and how it can help them, not just recalling memories because their therapist told them to without any engagement on their part or continuing to experientially avoid them. As part of informed consent in this

process, the client should be made aware that while the ultimate goal is enhanced quality of life for the client and improved agency and functioning, during this phase of the work, the client may feel worse before they feel better. This is because of the distress and confusion that may arise in facing troubling memories and emotions that have been previously avoided and lacked coherence. Daily functioning may prove temporarily more difficult during this process because the client is hopefully relinquishing familiar ways of coping and learning new ways of being and relating. (Courtois & Ford, 2013)

In considering whether to begin formal trauma processing the client should be informed about and consent to a few key features. One is what “processing” involves; that the client will need to engage emotionally with the traumatic memory at a sufficient intensity, but without becoming overwhelmed, and ways to navigate that. Another is what they are likely to experience emotionally and as stated above that they are likely to temporarily feel worse before they feel better. They should be made aware of the therapist’s role throughout this process and ways the therapist will ensure emotional safety and support. Lastly, the client should be aware of the control that they will have over ending the processing if they choose and if it becomes to aversive or overwhelming. (Courtois & Ford, 2013)

Trauma processing techniques. For a detailed description of many of the major evidence-based trauma processing protocols, as well as newer protocols still being researched see Courtois and Ford (2013, p. 156-165). Here I will briefly describe three of the most common emotion processing protocols currently utilized and which have a few preliminary studies showing success in clients with psychosis (discussed in the literature review): Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007), Cognitive Processing Therapy (CPT; Resick,

Nishith, & Griffin, 2003), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001).

PE is the protocol that has the most extensive evidence base backing it, but has been researched and developed for single-event PTSD. The focus is on confronting the traumatic event to decrease avoidance and fear response and increase habituation to the memory of the event. It is a verbal narrative technique that involves detailed recounting of the traumatic experience that is then recorded and listened to on a repeated basis, with planned graduated exposures to a trauma-reminder hierarchy created by the client. In session clients repeatedly imagine and describe a traumatic event as if it were happening in that moment, while being helped by the therapist in the moment to remain aware that the event is not actually occurring in the present. The PE protocol occurs over the course of usually around fifteen sessions. While it has the most research backing it, less intensive, more graduated exposure protocols have been recommended for clients with complex trauma (Courtois & Ford, 2013).

In CPT, the focus is on the evaluation and modification of problematic thoughts that have developed following a traumatic experience. CPT involves the client recalling and describing specific trauma memories in writing. The client writes a narrative in as much detail as possible, which is then read by the therapist and processed in session, with specific attention paid to beliefs and assumptions about the self, others, and the world. This protocol usually occurs over about twelve sessions and has been shown to be helpful for individuals with complex trauma. (Courtois & Ford, 2013; “Treatments for PTSD,” 2019)

EMDR does not yet have the scientific evidence base that PE and CPT have accumulated, but is conditionally recommended by the APA’s Clinical Practice Guidelines for the Treatment of PTSD, while it is further studied (“Treatments for PTSD,” 2019). It involves the vivid recall

of a specific traumatic incident, similar to PE, but the recall is completed only in the mind of the client without the client describing it out loud. Additionally, as the client focuses on the trauma memory, they engage in bilateral physical stimulation (eye movements, taps, or tones) led by the therapist. The targeted traumatic memories are considered in terms of an image, the associated cognition, the associated affect, and body sensations. The EMDR protocol is typically administered in about eight sessions, but has been shown to be helpful in as few as two to three sessions for individuals with Type 1 and Type 2 trauma histories. (Courtois & Ford, 2013)

When to stop. Clients will vary on how long they need to process their trauma memories, ranging from a few weeks to many months. Traumatic memories can be said to be adequately processed when a) the client is no longer troubled by the memory, b) the client has integrated the trauma experience into their life narrative and can express it verbally, and c) has developed the capacity for mentalization or theory of mind about others involved the traumatic situation, their thoughts, actions (or inaction), motives, as well as how they impacted the client (Courtois & Ford, 2013). Of course, if the client wishes to stop before the trauma memory has been adequately processed that should always be their choice. Before agreeing to stop however, the reasons behind wanting to stop should be discussed and processed to see if any part of the process can be altered to make it more tolerable for the client or if pausing or stopping is indeed in the best interest of the client.

Loss and mourning. Part of integrating the trauma memories into the larger life narrative of the client involves potentially connecting it back to the development of the client's psychosis and the impact it has had on them. Interpersonal trauma involves not only an assault on the self, it involves a major loss- a loss of the self as it might have been or as it was before, a loss of control, trust, innocence, identity, self-worth, agency, and loss of a sense of safety in the world

(Courtois & Ford, 2013). Courtois and Ford (2013, p. 179) write that “accepting the loss means, in part, admitting to its reality and to the inability to control the circumstances.” Mourning is an important part of emotional processing in trauma work and is often necessary to move into Phase III work. Though painful, grieving can lead to emotional resolution, and free up emotional and physical energy that can be applied to present and future life.

Even if trauma-specific processing does not occur, but the client works through and relinquishes their psychotic defenses, that often times leads to a period of mourning or depression as the client realizes their reality and what may have been lost during the periods of psychosis and because of their trauma and psychosis. Sometimes the client needs to mourn the loss of their psychosis, as it permitted a certain personal and precious tie to the world and was important part of inner life (Arieti, 1974). Without the rich inner world, no matter how painful and scary it may have been, the client may feel empty without it. Again, this is a part of the therapy process and leads into the work of Phase III, part of which is helping the client to create meaningful, rewarding connections in reality.

Phase III. The work of Phase III is about consolidating therapeutic gains and moving toward ending the treatment. This does not imply complete recovery and remission of all symptoms. Rather, it should be understood by both client and therapist to mean incorporating and applying the new knowledge, skills, and sense of self into their daily life and to the goals that motivated the client to come in for treatment to begin with (Courtois & Ford, 2013). Depending on who the client is and what they want for themselves this may involve bolstering their use of support systems and relationships with others, possibly involving the incorporation of family therapy or supportive group therapies to build the individual’s support network. The modern-Sullivanians talk about this phase of the work as one of helping the client to move toward a

realistic understanding and living of their life based on who they are and what they want, while acknowledging, processing, and overcoming a fear of improvement (Arieti, 1955; Karon and VandenBos, 1977). This phase is about honoring the hard work that has been done and making changes in their lives outside of the therapy room.

Consolidating gains. Following the increased resolution and control over trauma memories and their associated symptoms, as well as a relinquishing of psychotic defenses, the gains of Phase I are revisited, reinforced, and their application expanded upon (Arieti, 1974; Courtois & Ford, 2013). The use of safety planning, new emotion-regulation skills, new coping skills, and general self-care is discussed and reinforced such that it becomes engrained in the broader context of the client's life and becomes the client's natural way of being. The therapist should help the client plan proactively and realistically around ways to build the gains of Phase I into the structure of their life, including the engagement or connection piece. This may mean working on and revisiting interpersonal effectiveness skills and helping the client discern between trustworthy relationships to pursue and relationships to avoid or end, as well as setting and holding boundaries with others.

Regarding relationships, clients in this population frequently will need to make difficult decisions around separating from or limiting contact, temporarily or permanently, with family members or those in their larger social system who do not support the client's recovery and the healthy changes they are making (Courtois & Ford, 2013). Change can be extremely threatening to relationships that are based on old patterns, old patterns which may have been dysfunctional, abusive, or controlling (Courtois & Ford, 2013).

The gains of Phase II are also revisited, honored, and applied more broadly in Phase III. In Phase II, the client has learned to become more aware of and identify emotions, physical

sensations, beliefs, and their responses to stressful events. They have learned how to look at an interaction they have had and break it down into component parts to have a fuller understanding of their reactions, where their reactions are coming from, and how to regulate associated emotions. Ideally, they have also internalized a model of more secure attachment from the therapeutic relationship, aspects of which they can seek out and create with trusted others in their lives. Additionally, the work of Phase II can provide a template for continued organizing of fragmented and confusing life events into a coherent narrative that has meaning and utility, a roadmap from which the client can approach life more systematically, intentionally, and mindfully (Courtois & Ford, 2013).

Arieti (1974) suggests that in the final phase of treatment, as part of consolidation, it may be important for client and therapist to revisit the memories, circumstances, and characteristics surrounding any acute psychotic episodes that may have either brought the client into treatment to begin with or occurred during the course of treatment. The client being able to acknowledge, look at, and understand their psychotic episodes in the context of their life history shows not only that they have processed it and it no longer is traumatic (if it was), but it can be empowering. If this process elicits distress and possible decompensation, then the work of Phases 1 and 2 may need to be revisited with focus on integrating psychosis and the psychotic episodes into the client's personal narrative.

In summary, consolidating the gains of Phase I and 2 means getting the client to a place where in their daily lives they can respond to life events and make choices from a position of increased self-knowledge and healthier self-regard (Courtois & Ford, 2013).

Returning to prior phases as needed. As mentioned previously, successfully working through Phases 1 and 2 does not imply complete recovery, remission of all symptoms, and never

needing to go back and work on symptoms and issues that were addressed earlier. Needing to rework skills and return to issues that had previously felt “resolved” does not imply therapy failure and in fact it is common for the resolution of some issues to result in the emergence of others or needing to learn new skills to approach the new challenges (Courtois & Ford, 2013). It is important to remember that the phase model of treatment is not necessarily linear and there may be a cycling through or jumping around multiple times to address what needs to be addressed for the client to achieve their treatment goals. Even after termination, a client may need to return for a “tune-up”, check-in, follow-up, or return to work on a whole new issue (Arieti, 1974; Courtois & Ford, 2013). Life’s troubles and challenges do not cease after successful psychotherapy. As Fromm-Reichmann expressed to her client Joanne Greenberg (2009) who went on to write a book about their work together, “I never promised you a rose garden.”

Fear of improvement. Arieti (1974) and Karon and Vandenbos (1977) devote considerable attention to the client’s fear of improvement and facing the world without psychosis during the final phase of treatment. Clients often fear having to face life again and not succeeding, a fear of responsibility and having to make decisions about the challenges and threats that life will inevitably present (Arieti, 1974). Clients may feel guilt for feeling better or suddenly feel they do not deserve to improve. They may fear the practical decisions that lie ahead of them surrounding relationships, work, and living situation. It is important during this stage for the therapist to remind the client that this relationship is collaborative and reassure the client that they do not need to tackle everything at once by themselves and that together they can work through it. Clients often fear separation from therapy, so it is important to have a realistic assessment of whether the client is ready to stop treatment or perhaps start by taking longer

breaks between sessions. Arieti (1974) notes that it is often possible, after successful treatment, for the client to live a full and independent (or interdependent) life if they are given by the therapist a sense of trust, confidence, and belief in the client and their abilities and potential. It is often reassuring to the client and helps with separation, to know that a return to treatment is always an option if needed.

Moving forward. In helping clients move forward in their lives, there are some things to consider which have not yet been touched upon, but are important in the broader context of the client's life. One is that the client needs to find their place in society and to be able to feel reintegrated into the larger community (Arieti, 1974; Courtois & Ford, 2013). This could occur through volunteering, joining organizations or clubs of interest to the client, joining a support group or being part of a peer mentorship program, through work and career, through school, or through spiritual or religious organizations. Some clients as part of their healing and post-traumatic growth choose to do something to fight oppression, stigma, and victimization.

Forming and maintaining supportive and intimate relationships can be a frightening endeavor for this population, but finding and having them is important for the client's recovery. If the client needs more structure and guidance to work through interpersonal relationships, this can be accomplished through group therapy. As previously mentioned, work around boundaries and interpersonal skills will be important in this task and may take place during this phase of the treatment. For romantic relationships specifically, work will likely need to occur around healthy sexuality, open communication, respect, mutuality, and navigating conflict. Clients may need to think about if and what they want to disclose to others about their past and also may contemplate confronting family members or past abusers. In thinking about their larger life narrative and

meaning, existential or spiritual questions may arise, which may or may not need or want to be discussed in therapy.

Termination. It is generally agreed upon in the complex trauma literature and the broader psychodynamic literature that simple loss of active symptoms is generally not enough to signal a readiness for termination. Whether a client is ready will depend on their initial agreed upon goals for treatment and whether the client has sufficiently modified their view of their self, others, and the world (Arieti, 1974). Arieti (1974) suggests that the client's self-identity must be more coherent and definable with an increased sense of inner worth, reality experienced as less frightening and less impinging, and the client should be ready to return to the world with less fear, greater understanding, and a willingness to take on more ownership and responsibility for the course of their life.

Termination of treatment can be difficult for both client and therapist and the decision of whether to terminate is one that should be carefully assessed and discussed. The end of treatment is a time when much can arise for the client, intense feelings, especially related to other losses and endings they have experienced. This may have been the first non-abusive or dysfunctional relationship the client has engaged in. The therapist needs to devote adequate time (which will vary depending on the client) to termination and processing the loss of the therapist and any surrounding context. It is also important to discuss boundaries around termination and the nature of post-therapy contacts. Ideally, the work of Phase III has adequately prepared the client for termination and to be able to live a fulfilling and meaningful life with the tools and resources to handle what challenges life will continue to bring them.

Proposed Evaluation Framework

As the result of this process is essentially psychodynamic treatment guidelines for a specific population (individuals with schizophrenia with a history of childhood trauma), the model could then be tested in an experimental design. Participants would be randomly assigned to either the experimental group or one of two control groups. While the proposed integrated model does not have a set time or session limit, for the purposes of an experimental design and a comparison with other treatment models, it seems a treatment of limited duration would need to be studied.

For the purpose of evaluation, the experimental group would receive 30 sessions of the integrated model, control group one would receive up to 30 sessions of cognitive-behavior therapy for psychosis (CBTp), and control group two would receive 30 sessions clinical management (CM). CM defined here would include medication management and weekly non-specific supportive therapy. Per the methodological recommendations of Guidi et al., (2018), CM is recommended as a control group comparison because the participants in that group receive the same amount of time and attention from a professional figure as the experimental group, but without any specific interventions such as exposure, trauma processing, or cognitive restructuring.

It [CM] applies psychological understanding to the management of an individual patient, identifying current problems and providing opportunities for disclosure. It may be associated with medication monitoring, but its primary focus may also be unrelated to pharmacological treatment. Since CM provides the nonspecific ingredients of the psychotherapeutic approach, significant differences between an experimental treatment and CM are likely to reflect specific ingredients entailed by the experimental approach, unlike what takes place with treatment as usual (TAU) [usually just medication management] or waiting list control (WLC). (Guidi et al., 2018, p. 287)

According to a meta-analysis looking at CBTp (Naeem et al., 2016), most courses of CBTp are provided as weekly sessions over a period of six to nine months (24-36 sessions), so a median of

30 was chosen for this design. The various therapies would then be assessed at pre- and post-treatment for evaluation of therapeutic effectiveness, with a six-month follow-up. As one of the hypothesized benefits of psychodynamic psychotherapy over that of CBT, is lasting and increasing therapeutic effects post-treatment (Shedler, 2010), it is important to include the six month follow-up post-treatment to assess long-term outcomes.

Participants

Proposed inclusion criteria. Participants for the study could include individuals of any gender, age 18 to 65, who have suffered their first psychotic break. Average age of onset for first episode of psychosis is 18 in men and 25 in women (“Schizophrenia Facts and Statistics”, 2010). A NAMI (2011) survey reported the average age of first episode psychosis to be 24. Sullivan (1953) suggested early intervention promoted the best outcome, preventing a chronic course of schizophrenia and his observation has since been supported by later studies on the “critical period hypothesis” and the early window of opportunity (Birchwood & Fiorillo, 2000; Birchwood, Todd, & Jackson, 1998). The typical duration of untreated psychosis is on average one to two years with the critical period to intervene and effect the course of the disorder being the first two to three years (Birchwood, Todd, & Jackson, 1998; Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Participants would need to meet DSM-V criteria for schizophrenia, schizophreniform disorder, schizoaffective disorder, or delusional disorder and for PTSD as assessed by the SCID-5-CV, a semi-structured interview guide for making DSM-V diagnoses. Additionally, participants would need to be rated at a step 3S or higher using Lysaker et al.'s, (2011) adapted Metacognitive Assessment Scale, as that level of metacognitive functioning and up are what the

proposed integrated model is designed to treat. Per Garrett (2019, p.104) that is also the level of metacognition CBTp is geared to help.

To assess and discriminate between the various kinds of self-disturbances experienced by participants, the Examination of Anomalous Self-Experience (EASE) would be given. The EASE is a qualitatively rich, 57-item symptom checklist, with symptoms confirmed through a semi-structured interview that is designed to detect sub-psychotic experiences based on the ipseity or self-disturbance model of schizophrenia (Sass, 2014; Sass & Parnas, 2003) Many of the self-disturbances assessed in this measure can apply to those with a history of complex trauma as well, such as depersonalization (Sass, Pienkos, Nelson, & Medford, 2013). The scale has a strong descriptive, diagnostic, and differential diagnostic relevance for disorders within the schizophrenia spectrum (Parnas et al., 2005).

The Maltreatment and Abuse Chronology of Exposure (MACE) (Teicher & Parigger, 2015) would be used to gauge severity of exposure to ten types of childhood maltreatment (emotional neglect, non-verbal emotional abuse, parental physical maltreatment, parental verbal abuse, peer emotional abuse, peer physical bullying, physical neglect, sexual abuse, witnessing interparental violence and witnessing violence to siblings) and how exposure to the various types of maltreatment changed across that individual's development. The MACE is a 52-item self-report measure that was created to facilitate research on the importance of type and timing of exposure to abuse in complex trauma. It provides an overall severity score and multiplicity score (number of types of maltreatment experienced) with excellent test-retest reliability.

Additionally, participants would be assessed via the Life Events Checklist (LEC-5) Extended Version, a 17-item self-report measure designed to screen for potentially traumatic events in a respondent's lifetime developed at the National Center for Posttraumatic Stress

Disorder (Gray, Litz, Hsu, & Lombardo, 2004,; National Center for PTSD, 2019; Weathers et al., 2013). The LEC-5 demonstrated adequate psychometric properties as a stand-alone assessment of traumatic exposure (National Center for PTSD, 2019). The LEC-5 includes items designed to screen for Type 1 traumas and Type 2 traumas.

Proposed exclusion criteria. Exclusion criteria for the study would include psychotic symptoms due purely to substance use or severe substance use disorder as assessed through the SCID-5-CV, no history of childhood trauma as operationalized by not meeting any items on the MACE, and the participant being acutely suicidal or homicidal to the point of requiring hospitalization. Acute suicidality would be operationalized as meeting all criteria on the Columbia-Suicide Severity Rating Scale- Screen Version (C-SSRS; Posner et al., 2008) and preparations or a serious attempt within the last three months. Homicidality risk would be assessed using the Assault and Homicide Danger Assessment Tool (Hoff, 2015) and operationalized as the participant meeting a level four or five (high risk of homicide) on the scale. It would be expected given the population of interest that clients would frequently exhibit some suicidality. They could remain in the study, so long as the clinician did not feel they were at imminent risk of harming themselves or others, in which case the treatment would be suspended if hospitalization was required. Treatment could resume if desired by the participant, upon discharge from the hospital. That event would be recorded and reported as adverse event.

Use of medication would not necessarily be an exclusionary criterion for this study, as it is expected that this population will often have been prescribed medication, however any recent change in medication (operationalized as a change occurring at or within two months of beginning treatment and any change during treatment) would be considered exclusionary. In the few preliminary studies of PTSD treatment in psychosis, as well as studies on the effectiveness

of CBTp, *use* of medication was not exclusionary, but a *change* in medication during the course of treatment was considered exclusionary (de Bont et al., 2013; Gianfrancesco, Bubb, & Quinn, 2019; Tarrier & Wykes, 2004; van den Berg & van der Gaag, 2012). This is because if there was any change in symptomology, we would have no way of determining whether the change was due to the effects of the therapy or the medication. It has been noted that individuals with “medication-resistant” schizophrenia report exposure to significantly higher rates of stressful life events and childhood trauma, as compared to individuals with schizophrenia whose symptoms respond to medications, which could be an additional contribution of the proposed integrated therapy model (Hassan & De Luca, 2015; Misiak & Frydecka, 2016).

A final exclusionary criterion would be a history of prior PTSD treatment or CBTp treatment. Any prior PTSD or CBTp treatment could confound the results of the current proposed study. Additionally, there has been some research suggesting that if a client has dropped out of a PTSD treatment during the trauma-processing intervention prior to the resolution of the trauma memory, it can increase their avoidance of the trauma memories and stimuli going forward. This would place an additional obstacle to overcome on the proposed integrated model and could affect the outcome and interpretation of the results.

Outcome

Proposed measures. Measures of complex PTSD symptoms, schizophrenia symptoms, and overall functioning would be assessed at pre-treatment, post-treatment, and at a six-month follow-up.

The Trauma Symptom Inventory 2 (TSI-2; Briere, 2011) would be used to measure changes in complex PTSD symptoms over the course of the study. The TSI-2 is a 136 item self-report inventory that is written at a fifth grade level and takes an estimated 20 minutes to

complete. It includes assessment of the following phenomena associated with PTSD and complex PTSD: anxious arousal, depression, anger, intrusive experiences, avoidance, dissociation, somatic preoccupations, sexual disturbance, suicidality, insecure attachment, impaired self-reference, and tension reduction behavior (Briere, 2011). When scored, the listed phenomena are reported in subscales. The TSI-2 also combines subscales to break down scores into four main factors: self-disturbance, posttraumatic stress, externalization, and somatization. The TSI-2 includes validity scales that assess a participant's tendency to deny symptoms commonly endorsed by others, to over-endorse unusual or bizarre symptoms, to misrepresent PTSD, and to respond in an inconsistent or random manner. Additionally, eight "Critical Items" allow the assessor to identify issues that may require immediate intervention, such as suicidal ideation, substance abuse, and self-mutilation. The inventory also includes change scores that make it easier to monitor progress over time (Briere, 2011).

The Positive and Negative Syndrome Scale (PANSS) (Kay, Fiszbein, and Opfer, 1987), largely considered the "gold-standard measure of treatment efficacy" is a semi-structured clinical interview designed to measure symptom severity in schizophrenia. The measure, which takes roughly 45 minutes to administer, would be used to reliably assess patient symptom change over the course of treatment. While an older and lengthier measure, the PANSS is still widely used in treatment efficacy studies in schizophrenia and so would be included as an outcome measure here for comparability purposes. The PANSS is comprised of 30 items organized into three subscales: positive, negative, and general psychopathology. It has been previously demonstrated that the subscales show normal distribution and independence from each other.

The Social Adjustment Scale- Self-Report: Short (SAS-SR: Short; Gameroff, Wickramaratne, & Weissman, 2012) would be included as a measure of social and overall

functioning. It is a self-report scale that offers assessment of functioning in major roles and is useful as an outcome measure and to track progress over time (Gameroff, Wickramaratne, & Weissman, 2012). The SAS-SR: Short contains 24 questions that measure role performance over the past two weeks. It includes questions on work- for pay, unpaid work, and work as a student; social and leisure activities; relationships with the extended family, within a primary relationship, with any children, and relationships within the family unit; and perception of economic functioning. The questions within each area cover performance at expected tasks, friction with people, finer aspects of interpersonal relationships, and feelings and satisfactions. Each item is scored on a 5-point scale with higher scores indicating poorer functioning and will produce role area subscores in addition to an overall functioning score. The SAS-SR: Short contains skip-outs, so that non-applicable items are omitted.

Lastly, the Self-Esteem Rating Scale-Short Form (SERS-SF) (Lecomte, Corbière, & Laisné, 2006) is a 20-item self-report measure created for people with schizophrenia. The SERS-SF has two subscales, positive and negative self-esteem to capture the described paradoxical quality of self-esteem in schizophrenia, whereby some individuals can simultaneously have high scores on scales measuring both positive and negative self-esteem, thereby making the use of a global score difficult to interpret (Barrowclough et al., 2003). A total SERS-SF score can be calculated by subtracting the negative self-esteem score from the positive self-esteem score. The total score can therefore be either positive or negative. The scale is quick and easy to administer, has an adequate convergent validity, high internal consistency, and high test-retest reliability in patients with schizophrenia (Lecomte et al., 2006).

All of the above proposed outcome measures would be given pretreatment, posttreatment, and at six-month follow-up. The time to administer all of the above measures would take, at most, an estimated one and a half hours.

Proposed analysis. Per Guidi et al.'s (2018) methodological recommendations for studying psychological interventions, the proposed study design would be that of the 3-arm design comparing an experimental psychotherapy (the proposed integrated model), to another psychotherapy found to be effective in other studies (CBTp), to a placebo condition (the CM control group). The 3-arm design would allow the comparison of both psychotherapy treatments (experimental and CBTp) to the placebo (CM) and a comparison between the experimental and CBTp conditions. The design broadly would include 3 treatment conditions, 4 symptom outcome measures each broken down into multiple subscale scores, and assessment at 3 time points.

The outcomes of interest for this study would be a) comparing changes in the TSI-2 between treatment conditions and over the course of treatment, specifically the self-disturbance factor score and the posttraumatic stress factor score; b) comparing changes in the positive and negative subscale scores of the PANSS between treatment conditions and over the course of treatment; c) comparing changes in the overall functioning score between conditions and over time; and d) comparing changes in the total SERF-SF score between conditions and over time. An evaluation of such a model would also allow for the identification of limitations of the model. Perhaps future studies could then be targeted at developing therapeutic methods to address the shortcomings of the current proposed model. The data would be analyzed using a linear mixed model for each clinical outcome score of interest to allow for analysis of both fixed effects and random effects.

Summary and future directions.

The proposed evaluation of the integrated model of psychotherapy for schizophrenia would be used to revise and restructure future iterations of the model based on the data that would be collected. For example, it would be interesting to see whether the model reduces the severity of different symptoms clusters compared to the control conditions and whether it addresses both the complex trauma distress and psychotic symptoms (positive and negative). If not, it would be important to know what areas are targeted successfully in the treatment and where the model could be improved. For example, it would be expected based on the CBTp research to date (Klingberg et al., 2018) that CBTp would reduce positive symptoms better than CM, but it would be interesting to see how the proposed integrated model would do in reducing positive symptoms compared to the CM and compared to CBTp.

If the proposed integrated model performed better at reducing trauma symptomology (as would be expected), but not in reducing positive symptoms, then the model could be modified to include specific CBTp techniques, likely in Phase I of the model for improved efficacy. If the models performed equally well in reducing positive symptoms, or the integrated model performed better, that would warrant further research into the specific factors of the integrated model effecting positive symptoms. Negative symptoms have been shown to be resistant to treatment in CBTp (and in medication as well), so it would be important to see if the proposed integrated model has any impact on negative symptoms.

Additionally, there has been some debate in the PTSD literature about the utility and necessity of a Phase I prior to Phase II trauma processing (De Jongh et al., 2016). Future studies could look at whether incorporating Phase I prior to Phase II treatment is necessary or leads to

better outcomes in the short vs. long-term and whether that differs by treatment population (ex. schizophrenia with complex PTSD vs. complex PTSD only).

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