Integrative Practice & the IPTF Framework

THE TALKING THERAPIES UK PRACTITIONER SERIES



Integrative Practice & the IPTF Framework

The complete practitioner pathway, from foundation through to advanced practice

Advanced level · 121 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Integrative Practice & the IPTF Framework course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 14. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This volume gathers the whole of the Talking Therapies UK pathway in Integrative Practice & the IPTF Framework into a single book. Each of its parts is a complete course from the practice's training library, and each chapter is a lesson from that course, so the volume covers the subject in the order in which it is taught, from foundation through to advanced practice. It is written for psychotherapists, psychologists and other qualified psychological therapists, and it assumes a caseload and access to supervision.

The constituent courses are: The IPTF: Foundations; Understanding Personality Disorders; MBT Foundations; Integrative Practice Foundations; The IPTF in Practice: Stages One and Two; Assessing and Formulating Personality Disorder; MBT in Practice; The IPTF Framework in Practice; Advanced IPTF: Recovery, Adaptation and Implementation; Treating Personality Disorder: Evidence and Systems; Advanced MBT: Applications and Delivery; Advanced IPTF: Personality-Organised Difficulty.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 121 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in

the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Describe the IPTF's architecture and the problem it solves: principled integration instead of eclectic drift
- Explain each stage of the pathway and its clinical purpose
- Locate the major modalities within the framework and what each contributes
- Formulate a straightforward case in IPTF terms from intake material
- Explain the framework to a client in plain language that supports informed consent
- Recognise when a case exceeds the framework's, or your own, current reach
- Describe what personality disorder is and is not, and the harm loose usage does
- Explain the shift from categorical types to the severity-and-trait model in ICD-11
- Recognise the common presentations, including emotionally unstable and avoidant patterns, without caricature
- Explain aetiology evenhandedly: temperament, attachment, adversity and their interaction
- Challenge stigma, including your own service's, with evidence and language
- Describe the evidenced treatment approaches and what they share
- Define mentalizing and its four dimensions, and describe effective mentalizing in ordinary life
- Explain how attachment activation switches mentalizing off, and why that matters in therapy
- Recognise the non-mentalizing modes: psychic equivalence, teleological mode and pretend mode
- Describe how mentalizing failure produces the phenomena of personality difficulty
- Adopt the mentalizing stance: curious, not-knowing and actively enquiring
- Monitor your own mentalizing lapses in session and recover them
- Describe the major routes to integration: technical eclecticism, theoretical integration, assimilative integration and common factors

- Explain the common factors and their weight in outcome research
- Describe the IPTF's purpose: one coherent framework holding multiple modalities in disciplined relation
- Formulate a case in more than one modality's language and compare what each reveals
- Choose interventions by formulation and stage rather than by allegiance
- Describe your own developing integrative stance and its current limits
- Conduct stage-one work: engagement, stabilisation, risk containment and shared goals
- Build the stage-two formulation: pattern, origins, maintenance and the change plan it implies
- Select and justify modality methods for each formulation element
- Track stage progress and recognise genuine readiness to move on, versus flight into health
- Revisit earlier stages deliberately when destabilisation or new material requires it
- Document IPTF work so that another practitioner could pick up the thread
- Assess personality difficulty with structured tools alongside clinical interview
- Distinguish personality-level difficulty from mood, trauma and neurodevelopmental presentations that mimic it
- Formulate using severity, traits, attachment style and relational patterns together
- Assess and formulate risk, including chronic suicidality, without reflex escalation
- Share a personality-difficulty formulation with the client compassionately and usefully
- Write formulations that help teams hold, rather than reject, the client
- Structure MBT: trajectory, formulation and the session-by-session frame
- Use the MBT intervention spectrum, from empathic validation to mentalizing the relationship
- Work with arousal: reduce it when mentalizing collapses, raise engagement when pretend mode flattens it
- Interrupt non-mentalizing modes and restore mentalizing in the moment
- Mentalize the therapy relationship, including your own contribution and mistakes

- Handle crises and self-harm mentalizing-first within a coherent care plan
- Apply the IPTF stage by stage, from engagement and stabilisation through formulation-led change work
- Build integrative formulations that specify what is offered when, and why
- Blend cognitive-behavioural, relational and experiential methods without incoherence
- Use outcome and alliance feedback to steer the integration in real time
- Manage transitions between ways of working inside one therapy without losing the thread
- Articulate the IPTF rationale to clients, supervisors and colleagues clearly
- Lead stage-three recovery and adaptation work across modalities with complex presentations
- Run stage-four implementation: consolidation, relapse planning and endings that hold
- Adapt the pathway for personality-organised difficulty and chronic relational trauma
- Manage long treatments' arcs: plateaus, regressions and renegotiated goals
- Embed the framework in a service: supervision, audit and fidelity without rigidity
- Evaluate outcomes across an IPTF caseload and feed the learning back into practice
- Compare the evidenced treatments, including DBT, MBT, schema therapy and TFP, and their shared factors
- Apply general therapeutic principles for personality difficulty in any modality: consistency, coherence and continuity
- Design care pathways that avoid both neglect and iatrogenic over-intervention
- Work with the system around the client: crisis plans, admissions policy and team splits
- Hold staff dynamics: splitting, burnout and the pull to reject
- Evaluate long-term outcomes and argue for realistic, hopeful expectations
- Deliver MBT with severe and comorbid personality difficulty over full treatment arcs

- Run MBT groups: mentalizing the group process itself, not just members serially
- Apply MBT adaptations, including for antisocial presentations and adolescents, at awareness level
- Supervise for mentalizing: spotting and repairing therapist non-mentalizing
- Maintain the model under service pressure, and know what fidelity requires
- Weigh the MBT evidence base and its comparative standing honestly
- Apply the IPTF to personality-organised difficulty, where integration earns its keep
- Formulate personality structure, defences and relational patterns across modality languages
- Sequence long-term work: stabilising, understanding, recovering and implementing, revisited as needed
- Hold coherence under complexity: crises, comorbidity and systemic pressures
- Supervise and mentor others in disciplined integrative practice
- Contribute to the framework itself: evaluate, refine and document what works

PART 1

The IPTF: Foundations

Understanding the Integrated Personality Treatment Framework

CHAPTER 1

The problem the IPTF exists to solve

The mental health landscape in the United Kingdom has, for many decades, been characterised by a paradoxical mixture of ambition and fragmentation. On the one hand, the National Health Service and a growing private sector have invested heavily in evidence-based interventions such as Cognitive Behavioural Therapy (CBT), Psychodynamic Psychotherapy, and Acceptance and Commitment Therapy. On the other hand, the organisational structures that deliver these interventions have often been arranged in silos, each service aligning itself with a single therapeutic tradition and, consequently, a narrow diagnostic remit. This silo-based architecture has produced a pattern of exclusion that is especially evident when clinicians encounter complex presentations – for example, individuals whose difficulties span personality disorder, severe trauma, chronic substance misuse, and co-occurring mood or anxiety disorders. In such cases, the client does not fit neatly into the diagnostic categories that underpin the funding streams and referral pathways of many single-modality services. The result is a system that is, more often than not, crisis-driven, with contact that is sporadic, reactive, and fragmented rather than restorative and continuous.

The consequences of this fragmentation are profound. When a client is shuffled between services that each claim expertise in a particular modality, the therapeutic relationship, one of the most robust predictors of outcome across modalities (Wampold, 2015), is repeatedly interrupted. Each transition brings a new set of expectations, assessment tools, and therapeutic languages, which can erode trust and increase the sense of being misunderstood. Moreover, the administrative burden associated with multiple referrals and repeated assessments can consume valuable therapeutic time, leaving less room for the client's lived experience to be explored. Research on continuity of care points the same way, if less firmly than is often assumed: in a systematic review, 13 of 18 studies found continuity associated with at least one outcome, but the results for hospitalisation, symptoms and satisfaction conflicted, and only those for social functioning were encouraging (Puntis et al., 2015).

A further, and perhaps more insidious, problem lies in the reliance on

single-modality answers to complex clinical presentations. While CBT, for instance, has a robust evidence base for anxiety disorders and depression (Hofmann et al., 2012), its protocol-driven nature can become restrictive when a client's needs evolve beyond symptom reduction to include relational repair, identity reconstruction, or the integration of traumatic memories. Psychodynamic approaches, celebrated for their depth of relational insight, may be less efficient when a client requires immediate skill acquisition for emotion regulation. Reviews of what works for whom, such as that of Roth and Fonagy (2005), underscore that no single modality can address the full spectrum of human suffering, especially when comorbidity is the rule rather than the exception. Consequently, a therapist who adheres rigidly to one school of thought may inadvertently underserve the client by ignoring the dynamic interplay of symptoms, strengths, and contextual factors that shift over time.

The Integrative Psychotherapy Treatment Framework (IPTF) was conceived precisely to bridge this gap. Rather than positioning itself as a new therapeutic technique, the IPTF is a meta-theoretical scaffold that organises treatment around the stages of recovery that any client traverses, irrespective of diagnostic label. This stage-wise perspective draws inspiration from the dialectical model of Marsha Linehan (1993), which delineates a progression from safety and skill building to emotional processing and finally to life-valued direction. It also incorporates the integrative principles articulated by John Norcross and colleagues (Norcross & Wampold, 2011), who conclude that adapting the therapy relationship to the individual client, and not to the diagnosis alone, enhances the effectiveness of treatment. By viewing recovery as a journey through three identifiable stages (stabilisation and safety, cognitive mapping and schema work, and functional recovery), the IPTF provides a common language that can be shared across services, reducing the need for repeated re-assessment and re-orientation.

At the heart of the IPTF is the recognition that each stage of recovery carries its own therapeutic priorities and, consequently, its own optimal set of interventions. In Stage One, stabilisation and safety, for example, the primary goal is to establish safety, both internally and externally. Empirical support for this phase is found in the work of Cloitre et al. (2010), who found that women with PTSD related to childhood abuse who received skills training in affect and interpersonal regulation before exposure were more likely to

achieve sustained remission than those who received supportive counselling before the same exposure. During this phase, techniques drawn from Dialectical Behaviour Therapy (DBT) – such as mindfulness, distress tolerance, and interpersonal effectiveness – are often most appropriate, regardless of the client's primary diagnosis. As Stage One proceeds, the therapeutic focus shifts to consolidating coping strategies, and interventions may incorporate CBT-based psychoeducation, behavioural activation, or exposure hierarchies, depending on the presenting symptoms.

When the client reaches Stage Two, cognitive mapping and schema work, the therapeutic emphasis turns to the exploration of underlying narratives, attachment patterns, and core beliefs. Here, psychodynamic formulations, narrative therapy, and schema-focused work become salient, as they allow the client to integrate fragmented aspects of self-experience into a coherent story. Finally, Stage Three, functional recovery, supports the client in applying the gains made in therapy to real-world contexts – employment, relationships, community participation – and may involve solution-focused brief therapy, occupational therapy, or collaborative case management. By aligning the choice of modality with the client's stage of recovery, the IPTF ensures that the therapist is not constrained by allegiance to a single school, but rather is guided by a principled, evidence-based map of therapeutic priorities.

Operationalising such a comprehensive framework requires more than a theoretical textbook; it demands a practical companion that translates abstract stage concepts into concrete therapeutic actions. The IPTF manual fulfils this role. Structured as a step-by-step guide, the manual provides detailed session outlines, suggested interventions, assessment checkpoints, and decision-making algorithms that correspond to each stage of recovery. It is not a prescriptive checklist that forces therapists into a rigid protocol; rather, it offers a flexible toolkit that can be adapted to the nuances of each client's presentation. For example, in the stabilisation phase, the manual outlines a hierarchy of grounding techniques, from simple breathing exercises to more elaborate sensory-based interventions, and includes guidance on how to assess the client's readiness to progress to the next stage using measures such as the PHQ-9 and GAD-7 in conjunction with functional outcome scales.

To illustrate the practical utility of the IPTF, consider the case of Maya, a

32-year-old woman who presented to a community mental health team with a history of complex childhood trauma, borderline personality features, and a recent episode of severe depressive relapse. Maya's initial assessment revealed pervasive emotional dysregulation, self-harm behaviours, and a pervasive sense of emptiness. In a traditional single-modality service, Maya might have been referred exclusively to a DBT programme, which, while effective for emotion regulation, would have left her underlying trauma narratives largely unaddressed. Alternatively, a psychodynamic service might have focused on exploring early attachment wounds without first establishing the safety required for such work, risking overwhelming Maya and precipitating a crisis.

Applying the IPTF, the therapist first identified that Maya was in the stabilisation stage. The manual directed the therapist to prioritise safety planning, teach mindfulness-based distress tolerance skills, and implement a structured daily routine. Over the course of eight weeks, Maya's self-harm episodes decreased from daily to weekly, and her PHQ-9 score fell from 18 to 12, indicating a meaningful reduction in depressive severity. With these gains, the therapist consulted the IPTF decision-making algorithm, which suggested that Maya was ready to consolidate her skills within Stage One. The manual then recommended integrating CBT-based behavioural activation, encouraging Maya to schedule pleasurable activities and gradually re-engage with her part-time job. As Maya's functional capacity improved and she met the criteria of the Stage One gate, the therapist introduced schema-focused work to address her entrenched belief that she was unlovable, a belief that had been reinforced by early trauma.

By the time this work reached processing and restructuring, she demonstrated sufficient emotional regulation to tolerate the affective intensity of trauma-focused exploration. The therapist, guided by the IPTF manual, selected an integrative approach that combined elements of Eye Movement Desensitisation and Reprocessing (EMDR) with psychodynamic relational work, allowing Maya to process traumatic memories while simultaneously exploring the impact of those memories on her current relationships. Over the subsequent twelve weeks, Maya reported a marked reduction in intrusive memories, a more stable sense of self, and an increased capacity to form secure attachments.

Maya's trajectory exemplifies how the IPTF resolves the problem of

fragmentation by providing a coherent, stage-wise roadmap that aligns therapeutic interventions with the client's evolving needs. Rather than being bounced between services that each claim expertise in a single modality, Maya experienced a seamless continuum of care, with each phase building upon the previous one. The manual's role as an operational companion ensured that the therapist could navigate the complexities of each stage without resorting to ad-hoc improvisation, thereby preserving the therapeutic alliance and enhancing treatment fidelity.

The broader implication of the IPTF's solution is that it offers a blueprint for restructuring mental health services to be more inclusive and responsive. By adopting a stage-wise framework, services can design integrated pathways that allow clients to remain within a single therapeutic home while accessing a diverse repertoire of interventions. This reduces the administrative burden of multiple referrals, diminishes the risk of therapeutic ruptures, and aligns service delivery with the evidence that recovery is a non-linear, multidimensional process. Moreover, the IPTF's emphasis on evidence-based stage matching resonates with the growing policy focus on personalised care, as set out in the NHS Long Term Plan, which makes personalised care, based on what matters to people and on their individual strengths and needs, standard practice across the health and care system (NHS England, 2019).

In summary, the problem that the IPTF exists to solve is the entrenched fragmentation and exclusion that arise from traditional, single-modality service models. Single-modality answers, while powerful within their domain, are insufficient for the complex, comorbid presentations that dominate contemporary mental health caseloads. By organising treatment around the stages of recovery, the IPTF provides a flexible, evidence-informed scaffold that enables therapists to draw from the full spectrum of therapeutic modalities at the moment they are most needed. The manual, as the operational companion to the theoretical textbook, translates this scaffold into actionable guidance, ensuring that the principles of the framework are realised in everyday clinical practice. Through this integrative, stage-wise approach, the IPTF promises to reduce service fragmentation, enhance therapeutic continuity, and ultimately improve outcomes for those whose suffering has long been underserved by the existing mental health infrastructure.

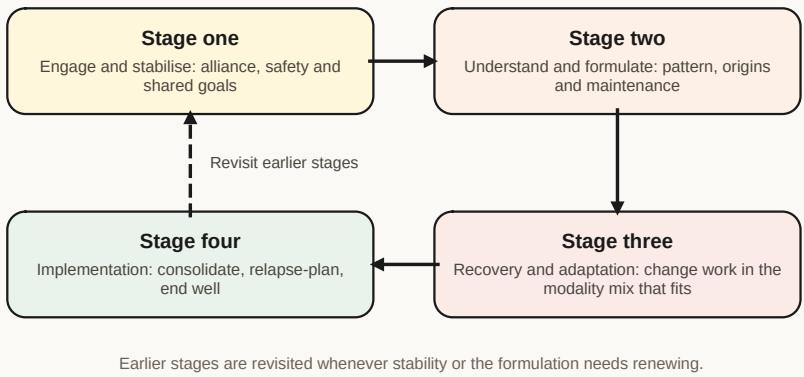


FIGURE 1.1 The IPTF pathway at a glance

The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- Fragmentation and exclusion in traditional services
- Why single-modality answers underserve complex presentations
- Treatment organised by stage of recovery
- The manual as the operational companion to the textbook

PRACTICE TASK

Write a short reflection on one person a service has failed, and which stage of care was missing.

CHAPTER 2

The three stages at a glance

Every later course in this pathway examines one part of the arc in detail, and detail is only useful inside a map you already hold. This lesson walks the whole arc once, deliberately at altitude, so that when you descend into stage-specific practice you always know where you are, what came before, and what the current work is preparing the person for. The Integrative Psychotherapy Treatment Framework (IPTF) is not a linear ladder to be climbed, but an arc of development that must be traversed in order. You cannot build a house on a foundation that has not yet been laid, and you cannot perform deep cognitive restructuring on a nervous system that is in a state of physiological alarm. Understanding the three stages—stabilisation, cognitive mapping, and functional recovery—is therefore the prerequisite for all subsequent clinical work. It provides the context for every intervention, every formulation, and every decision you will make as a therapist. Without this altitude view, you risk treating the symptoms of a complex presentation with the tools of a simple one, or conversely, overwhelming a person who is not yet ready for the depth of the work.

Stage One is stabilisation and safety. Its primary aim is not insight and certainly not character change; it is to create a life steady enough for therapy to be possible at all. In this stage, the person is often navigating a world that feels chaotic, threatening, or simply overwhelming. The targets are concrete and behavioural, organised hierarchically to address the most immediate threats first. The first target is life-threatening behaviour, such as suicidal ideation, self-harm, or substance misuse that endangers physical safety. The second target is behaviour that threatens the treatment itself, such as frequent missed sessions, aggression towards the therapist, or an inability to engage with the therapeutic process. The third target is the acute instability of mood, impulse, and crisis that makes every week feel like an emergency. The delivery structures in Stage One are correspondingly structured and skills-led, drawing heavily on the evidence base of Dialectical Behaviour Therapy. This involves a skills curriculum that explicitly teaches Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. The individual therapy strand applies these skills directly to the person's actual

week, breaking down complex emotional experiences into manageable components. There is also a crisis pathway with a written safety plan that has been rehearsed in session rather than merely filed away. The clinical stance in Stage One is active, warm, and unashamedly practical. The person is often drowning; the first task is to build a raft, not to teach them how to swim or to draw a map of the currents. The relationship here is the lifeline, providing the co-regulation that the person's own system lacks.

Stage Two is cognitive mapping and schema work, and it begins only when the stage-gate criteria say the person is ready, a discipline the end of this lesson returns to. The aim shifts from managing states to understanding and revising the patterns that generate those states. The work draws on the cognitive behavioural treatment of personality disorder and on schema-focused therapy. This involves a collaborative history that traces where the person's core beliefs about self and others were learned, often in early attachment relationships. The therapist helps the person identify the schemas and modes that organise their present difficulties, such as the 'Detached Protector' or the 'Vulnerable Child'. The mapping process involves tracing how these patterns fire in current relationships, including the therapeutic one, and identifying the specific triggers and early maladaptive schemas that are activated. Once the patterns are mapped, the work moves to the slow, deliberate process of processing and restructuring. This involves testing old conclusions against present evidence and building new responses through behavioural experiments. Mentalisation-Based Treatment contributes its characteristic discipline of slowing down interpersonal moments until the mental states inside them become visible, allowing the person to see the gap between their internal experience and the external reality. Stage Two is where the deepest change happens, and it is also where the strongest affect surfaces, which is precisely why it waits for the stability Stage One builds. You cannot heal a wound that is still bleeding.

Stage Three is functional recovery and identity consolidation. Its premise is that symptom reduction is not the same as a life. The aims are occupational and educational re-engagement, the building and repair of relationships outside services, the consolidation of an identity that is larger than the patient role, and a planned, gradual ending that the person experiences as graduation rather than abandonment. The delivery structures loosen to match the increased capacity of the person. Sessions typically space out, the agenda tilts from managing problems to working on projects, and

relapse planning treats future difficulty as expectable weather rather than as a failure. The person is no longer defined by their pathology; they are now defined by their aspirations and their relationships. Stage Three is the least protocolised stage and the most easily neglected, and services that neglect it buy symptom improvement that does not survive contact with an empty diary. A person may feel better, but if they have no job, no friends, and no sense of who they are outside of therapy, they are at high risk of relapse when the structure of the sessions is removed.

The stage-gates are the framework's discipline, and they answer the question every service struggles with: when does someone move on? Progression in the IPTF is by readiness, never by calendar. A person moves from Stage One when the behavioural criteria are met and sustained. This means a defined period without life-threatening behaviour, demonstrated use of skills in real crises, and an alliance that is stable enough to survive rupture. They move from Stage Two when the mapping work has produced not just insight but measurable change in the patterns themselves. The gates work in both directions, and this is the part services find hardest: a person in Stage Two who re-enters sustained crisis returns to Stage One work without shame or ceremony, because the stages describe the work currently needed, not a ladder of moral progress. Holding the gates honestly protects people from both of the classic service failures, being pushed on before they are ready and being held back after they are.

To make this concrete, consider the case of a man of twenty-eight who enters the framework at Stage One. He presents with weekly self-harm, two jobs lost in a year due to walked-out shifts, and a relationship maintained by alternating crisis and reconciliation. The Stage One work is intensive. He learns chain analysis to understand the antecedents of his self-harm, and he practises distress tolerance skills like ice-dive and paced breathing during moments of intense rage. A rehearsed safety plan is created, and he practises using it when he feels overwhelmed. Six months later, he reaches the first gate with nine clean weeks, having survived two minor crises by using the skills he learned. The alliance has weathered his fury at a cancelled session, proving it is robust enough to hold the difficult work ahead. Stage Two opens the history. He traces his early life to a father whose affection arrived only after storms, leading to the conclusion that calm means invisibility. The mapping identifies a specific loop: Provoke, Reconcile, Briefly Matter. Imagery rescripting and behavioural experiments spend months

revising this loop; his partner attends two sessions so the experiment can run where it counts. At the second gate, he can catch the loop mid-firing and choose, most weeks, to stay visible without a storm. Stage Three rebuilds outward. He enrols in a part-time qualification, builds the first friendship since school that is not organised around rescue, and sessions space out to monthly. An ending is planned for a named month and marked as graduation. Nothing in the sequence is exotic; every element will be taught in detail in the courses ahead. What the example shows is the grammar of the framework, each stage answering its own question, each gate demanding evidence, the relationship carried unbroken across the whole arc.

Two consequences of the staged design deserve naming before you descend into detail. First, assessment in this framework is continuous rather than episodic: every stage transition is an assessment decision, so the formulation you will learn to build in the next module is a living document, revisited at every gate. Second, the therapeutic relationship is the constant that carries the person across every transition; the work changes, the frame holds. Sketch the arc for yourself before moving on, one aim and one delivery structure per stage, and check it against this lesson. That sketch, refined by everything that follows, is the map you will practise from.

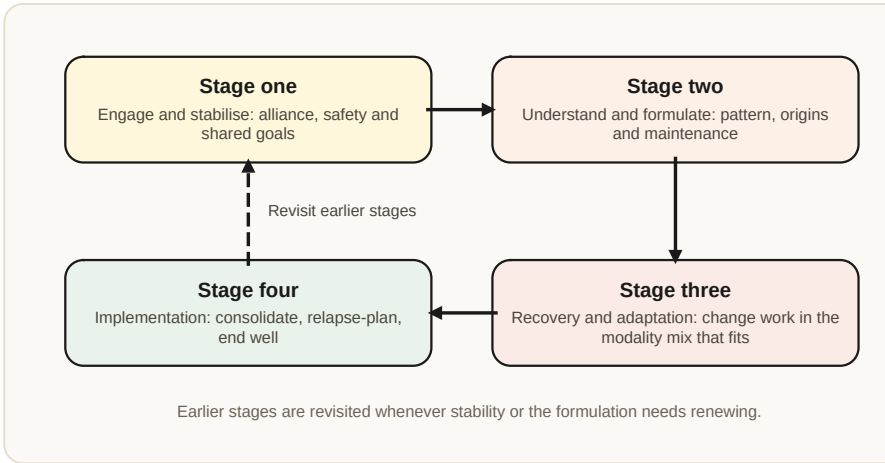


FIGURE 2.1 The IPTF pathway at a glance
The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- Stage 1: stabilisation and safety
- Stage 2: cognitive mapping and schema work
- Stage 3: functional recovery and identity consolidation
- Stage-gates: progression by readiness, not calendar

PRACTICE TASK

Sketch the three stages from memory with one aim and one delivery structure each.