SOCIETY FOR PSYCHOTHERAPY RESEARCH
ITALY AREA GROUP

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RESPONSE TO QUESTION POSED BY VITTORIO LINGIARDI re: PSYCHOTHERAPY FOR PSYCHOSIS: INTEGRATING COGNITIVE BEHAVIORAL AND PSYCHODYNAMIC TREATMENT

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1) In your book, you use the term "ambitious psychotherapy". I see the adjective "ambitious" as an attempt to challenge a widespread therapeutic nihilism regarding psychosocial treatments for psychosis spectrum disorders. As you discussed, this attitude has led most clinicians, mental health professionals, and policymakers to believe that, first, "schizophrenia" is fundamentally a chronic brain disease for which we have yet to find the biological cure, and, secondly, psychotherapy for psychosis is of no value and should be rejected as a treatment modality. I would like to ask you:

a) whether and how this pervasive pessimism has been disproved by scientific evidence;

If you permit me, I would like to approach this question about therapeutic efficacy first from a somewhat different direction. Justice requires that the accused be considered innocent until proven guilty. Although of course we cannot assume that a treatment is effective until proven ineffective, but let's start with the question, "How effective is the biological treatment of psychosis diagnosed as schizophrenia?" Estimates vary, but roughly one in seven people substantially recover with treatment as usual (TAU). Medications, while unquestionably helpful in suppressing some psychotic symptoms in some patients, often have emotion-numbing and body-damaging side-effects, some life-threatening. The distinguished biological psychiatrist Nancy Andreasen notes that total exposure to neuroleptic medication is associated with loss of brain tissue (Andreasen, Liu, Ziebell, Vora, & Ho, 2013). In a 15-year follow up, a larger percent of schizophrenia patients not on antipsychotics showed periods of recovery and better global functioning (Harrow & Jobe, 2007).

Tom Insel, MD, former Director of the National Institutes of Health in the United States, has been quoted as saying that the 20 billion dollars invested in biological research during his 13-year term did little to "move the needle" of patient care (Dobbs, 2017). In a recent assessment of the state of the art in biological psychiatry, a panel of pre-eminent neuroscientists concluded that "few, if any, breakthroughs in basic scientific research have led to substantive improvements in psychiatric clinical practice" (Stephan et al., 2016). We can now ask the question, "Has biological psychiatry, helpful as it can sometimes be, claimed more than it can deliver?"

Now, we can turn to the question, "Does an aspiration to provide ambitious psychotherapy claim more than it can deliver?" An honest answer might be "perhaps." We just don't know. There are too few practitioners specifically trained to do psychotherapy for psychosis to estimate the impact on public health. For example, it has been estimated that in the United States, training at present stands at .5% of what is needed. Since the advent of chlorpromazine in the early 1950s, although some funding has been allocated to support psycho-social research, the vast majority of the money available for psychiatric research has gone to biological psychiatry. Like the oldest son in a large family of limited means who is the only sibling to have his education funded, the remaining siblings are left to educate themselves as best they can. Little funding, minimal research. One can only imagine how investing 20 billion dollars in psychotherapy research might have advanced the efficacy of psychotherapeutic approaches.

Despite the relative lack of research funding for psychotherapy compared with biological psychiatry, one can still make a strong case for the efficacy of psychotherapy for psychosis. Randomized, double-blind controlled trials (RDCT) are the gold standard in biological research. RDCTs of cognitive-behavioral therapy for psychosis (CBTp) show a small-to-modest effect size in the range of .35 in the amelioration of psychosis (Jauhar et al., 2014; Wykes, Steel, Everitt & Tarrier, 2008), without any of the biologically damaging side-effects of medication. The neuroleptics lurasidone, chlorpromazine, and olanzapine show comparable effect sizes to CBTp (Leucht et al., 2013). Effect sizes in unpublished studies of neuroleptic efficacy average .23, much smaller than the .47 reported in published studies (Turner, Knoepflmacher & Shapley, 2012). In other words, pharmaceutical companies and journals have been exaggerating the efficacy of medication by not publishing negative studies. CBTp has been shown to be effective in patients resistant to medication (Rathod, Kingdon, Weiden, & Turkington, 2008). Despite a lack of investment in researching psychodynamic psychotherapy for psychosis, there is some controlled-trial research evidence for its efficacy (Karon, 2003; Rosenbaum et al., 2006).

Not only has biological psychiatry claimed most of the money available for research, but it also claims the moral high ground in setting RDCT as the gold standard of what can be known, as though other forms of evidence should be discounted. Returning to the question of whether the idea of ambitious psychotherapy for psychosis overstates a claim, there is overwhelming evidence for the efficacy of psychodynamic psychotherapy in many case reports and clinical vignettes demonstrating its value. If one regards these case reports as *evidence* they are, in effect, pilot studies of the efficacy of psychotherapy. The study of long-term psychotherapy for psychosis is in many ways ill suited to a RDCT method – it is not impossible to do, but it is difficult to do, much more difficult than a drug trial (Carey & Stiles, 2015). RDCTs work best when an independent treatment intervention can be standardized and delivered in an identical way to subjects in a study (the same dose of the same medication to all patients receiving the active compound). But everything we know about psychotherapy indicates that it is extremely difficult to study as the impact of a standardized independent variable upon a research subject. The first time the patient and therapist meet, the patient influences the therapist, and in turn the therapist influences the patient, and so on in a cycle of relational influence. There is no independent variable. Even when one rates psychotherapy outcomes on a standardized scale, one cannot standardize the therapist. There is overwhelming evidence that the quality of the therapeutic alliance, which depends on the personhood of patient and therapist, is a most important factor in psychotherapy outcomes (Norcross, 2011). For two case studies which provide detailed autobiographical accounts of the role of long-term psychotherapy in recovery from chronic psychosis, see Joanna Greenberg's *I Never Promised You a Rose Garden* and Arnhild Lauveng's *The Road Back from Schizophrenia – A Memoir*. The psychiatric and psychoanalytic literature contains many other reports and clinical vignettes supporting the efficacy of psychotherapy for psychosis. These should be regarded as positive case studies that invite funding for long-term trials. But that money for research is not forthcoming, for many reasons.

b) What are the historical, clinical, political, and financial reasons underlying this pessimistic attitude?

In the mid-1950s many who headed departments of psychiatry in the United States where psychoanalysts. In my view, psychoanalysts oversold what standard psychodynamic technique could accomplish with psychotic patients. After an influential study in the mid-60s reported by May in book form (May, 1968) failed to demonstrate an advantage for psychotherapy in the treatment of psychosis, drug companies promptly mailed a copy of the book to members of the American Psychiatric Association as a free gift. The study was quite flawed, despite its seemingly impressive comprehensiveness. The therapists were inexperienced early-career clinicians. The supervisors were psychoanalysts, who despite

rigorous psychoanalytic training, were not reported as having any particular expertise in the treatment of psychosis. One might as well study the outcome of cardiac transplant surgery conducted by first-year surgical residents supervised by highly trained pediatric brain surgeons acting as supervisors. Good outcomes could not be expected. The May study cast a dark shadow over psychotherapy for psychosis.

Investigators learn to "follow the money" when trying to discover reasons why circumstances are as they are. If one follows the money in the last 5 decades, it leads to the pharmaceutical industry, not to psychotherapists. Because most prescriptions for neuroleptic medications are paid for by the government, drug companies have a payer with deep pockets. In order for insurance, government funded and otherwise, to pay for medication, a prescription must be tied to a diagnosis. DSM diagnostic criteria play this role. More recent versions of the DSM and the *Psychoanalytic Diagnostic Manual* (PDM) challenge the idea that psychiatric conditions are discrete illnesses by emphasizing the dimensional aspects of psychological conditions. Modern genetic research suggests that schizophrenia, bipolar illness, and autism may not be distinct illnesses because they have a shared genetic pedigree. What for decades psychiatry has called "co-morbid illnesses" are likely not multiple discrete disorders but reflections of a continuum. It is much more difficult to bill for a continuum than to bill for pharmacological treatment and medication tied to a seemingly discrete illness.

At present in the United States, most positions of administrative power in the mental health arena are held by psychiatrists. Psychiatrists are trained to prescribe medication and expected to do that, often carrying caseloads of 200 patients. Even if psychiatrists were trained to do psychotherapy, it is impossible for one practitioner to do ambitious psychotherapy with 200 patients. What is needed is for psychiatrists to facilitate conditions in which psychologists, social workers, counselors, and mental health therapists with other backgrounds can do their work. In my book, in the final two chapters, I discuss in detail what might be needed to create conditions that might make psychotherapy for psychosis practically possible.

c) What are the consequences for so many patients suffering from psychosis who receive "treatments as usual" for their condition?

I once saw an amusing printed card taped to the refrigerator of a friend, who had three children ages 3, 5, and 8. Below an Andy Warhol-like drawing of a mother, the card read, "If the children are alive by dinner time, it has been a good day." Treatment-as-usual (TAU) aims to keep patients alive and out of the hospital, and to a degree it succeeds in this aim. Everyone who works with psychotic patients knows that few achieve long-term recovery. A biological perspective provides a ready rational to explain the limitations of our treatments. While psychiatry has failed to make significant advances in treatment, other branches of medicine have made substantial gains. In internal medicine, when a treatment doesn't work, clinicians are apt to blame the treatment for lack of efficacy, as if to say, "We must be doing something wrong. Our treatment is inadequate to the disorder." In biological psychiatry, pessimism about outcomes provides a convenient rationale for therapeutic failure, as if to say, "We are offering the patient all we can by prescribing drugs [even when ambitious psychotherapy is not offered]. The patient failed to improve not because our treatments fall short of the task, but because schizophrenia is a treatment-resistant disease. If the patients are still alive and out of the hospital at the end of the day, we have done all we can."

Most patients soldier on despite their chronic disability, but some see the fallacy in psychiatric treatment clearly. More than one patient has told me, "Doc, I have been diagnosed as having 8 different conditions. You doctors don't really know what is wrong with me, do you?" Another patient who was about to be

discharged from the hospital after a 6-week stay said to me, "The staff took care of me 24/7 for weeks. Everyone here did the best they could. I know that if they had something else to offer me, they would have. But I am not really that much better. I still think about killing myself, and when 6 weeks in the hospital doesn't do any good, I wonder what's the point in going on." In this particular patient's case, his discharge was delayed. A CBTp trained clinician was brought in to work with him. He remained in the hospital an additional 3 weeks, and did well.

2) Why and in what way was Freud wrong when he became convinced that psychotic patients cannot form an analyzable transference and, consequently, are not good candidates for psychotherapy?

Unlike Jung, who worked with Eugen Bleuler at the Berghölzli Hospital in Zurich and treated psychotic patients, Freud's clinical experience was primarily with non-psychotic ambulatory patients. Freud's conception of psychosis as a narcissistic disorder in which libido is withdrawn from the outside world and re-directed to the self encouraged the belief that psychotic patients are insufficiently invested in reality to muster sufficient feelings toward the analyst to form an analyzable transference. Drive theory and ego psychology did not provide a good enough conceptual understanding that psychotic people do form transferences to the therapist, but transferences of a different sort than neurotic patients. Melanie Klein and object-relations theory provided a better framework for thinking about transference in general and the transference of psychotic patients in particular. In the transference of a non-psychotic patient, the relationship with the therapist revives unconscious mental representations of past relationships, as when the patient experiences the therapist as being critical in the way the patient's mother was critical. A similar thing happens in the transference of psychotic patients, but the mental representations that are revived in the transference are not nuanced distortions of representations of actual people, but primitive object representations infused with the fantastic terrors of early mental life, mental representations that Klein called "persecutory objects." Heinz Kohut and self psychology faced similar doubts as to whether patients diagnosed with narcissistic personality could by treated in psychotherapy because they took insufficient interest in the 399therapist to form a transference. The solution to this was to describe types of narcissistic "self-object" transference, including idealizing and mirroring versions, and to conceptualize narcissistic self-objects whose psychological role was to support self-esteem.

Patients with borderline or psychotic personality organizations may form a *psychotic transference*, in which the relationship with the therapist stirs up a delusional image of the therapist while the patient is not observed to be psychotic outside the consulting office, or a *transference psychosis*, in which the treatment engenders a psychosis that engulfs the therapist and extends into the patient's outside life. It is not uncommon for psychotic persons to wonder if the therapist is part of a plot against the patient. Often this form of transference can be managed by interpretation and reassurance, allowing the treatment to pass beyond this threat. A patient once told me he thought I *might* be in on the plot to have him arrested. The "might" indicated some doubt. I asked him, "Do you think that I would risk my medical license, my livelihood, and my family's well-being by plotting against a patient whom I was duty bound to help?" The alliance had been sufficiently positive before the psychotic transference escalated that he was able to see his suspicions of me as part of the larger paranoid picture we had been exploring. At times, the psychotic transference is intense and enduring and may derail the treatment. For example, after two years of a comfortable working alliance with me, a man who claimed to be a top military general in touch with the President became deeply disappointed with his mother. She had failed to express her sympathy when a relationship with a woman he believed the President was arranging for him failed to materialize. To exonerate his mother and preserve his relationship with her, he became convinced that I

was responsible for his mother's belief that he was mentally ill, a belief which had led her to not take his girlfriend story seriously. This transference psychosis proved insurmountable. As with the self-object transference described by self psychologists, special parameters are required to manage transference with psychotic patients. First and foremost is the requirement that the therapist not try to be a blank screen that encourages projection. Rather, the therapist should aim to build a collaborative alliance in which the therapist talks in a relaxed, familiar, down-to-earth manner that is at times self-disclosing, allowing the psychotic person to learn who the therapist really is as opposed to who the patient imagines the therapist to be.

3) Now I'd like to get into the more innovative aspects of your book. Your proposal for an ambitious psychotherapy is a technique that integrates CBT and psychodynamic approaches, an integration routed in a compelling synthesis between both biological and psychological theories of psychosis. Why should CBT and psychodynamic approaches be integrated, and what are their limitations if used separately?

I believe that integrating CBTp with a psychodynamic approach follows naturally from my understanding of the psychology of psychosis. Person's suffering from psychosis often believe that the source of their suffering lies in a persecutor outside their mind (a government agency, a critical voice) determined to inflict harm. In many cases, psychotic persons have really been harmed by an abuser, but in the psychotic state the person fails to grasp that the persecutor they believe exists in the real world outside their mind is actually a projection of real grievous harm suffered in the past. The patient in effect thinks about the persecutor rather than the real people who injured him or her. In my view, this conception of psychosis invites the use of CBTp techniques early in treatment, techniques that employ logic to gently increase doubt about whether the delusion is literally true. If the CBTp work is successful, the focus on the external persecutor diminishes, and then the patient and therapist can turn their attention to exploring the figurative, metaphorical, and symbolic truth of the psychotic symptom. Chapters 14 and 15 in my book give detailed summaries of this approach with three patients who did well in treatment.

4) In your integrative proposal, the phenomenological theories are just as important as the psychodynamic and CBT ones. For example, in your model, diminished ipseity (or basic self-disorder) is a key framework for understanding the subjective experience of individuals with psychosis. Once again, it seems that eclectic training is essential for students and clinicians interested in psychotherapy for psychosis.

Yes, I believe it increases the chances of success in psychotherapy if the psychotherapist is familiar with the phenomenology of psychosis as well as having training in both CBTp and psychodynamic technique. Many psychotic symptoms which might otherwise appear baffling can be better understood as the patient's particular individual experience of phenomenological states in psychosis, including self-states. I once consulted on the treatment of a young woman who suffered a first-episode psychosis that required her to drop out of school. She claimed that her younger sister, with whom she maintained an intense sibling rivalry, had "smoked her soul" and had invited aliens to plant a computer chip in her mind that took over directing her actions, leaving her feeling like an automaton. In the delusion, her sister is a persecutory object, and the computer chip idea is the patient's explanation for the diminished ipseity she is feeling.

5) You often draw similarities and dimensional continuity between psychotic symptoms, such as delusions and hallucinations, and some transient phenomena in the ordinary mental life of children and adults. This is a lesson that has certainly been given to us from psychoanalytic literature. Although this is quite convincing and has the merit of making the psychotic experience less alien and stigmatizing, I have heard many clinicians forcefully refute it. Don't you think that it is alarming for so many people to be thinking of psychosis as a variation on the theme of ordinary mental life?

This is a difficult question to answer without knowing what specific objections the detractors you mention use to forcefully refute the existence of a connection between psychosis and ordinary mental life. Perhaps we can approach this question this way. People who believe there is no connection between psychosis and ordinary mental life must then take up the burden of explaining how a state of mind arises *de novo* that has no antecedent in a person's previous mental life. People who believe there is no connection will likely not believe in the possibility of psychotherapy for psychosis, because if psychosis lies beyond our empathic capacity, there is no basis for the therapist to reach a psychological understanding of the patient. I go to considerable lengths in my book to demonstrate connections between ordinary mental life and psychosis. Needless to say, I do not claim that everyone is psychotic or potentially psychotic. I do make the claim that analogies to psychosis can be found in ordinary mental life.

A fundamental truth about human beings is that we create stories to explain our experience. My book frames psychosis as an autobiographical play staged in the real world, where a delusion is a particular kind of story, expressive of the patient's life history, meant to modulate the person's psychological state. Consider the example of déjà vu, an experience many ordinary people have had. Déjà vu and other disturbances of time sense, depersonalization, and derealization are well documented in psychosis (Christodoulou, 1986). Most people don't worry when they have an occasional experience of déjà vu because we have a name for it, we know that other people experience it, it is usually brief, and episodes are widely spaced. We may explain occasional déjà vu experiences as "just one of those brain glitches." Imagine, however, that you start having déjà vu once a month, then every week, then for periods spanning days at a time. At some point, a new story is required. Whereas a non-psychotic person might form the explanation, "I am having déjà vu all the time. Maybe I have a brain disorder," a psychotic person might explain persistent déjà vu as, "I am a time traveler who goes back in time to prevent disasters. Lately there has been a problem with the computer that handles my reentry into current time. When I reenter the present, I feel like I have been there before."

It is possible that people who see no connection between psychosis and ordinary mental life are afraid to see any link between themselves and people who have lost their minds. I would say that
we all have to manage fears of various sorts, to ignore disturbing realities like our mortality, to manage the inevitable anxieties that attend making an intimate connection with another person while maintaining a space for our individual personhood. We all tell ourselves stories about how we came to be who we are and about where we and the world are headed. Psychotic people tell delusional stories to manage their terror, grief, and longing. For many people, climate change is becoming an increasingly frightening reality that prompts us to tell a story such as: "Technology will figure out how to bind excess carbon dioxide" or "Human political and social systems are up to the task of creating a society based on zero increase in gross national product."

I think the best way to address the question of whether psychosis bears any connection with ordinary mental life would be in a debate with people who think it has no link, a debate in which I would be happy to engage.

6) Now, I would like to return to the therapeutic nihilism regarding psychosocial treatments for psychosis. Do you think things are currently changing? Or rather, do you think that such pessimism is updating based on the recovery movement, as well as based on first-episode psychosis studies and pre-syndromal detection and intervention research (i.e., clinical high risk)?

I am sorry to say that I am not optimistic about progress at the present time. The forces of Mordor arrayed against ambitious psychotherapy are considerable. As noted above, in the United States it has been estimated we have .5% of the staff we need to do CBTp. In Great Britain CBTp is included in the NICE guidelines, but only a minority of patients receive CBTp. I tried to build a robust psychotherapy for psychosis service at the public hospital where I work, but I had only modest success, for a variety of reasons. Even though colleagues in the senior leadership of the psychiatry department were in theory supportive of psychotherapy for psychosis, administrative agendas often contravened. For example, after I reached out to the director of the psychology department to discuss closer collaboration, he informed me in a terse email that, "My staff are not in need of your supervision at this time." He apparently experienced my effort to build a stronger psychotherapy service as an encroachment on his authority.

I do have a plan. Since positions of power in the public hospital mental health are most often held by psychiatrists, I am collaborating with a colleague to develop a curriculum for psychiatric residents-in-training that is tailored to their needs. It would be too ambitious a goal to teach psychotherapy. Rather, the aim would be to address what might be called the "conversation-stopping moments" that young doctors encounter with psychotic patients. For example, a young psychiatrist recently presented a patient to me who claimed that he had once had the identity of Mickey Mouse inside Abraham Lincoln's body. This is a conversation-stopper. What should the psychiatrist think? What should the psychiatrist say? The patient mentioned several different US Presidents and Walt Disney in the interview, and claimed that "the pretty lady" in the record room was Minnie Mouse. These statements and others by the patient indicated that the Mickey Mouse/Minnie Mouse idea was a form of daydreaming about a woman he found attractive. He felt his relationship with Minnie Mouse in the record room had been sanctioned by a powerful man, Walt Disney, who had created these characters. The patient's fantasy of being inside Abraham Lincoln's body expressed his wish to be a powerful man in a fantasy of physical merger with such a man. This training aimed at helping young psychiatrists see meaning in psychotic symptoms will hopefully result in their being sympathetic to psychotherapy for psychosis as their careers evolve. These psychiatrist leaders of the future might take an interest in doing psychotherapy themselves, or facilitating this work by others.

7) According to the evidence-based medicine, the randomized control trials and the meta-analytic studies are the most important building-block to inform and update clinical guidelines. I have often been surprised to note the paucity of research on the efficacy of psychotherapy for psychosis, especially when compared to the number of studies addressing psychosocial treatments for other mental disorders. It would be fair to say that such therapeutic nihilism is widespread in research settings as well. What do you think?

Many of my thoughts about the issue of psychotherapy for psychosis research are included in my answer to Question 1a. Although I think some of the obstacles to psychotherapy for psychosis research could be overcome if sufficient funding existed, the challenges are daunting. In the United States, most psychotic patients are treated in public hospitals and clinics. That is where most potential research subjects are,

and that is where outcomes should be measured, because outcome studies in settings other than *in vivo* conditions where care is actually provided, while useful, are of limited value. One would want to know if the treatment patients ordinarily receive in the setting where they are ordinarily treated was effective. Outpatient psychiatrists may be responsible for 200 patients; psychologists and social workers have caseloads averaging 80 patients or more.

It is possible to do research in public settings in the United States, but in the large city hospital where I work, anyone who submits a research proposal for ethical review and approval that is not supported by an independent grant must sign a legal affidavit that zero time or resources belonging to the hospital are going to be used in the research. The hospital is paying people to see patients not do research. Caseloads can be overwhelming. If staff did research on hospital time, it would be considered a fraudulent diversion of resources from clinical care. Administrators are rightly concerned that research subjects sign informed consent to participate in a study, but some administrators are skeptical whether psychotic patients can give informed consent, and they understandably worry that a psychotic person might sue the hospital or that the hospital might end up in the newspapers charged with doing unethical research.

Even in academic medical centers where doctors applying for a job might be told that some percentage of their time can be allocated to research, clinical and administrative demands often squeeze research out of the picture. Doctors may be told they can do research, but the administration provides no protected time safe from the encroachment of other demands. Research is certainly possible when part or all of a person's salary is paid by a research grant rather than by the hospital, but such positions are few and far between. Another factor in the United States is career development. People need to decide early in their career whether research is going to be an important part of their professional life. One factor determining whether a research proposal is funded is the track record of the principal investigator. If one gets involved in research early, meaning in one's late 20s or early 30s, there is a chance of receiving additional grants as time goes by if one's previous research has been well conducted. If a doctor doesn't have an established record of prior grants by age 40, chances of having a project funded are minimal. It would be interesting to discuss how time and research funds are distributed in different countries.

8) Do you think your proposal for a CBT and psychodynamic approaches integration may be manualized and tested in randomized control trials, sooner or later?

I have addressed the limitations of double-blind controlled trials of long-term psychotherapy and the challenges to research in answers to previous questions. Psychosis is a severe condition. Psychotherapy takes time. To do manageable research, CBTp clinicians follow manualized protocols and measure standardized outcomes over short periods. Since few granting agencies are willing to support research that spans years, one reads that CBTp requires a minimum of 12-20 sessions, which doesn't mean that 12-20 sessions are required to achieve recovery. It just means that was how long the grant lasted. The small amount of research that has been done on longer-term outcomes in CBTp trials suggests that patients may relapse without "booster sessions." In my view, the manualized treatment protocols developed to conform to the needs of research have been naively prescribed to the clinical community as guidelines for treatment in the clinic. One cannot assume that a research protocol has general applicability in *in vivo* settings, where problems are complex and long-term treatment is required. For example, most patients in the public sector have complex co-morbidities and difficult living circumstances that hamper recovery. Most research protocols that are focused on a particular diagnosis exclude patients with co-morbidities, which means most research is not conducted with subjects truly representative of patients in the public sector. There is some evidence that too close adherence to a

psychotherapy manual may actually be negatively associated with outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). I have no doubt that an approach integrating CBTp and psychodynamic treatment could be studied, but to do the study correctly would require considerable thought and very significant resources. In my career I have been a clinician and administrator. I could not have accumulated the clinical experience necessary to write my book had I focused on research. If anyone has the resources to study integrating CBTp and psychodynamic treatment, I would be very pleased to advise in the design of the study and its conduct.

9) What kind of reception is your book getting? Do you think that clinicians from different theoretical frameworks are ready for your ecumenical proposal?

Needless to say, the information I have about this is biased. No one has gone out of their way to tell me they didn't like the book. The book is hardly light bedtime reading. But there are some objective indicators. It won second prize in the American Journal of Nursing book competition last year. I didn't submit the book to the award committee; they came across it somehow and felt it deserved an award. At first I thought, "Why didn't the American Psychiatric Association notice the book?" but then I thought, "No. An award from a nursing organization suggests that psychiatric nurses, who do not receive extensive training in psychotherapy, found the book valuable, which is a good sign that the book is accessible to clinicians on the front lines." The book was very positively reviewed in the journal *Psychosis*, and a similarly positive review will be coming out in the *Journal of the American Psychoanalytic Association* early next year. A number of instructors have told me that they are using my book as the source text in a course on psychotherapy for psychosis. People who have read the book tell me, often conveying a sense of surprise, "Your book is clear and well written. I could understand it. It seems useful." Since its publication, I have experienced a slow but steady increase of emails from people who have seen it or read it, who want to consult with me. For example, I am in the midst of working with a family in which one parent, who for years suffered from Charles Bonnet Syndrome, has now developed a Capgras delusion that family members are imposters. So overall, I am very pleased with the book's reception, and I am delighted that it has been translated into Italian!

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