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2 Moving from risk to resilience in psychosis research
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Abstract

Psychosis research has traditionally focused on vulnerability and the detrimental outcomes of risk exposure. However, there is substantial variability in psychological and functional outcomes for those at risk for psychosis, even among individuals at high risk. Comparatively little work has highlighted the factors associated with resilience and the processes that might avert serious mental illness and promote positive outcomes. In this Review, we first discuss the prevailing risk-based approach to psychosis. We then outline a resilience-based approach by defining multisystemic mental health resilience and considering what constitutes a positive outcome. Based on this background, we examine evidence of biological, psychological, social and environmental protective and promotive factors that might confer resilience in the context of psychosis risk. A greater understanding of the factors and processes implicated in resilience has the potential to inform psychosis intervention and prevention efforts at multiple levels, including individuals, institutions, and policy.

[H1] Introduction

Psychotic disorders, including schizophrenia, are characterized by signs of departure from consensus reality, for example, hallucinations and delusions. This departure is often accompanied by disorganization of thought and behavior and diminished expressivity and motivation. The impact of psychotic disorders, and the discrimination and marginalization that occur in their wake, are tremendous. People diagnosed with schizophrenia have a lower life expectancy in Western countries¹, higher rates of homelessness worldwide²⁻³, and drastically reduced quality of life⁹ compared to those without a diagnosis of schizophrenia.

Psychotic disorders were historically viewed as irreversible and progressively deteriorating conditions that were inevitably associated with poor outcomes and disability¹⁰. However, in the past 30 years a more optimistic paradigm focused on psychosis prevention has emerged¹¹⁻¹³. To this end, there has been a massive effort to identify factors that increase an individual's risk for developing a psychotic disorder, with the hope that targeted interventions might prevent or delay onset. Individuals seeking mental health treatment who are identified as at high-risk for psychosis show markedly increased rates of developing a psychotic disorder, relative to lifetime incidence rates in the general population¹⁴. However, around two-thirds of help-seeking at-risk individuals are never diagnosed with a psychotic disorder¹⁵, and around 40% remit from high-risk status after 3 years¹⁶. These findings dovetail with the variability in clinical trajectories of individuals diagnosed with psychotic disorders—although many have poor long-term outcomes, over 50% show extended periods of recovery¹⁷⁻²¹. These data suggest the presence of internal and/or external assets and resources that can be leveraged to avert serious mental health symptoms in people with or at high-risk for psychotic disorders.

There has been comparatively little work examining those factors that might promote multifaceted positive outcomes in the face of psychosis risk. Understanding the factors that buffer against risk will help elucidate the etiological heterogeneity observed in individuals at-risk for psychosis and offer mechanistic insights into why many of them do not experience negative outcomes. Furthermore, identifying modifiable protective and promotive factors can provide important malleable targets for clinical treatments, and intervention strategies based on resilience can complement those designed to eliminate preventable risks²². Thus, a greater focus on resilience in the context of psychosis risk is critical for advancing the field and promoting therapeutic discovery²³.

In this Review, we first briefly summarize the literature on risk factors for psychosis and then describe the strengths and drawbacks of a purely risk-based approach. Next, we present modern conceptualizations of mental health resilience and consider what constitutes a positive outcome. Finally, we describe the factors that might confer resilience in the context of psychosis risk and conclude with recommendations for future directions. Although we focus on psychosis, many of the factors we identify throughout the Review are transdiagnostic and might convey risk and resilience for a host of psychopathological disorders.

[H1] The risk-based approach to psychosis

Converging evidence supports a diathesis-stress etiological model of psychotic disorders, whereby genetic risk interacts with social and environmental stressors to influence the development of symptoms²⁴⁻²⁶. There is strong evidence for a genetic contribution to the onset and maintenance of these disorders. Having a first-degree relative with a serious mental illness is one of the most well-established risk factors for psychosis. In a study of over 30,000 twin pairs spanning 50 years, concordance rates of schizophrenia were approximately 33% in monozygotic twins with an estimated heritability of 73% for schizophrenia-spectrum disorders²⁷.

102 Having a parent with a serious mental illness also increases risk for psychosis: a meta-analysis
103 of 33 studies showed that the children of parents with serious mental illness were 6.5 times
104 more likely to develop schizophrenia than the children of parents without serious mental
105 illness²⁸. Genome-wide association studies have also identified specific genes that confer
106 greater risk for psychosis, with one report detecting 10 gene variants with odds ratios ≥ 3.0 for
107 the development of schizophrenia²⁹. Variations in *GRIN2A*, a glutamate receptor, and *SP4*,
108 involved in transcription regulation, have been implicated in multiple reports as carrying greater
109 risk for psychosis and for developmental disorders such as autism^{29,30}.

110 In terms of non-genetic risk factors, the earliest stressors might occur during prenatal and
111 perinatal periods^{31,32} and include maternal infection, medical conditions, experiencing stress
112 during pregnancy, and complications during pregnancy or delivery. In early childhood, a variety
113 of factors (such as early hearing impairments³³, communication deviations in parents³⁴, and
114 delays in sitting, standing, or walking independently³⁵) have also been associated with
115 increased risk. These early behavioural risk factors might be secondary to prenatal and
116 perinatal environmental risk exposure.

117 Social and environmental risk factors during late childhood and more proximally to illness onset
118 (typically in late adolescence and early adulthood) have been summarized and evaluated in
119 several meta-analyses³⁶ and reviews^{32,36,37}. One prominent risk factor during this period is
120 childhood trauma, which has been consistently found at high rates among individuals who later
121 develop psychosis^{38,39}. There is also extensive evidence that stressful life events in adulthood
122 are associated with an increased risk for subclinical psychotic symptoms and a psychotic
123 disorder diagnosis⁴⁰. In the past decade, there has been increased focus on the role of
124 discrimination as a risk factor for psychosis. Higher rates of subclinical psychotic symptoms,
125 psychotic experiences, and psychotic symptoms have been found in individuals from
126 communities that have been marginalized on the basis of race and ethnicity^{41,42} as well as in
127 sexual and gender minority communities⁴³, and structural racism in the United States has been
128 explicitly linked with psychosis risk⁴⁴. Finally, the environment where one lives and who inhabits
129 those spaces plays an important role in the development of psychosis. A meta-analysis of eight
130 studies and nearly 46,000 people found that the risk for schizophrenia was 2.37 times higher in
131 urban areas than in rural environments⁴⁵. Exposure to such environmental stressors might
132 account for the widely replicated finding of increased stress-sensitivity in individuals with
133 psychosis^{46,47,48}. Here stress sensitization, whereby the response to some environmental
134 stressor increases in intensity with repeated exposures, transpires and results in enduring
135 alterations in stress-sensitivity.

136 This vast body of evidence describing factors that are associated with an increased risk of
137 psychotic disorder onset has contributed to the development of mental health policies and
138 practices that emphasize the importance of reducing the burden of these disorders in the
139 population^{49,50}. Over the past 30 years the clinical high-risk paradigm¹³, which aims to identify
140 individuals in the prodromal phase of a psychotic disorder as part of a preventative approach,
141 has been the major focus within psychosis research. Current criteria define individuals at clinical
142 high-risk as those who have either attenuated psychotic symptoms, full psychotic symptoms for
143 a brief period, or substantial genetic risk paired with functional decline. Formal risk calculators
144 have been created to enhance prediction of which individuals identified at clinical high risk will
145 transition to psychosis^{51,52}. These enhanced predictive models represent an important strength
146 of risk-based approaches. Moreover, studies of risk can also help quantify how much risk is
147 conveyed by specific factors. For example, according to meta-analyses the odds of
148 experiencing childhood trauma is almost 3 times higher³⁷ and the odds of perceived
149 discrimination is almost twice as high⁴⁰ among individuals who later develop psychosis

150 compared to controls. A risk-based approach also has important clinical implications for help-
151 seeking youth. Early identification permits both preventative care and intervention earlier in the
152 course of illness. This is important because shorter durations of untreated psychosis are
153 associated with better prognosis post-diagnosis^{53,54} (but see⁵⁵), and reducing the duration of
154 untreated psychosis is a major emphasis of treatment programs. Finally, identifying individual
155 risk factors can enable increased personalization of treatment on the basis of specific risk
156 exposure. Thus, a focus on risk factors sets the groundwork for treatment development and
157 treatment targets, usually aimed at eliminating preventable risks.

158 Despite these strengths, relying solely on a risk-based approach for psychosis, where risk is an
159 event or context that is directly associated with poor outcomes, has several shortcomings⁵⁶. For
160 example, relying solely on risk might lead to over-prediction of risk⁵⁷ and, accordingly,
161 suboptimal treatment planning such as excessive or unnecessary interventions. Indeed, up to
162 70% of people identified as high-risk do not develop a psychotic disorder within three years^{14,58-}
163 ⁶⁰. This percentage is even higher in studies that use broader recruitment strategies, resulting in
164 samples that are less biased towards help-seeking individuals with more severe subclinical
165 symptoms⁶¹⁻⁶⁷. Furthermore, opportunities to develop novel treatments might be limited given
166 that the risk factors that have received the most robust support (for example, subclinical
167 psychotic experiences and genetic risk) do not easily lend themselves to therapeutic innovation.
168 Indeed, meta-analytic findings indicate that no specific preventative interventions have yet been
169 identified^{13,68}. In addition, an exclusive focus on risk and deficits might exacerbate the stigma
170 associated with psychosis^{69-71,72,73}, which is itself linked to poor mental health outcomes^{74,75}.

171 Finally, a risk-based perspective spotlights vulnerability and fails to consider the possibility that
172 individuals who are highly sensitive to negative contexts might also be most responsive to the
173 enhancing effects of positive contexts—a pattern described by the differential susceptibility
174 model⁷⁶. That is, individuals at high-risk for psychosis might also be particularly sensitive to the
175 beneficial effects conferred by internal and external resources and assets. A large population-
176 based study showed that individuals with high levels of childhood adversity had more dramatic
177 changes in mental health during adulthood as a function of both increases and decreases in life
178 stress across the lifespan compared with individuals with low levels of adversity⁷⁷. These
179 findings suggest that childhood adversity might function as a differential susceptibility factor that
180 increases responsiveness to both negative and positive contexts later in life.

181 In sum, the transition rates of high-risk individuals are higher than incidence rates of psychotic
182 disorders in the general population and therefore a risk-based approach is useful for identifying
183 individuals who will develop a disorder. But an approach purely focused on negative outcomes
184 neglects valuable information about what is protecting those at high-risk from developing
185 psychotic disorders or other severe mental health outcomes and—perhaps more importantly—
186 what helps people function and thrive despite risk factors^{78,79}. Risk-based approaches can be
187 complemented by resilience-based approaches that focus on the access to resources and
188 cultivation of assets and strengths that help people weather atypical risk in ways that yield
189 positive outcomes.

190

191 **[H1] The resilience-based approach**

192

193 In this section, we define resilience and discuss the challenges in defining positive outcomes in
194 the context of psychosis. Modern research on human resilience originated largely from the child
195 development literature that aimed to identify factors that lead to positive adaptation despite early
196 adversity. We provide relevant background bridging the gap between this developmental
197 literature and the interpretation and contextualization of resilience factors in psychosis.

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[H2] Defining resilient processes.

Resilience is the process by which a system (an individual, a community, or a biological entity) fares better than expected given exposure to some risk or adversity that threatens functioning^{22,80,81}. Central to this definition is that resilience is a process—not a stable trait—in which protective and promotive factors support recovery, persistence, resistance, or adaptation (**Figure 1**). Furthermore, because human development across the lifespan transpires within a set of interacting systems⁸², individual resilience is inherently multisystemic⁸³. Specifically, human resilience can be conceptualized as a network of protective and promotive factors that confer positive outcomes and span multiple interacting subsystems or levels ranging from individual biology (such as genes) to the natural environment (such as green space)⁸³.

Resilience can only be studied in the context of risk or adversity. In the context of psychosis, risk might refer to factors that increase the chance of a psychotic disorder diagnosis, the experience of those symptoms (for example, experiencing persistent hallucinations might be a source of psychological distress⁸⁴), or secondary factors that might emerge after a diagnosis of psychotic disorder (for example, poor physical health or discrimination^{85,86}). Vulnerabilities and protective factors moderate the impact of risk and lead to outcomes that are worse or better than expected, respectively (**Box 1**). That is, a vulnerability factor intensifies the maladaptive outcomes in response to risk exposure and a protective factor reduces them⁸⁷. Note that the terms ‘vulnerability factors’ and ‘protective factors’ refer to the mechanisms by which these factors exert their effects on a specific set of outcomes given a specific risk⁸⁸. That is, vulnerability factors are not inherently bad and protective factors are not inherently good. Protective factors are distinguished from promotive factors. Promotive factors are associated with positive outcomes regardless of risk exposure; promotive effects are indicated by a main effect of a particular factor on a positive outcome measure. By contrast, protective factors are associated with positive outcomes in a risk-dependent manner and are indicated by an interaction effect, where the magnitude of association between the factor and the positive outcome is moderated by risk status. For example, social support would be considered a protective factor in the context of psychosis risk if it showed a stronger association with positive outcomes in young adults at clinical high-risk for psychosis than in a population sample of young adults; however, social support would be considered promotive if it was associated with positive outcomes regardless of clinical high-risk status.

[H2] Defining positive outcomes.

In the context of mental health, positive outcomes include functioning that aligns with or exceeds developmental or contextual norms. Defining a positive outcome that is indicative of a resilient process is challenging for several reasons. First, positive outcomes are multifaceted and include both developmental competence (for example, academic and occupational achievement, interpersonal competence, completing developmental milestones) and mental health⁸⁹. Importantly, although a person might exhibit resilience in some aspects of functioning or mental health, few people are resilient in all domains⁹⁰. Longitudinal studies of recovery in people with schizophrenia have revealed that positive functional outcomes (such as increased community integration) are independent of mental health outcomes such as reduced depression⁹¹. There is further nuance within psychological health, which entails both subjective well-being and the absence of distress or diagnosis⁹²⁻⁹⁶. Indeed, well-being and psychopathology are not two sides of the same coin. For example, some teens exhibit high well-being despite significant psychopathology; others conversely exhibit low well-being without significant psychopathology⁹². Positive mental health outcomes in the context of psychosis risk go beyond the absence of distress or formal diagnosis and measurements should include all dimensions of psychological health.

249
250 Second, who defines a positive outcome is shaped by power dynamics⁹⁷ and which individuals
251 or systems benefit from a particular outcome must be carefully considered. The priorities of the
252 health care systems, clinical care providers, and families might not always overlap with the
253 priorities of the individual with psychosis. Research in psychosis prevention and recovery has
254 traditionally focused on the absence of clinical psychotic symptoms and identifying the factors
255 that prevent, delay, or reduce psychosis. This narrow definition diverges from the richer
256 qualitative and psychosocial descriptors of well-being in individuals with psychotic disorders,
257 whereby personal recovery is not necessarily contingent on clinical recovery⁹⁸⁻¹⁰¹. To individuals
258 seeking treatment, symptom remission alone might be insufficient to achieving a positive
259 outcome. Rebuilding or regaining a meaningful life is central to recovery from psychosis,
260 together with symptom management. Qualitative studies suggest that some positive changes at
261 individual, interpersonal, and spiritual levels can occur for many individuals and their caregivers
262 after the first episode of psychosis, despite broadly negative experiences¹⁰². Furthermore, a rich
263 literature in phenomenological psychiatry has highlighted that some aspects of psychosis, which
264 are considered to be a clinically negative outcome, might in fact provide an individual with
265 meaning and relief and thereby confer resilience. An illuminating example is the case of
266 delusions (**Box 2**).

267
268 Although objective and subjective indicators of well-being and quality of life are increasingly
269 being used as outcome measures in psychosis research¹⁰³, frequently used scales might not
270 align with the qualitative descriptions provided by mental health service users¹⁰⁴. Taken
271 together, current metrics of positive outcomes might not fully capture the heterogeneity of
272 individual experience. Whilst efforts to quantify outcomes into categories and metrics are
273 pragmatic and valid solutions to capturing subjective illness experiences, much is lost in the
274 process. The result is that the vast scope and richness of meaning embedded in the internal
275 landscape of individuals with psychosis-spectrum conditions are reduced to impoverished
276 ratings that obscure the phenomenology of lived experience.

277 278 **[H1] Resilience factors for psychosis**

279 Meta-analyses have highlighted a striking dearth of studies investigating the factors that lead to
280 positive mental health and functional outcomes despite psychosis risk^{105,106}. In this section, we
281 review potential promotive and protective factors in the context of psychosis risk with the
282 aforementioned limitations and challenges in defining positive outcomes in mind. Protective and
283 promotive factors are identified as those for which increased levels lead to increases in positive
284 outcomes. We include potential protective and promotive factors that: decrease the chances of
285 being diagnosed with a psychotic disorder in individuals at clinical high-risk and in general
286 population samples; promote well-being and daily functioning and reduce relapse in individuals
287 diagnosed with a psychotic disorder; and distinguish individuals experiencing psychotic
288 symptoms that do and do not require care (such as those for whom auditory hallucinations
289 cause impairment or disability versus those for whom auditory hallucinations are not distressing
290 and often perceived to have a positive impact^{84,107}).

291
292 The reviewed promotive and protective factors (**Table 1**) are organized by interacting levels of a
293 biopsychosocial-ecological system that supports resilience of an individual (**Figure 2**). We
294 include distal factors that might precede the onset of psychosis (for example, those occurring in
295 childhood) as well as factors that would be expected to play a proximal role in promoting
296 positive outcomes and buffering against more immediate risks (for example, current health
297 behaviors). We recognize that these factors do not necessarily fit neatly into one level but rather
298 behave as a cross-level system and are expected to exert their effects via their interactions⁸³
299 (**Box 3**). Finally, this review of resilience factors is not exhaustive but is intended to provide an

300 overview to identify trends and offer a basis for future work. Across categories the factors
301 reviewed were chosen based on the breadth of the evidence base (factors that were identified in
302 only a single study are not included). We furthermore focused our review on modifiable factors,
303 which likely have more proximal clinical implications. For a broader discussion of biological
304 resilience factors see ref³¹ for a review of prenatal and perinatal factors and refs^{108,109} for
305 reviews of neuroimaging findings.

306 [H2] Biological factors

307 In this section, we focus on three potentially modifiable protective and promotive factors at the
308 biological level: sleep, physical activity, and homeostatic regulation of the autonomic nervous
309 system.
310

311
312 Better sleep quality is associated with better mental health and well-being in the general
313 population¹¹⁰, particularly among young adults¹¹¹, and interventions to improve sleep quality
314 decreased paranoia and hallucinations in college students with psychotic-like symptoms¹¹².
315 However, sleep quantity has a non-linear relationship with mental health. Although sleep
316 deprivation can precede the onset of psychosis¹¹³ and is associated with impaired cognitive
317 function and reduced physical and mental well-being¹¹⁴, excessive sleep quantity is associated
318 with increased depression and negative affect¹¹⁵. It is therefore possible that there is an optimal
319 amount of sleep that confers mental health benefits in the context of psychosis risk; however,
320 these optimal sleep parameters still need to be determined.

321 Physical activity also promotes mental health benefits in the general population¹¹⁶⁻¹¹⁸ even at
322 lower levels of intensity¹¹⁹⁻¹²¹ than the current World Health Organization recommendations¹²²
323 (but see ref¹²³). Physical activity during childhood protects against later psychotic symptoms in
324 children with multiple adverse childhood experiences¹²⁴ and in the general population^{125,126}.
325 Moreover, increased physical activity is associated with increased well-being and functioning,
326 improved cognitive performance, and reduced psychiatric symptoms in those with psychotic
327 disorders¹²⁷⁻¹³¹. Akin to sleep quantity, physical activity has protective and promotive effects at
328 low to moderate, but not high, levels¹³².

329 Finally, homeostatic regulation of the autonomic nervous system in response to moment-to-
330 moment demands might be a biological correlate of adaptive capacity^{133,134}. In individuals with
331 normal cardiac function, higher resting state heart rate variability and respiratory sinus
332 arrhythmia are associated with better emotion regulation^{133,135} and cognitive performance^{136,137},
333 whereas low heart rate variability and respiratory sinus arrhythmia suggest a rigidity of
334 autonomic response and are associated with poor physical^{136,137} and mental health^{135,138}.
335 People with psychotic illness have lower resting state heart rate variability and respiratory sinus
336 arrhythmia compared to controls¹³⁹⁻¹⁴³, and individual differences in heart rate variability and/or
337 respiratory sinus arrhythmia have been associated with emotion regulation¹⁴⁴, psychiatric
338 symptom burden¹⁴², cognitive performance^{143,145,146}, and functioning in this clinical population<sup>142-
339 146</sup>. Notably, these autonomic responses are malleable through biofeedback training¹⁴⁷⁻¹⁵⁰,
340 breathing retraining^{147,150}, mindfulness practice¹⁵¹, and physical exercise^{149,152}. Two studies of
341 heart rate variability biofeedback training in individuals at-risk for psychosis suggest potential
342 benefits to both autonomic activity and clinical symptoms^{153,154}.

343 [H2] Psychological factors

344 The psychological factors that have garnered significant support as potential protective and
345 promotive factors in the context of psychosis risk can be roughly organized into three main

346 categories: traits and personal characteristics; attitudes, cognitions, and orientations; and
347 psychological abilities.

348 [H3] *Traits and personal characteristics*

349 Adaptive coping—a cognitive or behavioral process that has long-term benefits for minimizing
350 stress^{155,156}—is associated with less severe psychotic-like symptoms in both the general
351 population^{157,158} and in at-risk youth¹⁵⁹ and is correlated with reduced symptom severity and
352 increased quality of life in individuals diagnosed with schizophrenia¹⁶⁰⁻¹⁶⁴. One longitudinal study
353 found that adaptive coping at baseline was associated with attenuated clinical symptom severity
354 and better social functioning one year later in youth at high-risk for psychosis, suggesting a
355 causal effect of adaptive coping on outcomes¹⁶⁵. Relatedly, some emotion regulation strategies
356 might also confer resilience in the context of psychosis risk. Trait use of reappraisal strategies,
357 which aim to modify the meaning and impact of emotion-eliciting events, is associated with less
358 severe psychotic-like experiences¹⁶⁶ and protects against the distress of these experiences¹⁶⁷.

359
360 Self-esteem, locus of control, and personality dimensions might also confer beneficial effects.
361 Higher self-esteem is associated cross-sectionally with reduced psychotic and psychotic-like
362 experiences in at-risk youth^{168,169}, improved quality of life¹⁷⁰ and reduced suicidality in individuals
363 diagnosed with schizophrenia¹⁷¹, and protects against distress associated with persistent
364 psychotic experiences¹⁷². Longitudinal studies have shown that baseline self-esteem is
365 associated with a lower likelihood of psychosis onset 3 years later in the general population¹⁷³.
366 Internal locus of control refers to the degree to which an individual feels that they are
367 responsible for their own outcomes and is associated with a number of positive outcomes in the
368 context of psychosis risk. Qualitative studies indicate that individuals experiencing their first
369 episode of psychosis identify loss of control as their primary psychosocial problem¹⁷⁴, and
370 regaining self-efficacy is a major component of recovery¹⁷⁵. In addition, an internal locus of
371 control might buffer the effect of harsh parenting on later psychotic symptoms¹⁷⁶. Among
372 individuals with auditory-verbal hallucinations, the ability to exert volitional control over voices is
373 one of the main characteristics that distinguishes individuals who seek treatment from those
374 who do not^{177,178}. Finally, broad personality domains such as openness, extraversion, and
375 emotional stability (the inverse of neuroticism) protect against the distress surrounding
376 delusional ideas¹⁷⁹. In people with schizophrenia, emotional stability, extraversion, and
377 agreeableness are also related to better subjective quality of life and might buffer against some
378 of the negative impacts of traumatic experiences¹⁸⁰⁻¹⁸².

379 [H3] *Attitudes and orientations*

380
381 In the context of psychosis risk, there are three candidate protective and promotive factors and
382 processes that represent attitudes, cognitions, or orientations that might contribute to positive
383 outcomes: stigma resistance, spirituality and/or religiosity, and meaning-making around unusual
384 experiences. These three factors are a part of a broader category of attitudes and orientations
385 that help people contextualize psychological experiences.

386
387 Public stigma about mental illness, which manifests in negative beliefs and attitudes about
388 people with mental illness and overt discrimination¹⁸³, can result in internalization of those
389 negative attitudes¹⁸⁴. Self-stigma is associated with negative clinical outcomes^{185,186}, whereas
390 the capacity to counteract or be unaffected by stigma (stigma resistance) is related to well-being
391 and quality of life in individuals with psychotic disorders¹⁸⁷⁻¹⁸⁹. Importantly, cognitions about
392 stigma (for example, rejecting stigma as unfair), rather than perceived stigma (for example, the
393 observed level of stigma against people with mental illness) predicted help-seeking in those with
394 psychosis¹⁹⁰. Although more work is needed to evaluate interventions that boost stigma
395 resistance in individuals with schizophrenia, there is evidence that self-stigma reduction
396

397 strategies, such as providing psychoeducation about the illness experience and the
398 consequences of stigma and teaching methods for reducing self-stigmatizing attitudes, can
399 improve psychological outcomes^{191,192}.

400
401 Spirituality generally confers benefits to mental health^{193,194}. Spirituality (commonly defined as
402 “the search for the sacred”¹⁹⁵) is related to self-reported adaptation in the face of adversity
403 among individuals diagnosed with a psychotic disorder¹⁹⁶. Furthermore, sensing the presence
404 of the divine is associated with better social functioning in individuals at clinical high-risk for
405 psychosis¹⁹⁷. Individuals with non-distressing psychotic experiences report being more spiritual
406 (but not religious) than individuals diagnosed with a psychotic disorder or community controls
407 without a history of psychotic experiences¹⁷² and are more likely to ascribe voices to a spiritual
408 being rather than real people¹⁹⁸. Although one interpretation of these findings is that spiritual
409 practices increase the likelihood of hearing voices, qualitative and mixed method
410 phenomenological studies instead suggest that spiritual practices and beliefs generally do not
411 precipitate the onset of voices^{199,200}. Instead, these practices and beliefs play an important role
412 in controlling voices and interpreting the nature of these experiences, thereby buffering against
413 their potential negative impacts.

414
415 The protective and promotive effects of religion are more complex. Although religion often
416 includes spiritual components, they are enacted in the context of a structured system and
417 sanctioned set of beliefs, practices, and rituals¹⁹³. Religion might act as both a vulnerability
418 factor as well as a protective or promotive factor. On the one hand, religious delusions are
419 common in individuals diagnosed with a psychotic disorder²⁰¹, thereby calling into question the
420 role of religious beliefs and practices in symptom etiology. Indeed, some studies have reported
421 relationships between greater religiosity and more severe symptoms and worse functional
422 outcomes in individuals diagnosed with a psychotic disorder^{193,202}. Furthermore, in individuals at
423 clinical high risk, increased participation in religious activities was associated with more severe
424 depressive symptoms¹⁹⁷. On the other hand, religious involvement within a community of
425 believers wherein beliefs and values have been adopted over generations has also been found
426 to confer benefits to mental health¹⁹³. Qualitative studies^{203,204} and data suggesting that religious
427 beliefs protect against suicidal behaviors²⁰⁵ and promote quality of life¹⁹⁶ attest to a possible
428 protective effect of religious beliefs and practices in individuals diagnosed with schizophrenia.
429 The effects of religion on well-being and mental health might depend on cultural influences.
430 Higher rates of religious beliefs and activity are reported among ethnic minority communities in
431 Europe, the United States, and Australia compared to ethnic majority communities, and there is
432 greater use of religious coping in marginalized and/or socially disadvantaged groups²⁰⁶⁻²⁰⁹.

433
434 Expanding beyond the global meaning structures provided by religion and spirituality, personal
435 appraisals of anomalous experiences influence outcomes in individuals with psychosis or
436 psychotic-like experiences. For example, compared to voice-hearers with a need for care, non-
437 treatment seeking voice-hearers often integrate psychotic experiences with their personal
438 context via intra-personal processes or acceptance from others^{210,211}, leading them to ascribe
439 meaning and purpose to the experience. Activities whereby individuals with schizophrenia make
440 sense of symptoms and other illness-related experiences and integrate them into their own
441 personal narratives promote well-being²¹² and are a central aspect of mental health services
442 associated with positive outcomes²¹³. The potential benefits conferred by meaning-making
443 processes are further highlighted by findings from a longitudinal study in India, which found that
444 having insight into one’s mental health condition while also holding non-medical explanations for
445 the illness experience was associated with remission within five years following a schizophrenia
446 diagnosis²¹⁴.

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[H3] Abilities

Psychological abilities that might serve as protective or promotive in the context of psychosis include social competence and neurocognitive abilities. Social competence entails having the skills needed for successful social functioning, which include the ability to verbally and non-verbally communicate with others, to interpret communication from others, and to regulate oneself during social interactions²¹⁵. Social skills training has been found to be protective against relapse in patients with psychosis²¹⁶ and to reduce the risk for and severity of psychotic-like experiences in individuals with a history of adversity^{217,218}

A rich literature suggests that general cognitive functioning (measured using tests of general intelligence) and specific neurocognitive abilities have protective or promotive effects. First, better neurocognitive abilities²¹⁹, particularly verbal fluency, verbal and visual memory, and working memory, are associated with a decreased risk for transitioning to psychosis in high-risk youth^{220,221}. Second, individuals with higher general cognitive functioning and better executive functioning early in the course of illness have a greater chance of a resilient illness trajectory²²². In addition, better general cognitive functioning attenuates the relationship between a history of multiple adverse childhood adverse experiences and later psychotic symptoms²²³. Finally, on average, individuals with persistent psychotic experiences who do not seek help have higher general cognitive functioning than those that do seek help¹⁷².

[H2] Social factors

Social factors are strongly linked with mental health²²⁴. Greater social support is related to reduced psychotic experiences in young adults with significant psychosis risk factors^{124,223,225-227}, and to reduced symptom severity^{203,228,229} and improved functioning²²⁹ in people diagnosed with a psychotic disorder. A meta-analysis further indicates that family interventions aimed at improving family support are associated with reduced relapse rates²¹⁶. These benefits are not derived exclusively from receiving support, but also from giving support. Relationship reciprocity (the mutually beneficial exchange of support) is higher in individuals with persistent psychotic experiences that do not have a need for care, versus those who do²³⁰. Furthermore, help-seeking individuals with psychosis reported the highest distress from their symptoms when relationship reciprocity was low, regardless of symptom severity²³⁰. Relatedly, in individuals with schizophrenia, better relationship quality is related to reduced symptom severity²³¹ and predicts better functional outcomes three years later²³². In individuals at clinical high risk for psychosis, better quality of relationships and number of relationships are related to reduced severity of psychotic experiences and better functioning²³³.

Social network size and social interactions are additional factors associated with positive outcomes²³⁴. For example, interactions with friends predicted two-year clinical recovery in people diagnosed with a psychotic disorder²³⁵, living with someone else predicted remission in a prospective 20-year follow-up study of individuals experiencing their first episode of psychosis²³⁶, and the immediate presence of family or friends decreased the moment-to-moment risk of mental states associated with delusions in individuals with chronic schizophrenia²³⁷. Number of relationships is associated with a reduced risk of developing schizophrenia 15 years post-baseline²³⁸ and is further associated with reduced symptom severity in individuals diagnosed with schizophrenia²³¹. At broader social levels, involvement in activities that align with interests and values also provides mental health benefits. Withdrawal from extracurricular activities has been found to precede a delusional moment²³⁷, and holding valued social roles (for example, club membership) prevents relapse in people with psychosis²³⁹.

497
498 Finally, broader aspects of the social environment play a crucial role in mental health.
499 Epidemiological studies have shown that living among people of the same ethnicity reduces the
500 chance of developing psychosis²⁴⁰⁻²⁴². However, findings that neighborhood ethnic diversity has
501 negative impacts on well-being and health are contested^{243,244}, and negative impacts might even
502 reverse over longer periods of intergroup contact²⁴⁵. The mechanism underlying the association
503 between ethnic diversity and psychosis is unclear but is almost certainly culturally-dependent²⁴⁴.
504 One possibility is that higher ethnic density reduces exposure to discrimination and racism or
505 exerts a buffering effect against their negative impacts^{242,246}. Alternatively (or in addition), higher
506 ethnic density might increase positive social neighborhood characteristics, at least in the short-
507 term²⁴⁴. These social characteristics of the neighborhood confer beneficial effects in the context
508 of psychosis risk, although work here is more limited²⁴⁴. Residing in a more socially cohesive
509 neighborhood (that is, a neighborhood that fosters a sense of belonging²⁴⁷) is associated with a
510 reduced risk for psychotic symptoms in children of mothers diagnosed with schizophrenia²²⁷ and
511 attenuates the association between adverse childhood events and later psychotic
512 symptoms^{124,223}. Finally, higher social capital (a community's bank of trust and expectations
513 regarding reciprocity that fosters and facilitates collective action, generally measured by civic
514 engagement²⁴⁸), has been associated with a reduced risk of developing a psychotic disorder<sup>249-
515 251</sup>, but findings are mixed²⁵². Taken together, these findings align with the 'social defeat'
516 hypothesis, whereby repeated experiences of social exclusion increase risk for
517 schizophrenia^{253,254}. Resilience factors at the social environmental level might buffer against
518 these risks.

519 520 [H2] Built and natural environments

521 Mental health benefits can be conferred by broader aspects of the natural and built
522 environment. There is robust evidence that access to green and blue space²⁵⁵ and exposure to
523 natural sounds²⁵⁶ increase positive affect and social engagement, reduce stress levels and
524 negative affect, improve sleep quality and cognition, and enrich meaning in life. Notably,
525 epidemiological studies have shown that exposure to natural green and blue space during
526 childhood is associated with psychosis risk²⁵⁷⁻²⁶⁰, independent of urbanicity, and increased
527 levels of green space density are associated with decreased schizophrenia risk in a dose-
528 dependent manner in man-made areas²⁵⁸. Furthermore, exposure to green spaces is related to
529 better clinical symptoms in individuals diagnosed with schizophrenia²⁶¹.

530
531 The mechanisms by which green space exert protective or promotive effects are not yet
532 determined. Current theories suggest that natural settings foster restoration from mental
533 fatigue²⁶², promote relaxation, and/or enhance well-being owing to an innate preference for life
534 forms and lifelike processes²⁶³. Qualitative evidence suggests that spending time in open green
535 space might buffer against the stress of living in an urban environment in individuals with
536 schizophrenia²⁶⁴. Importantly, forest therapy^{265,266} (a guided outdoor healing practice) is broadly
537 promotive for a range of mental health conditions. Even simulated or virtual forest walks might
538 confer psychological benefits^{267,268}. A recreational program involving a walk through a suburban
539 forest reduced negative affect and anxiety in individuals hospitalized for psychosis²⁶⁹. Given the
540 known beneficial effects of the natural environment on mental health, expansion of green and
541 blue space in urban areas, and even within buildings, seem warranted²⁷⁰.

542
543 Characteristics of the built environment such as walkability, transit access, or housing quality
544 have also been shown to contribute to positive mental health outcomes²⁷¹⁻²⁷³. There has been
545 little direct investigation into how aspects of the built environment confer resilience in the context
546 of psychosis risk. However, several studies have shown that neighborhood walkability increases
547 physical activity in individuals with schizophrenia²⁷⁵⁻²⁷⁷, which might in turn lead to mental health

548 benefits. Furthermore, the built environment influences access to care²⁷⁸, and therefore high-
549 quality built environments might be associated with better outcome trajectories via access and
550 adherence to treatment. Indeed, a study in China showed that individuals with schizophrenia
551 living in neighborhoods with high walkability had lower re-hospitalization rates than those living
552 in less walkable neighborhoods²⁷⁴. These findings underscore the crucial role of judicious urban
553 planning, smart policies, and architectural design in public health outcomes.

554 **[H1] Limitations of the resilience literature**

556 There are several limitations to the literature reviewed above. First, it does not distinguish
557 protective from promotive factors. Most of the factors associated with positive outcomes in the
558 context of psychosis risk reviewed above are widely regarded as good for health, well-being,
559 and functioning and are potentially promotive factors. Whether these factors also have a
560 differentially positive effect in contexts of heightened risk, particularly in the context of psychosis
561 risk (protective factors), remains unclear²⁷⁹. Answering this question would require evaluating
562 whether a given factor was associated with positive outcomes in a risk-dependent manner. For
563 example, spirituality could be considered a protective factor in this context if it showed a positive
564 relationship with subjective well-being in youth identified as clinical high-risk for psychosis, but
565 no relationship in a population sample of young adults. Distinguishing protective and promotive
566 factors is important for developing implementation strategies. Should a factor be broadly
567 promotive, then intervention or prevention efforts aimed at enhancing that factor stand to be
568 effective when delivered to a wide audience through broad public health initiatives. By contrast,
569 strategies aimed at shoring up protective factors in the context of psychosis risk might be most
570 effective when delivered to population subgroups, such as at psychosis specialty clinics.

571 Second, although modern conceptualizations of resilience highlight its multisystemic nature⁸³,
572 the majority of reviewed studies have focused on biological and psychological factors at the
573 level of the individual and immediate family unit. Assets and activities within broader social and
574 ecological levels that confer substantial mental health benefits have yet to be explored in the
575 context of psychosis risk^{272,273,280,281}. Research into the impact of the built environment is
576 particularly scant. Furthermore, most studies have investigated the effects of single factors
577 rather than a constellation of intersecting and multisystemic risk and protective and promotive
578 factors. This makes it impossible to unpack the mechanisms by which these factors come to be
579 associated with resilient outcomes—that is, whether they directly impact outcome measures, or
580 indirectly influence outcomes via other protective, promotive, or vulnerability factors. Moreover,
581 the reviewed factors should be considered on a continuum, whereby optimal levels are
582 protective or promotive and sub-optimal levels confer vulnerability. For example, social support
583 can buffer against risk whereas social isolation might create vulnerability. It is unclear whether
584 there are shared underlying mechanisms, or whether factors operate via distinct pathways at
585 each end of the continuum.

586
587 Third, there is little examination of contextual effects in the current psychosis resilience
588 literature. This is a critical gap because when it comes to resilience, one size does not fit all. For
589 example, risk context might influence the degree to which a resource or positive behavior
590 confers benefits. Risk context refers to whether risk occurs in the preliminary circumstances that
591 might lead to a psychotic disorder diagnosis, in distress that emerges from the symptoms
592 themselves, or in secondary risks after diagnosis. The degree of overlap in the factors that
593 promote resilience in the context of these different types of risk and the mechanisms by which
594 they might do so is unclear. Many of the resilience-promoting factors reviewed here, such as
595 positive health behaviors, adaptive coping strategies, or access to green space, reduce the
596 likelihood of being diagnosed with a psychotic disorder. They also engender beneficial effects in

597 those already diagnosed, which is consistent with the fact that these factors promote mental
598 health and well-being in the general population. Other factors, such as stigma resistance and
599 meaning making, might only produce positive outcomes in the context of a mental health
600 diagnosis and clinically significant psychotic experiences.

601
602 The benefits conferred by a putative protective or promotive factor might also depend on other
603 contextual factors. Specific factors might have a more profound impact during sensitive periods
604 of brain development characterized by higher plasticity. Notably, the timing of these critical
605 periods are themselves malleable and changed by environmental factors²⁸²⁻²⁸⁵. In addition,
606 culture is a critical contextual factor. The definition of a positive outcome and the ways in which
607 resilience at the level of the individual is prioritized relative to other levels of the social ecology
608 are inherently culturally-dependent^{286,287}. Furthermore, there are robust cultural and geopolitical
609 differences in the clinical course of psychotic disorders that cannot be explained exclusively by
610 diagnostic differences. For example, individuals in low-income and middle-income regions fare
611 better following a diagnosis of schizophrenia than individuals in high-income regions²⁸⁸⁻²⁹⁵.
612 Finally, the positive effect of engaging in positive coping strategies might be stymied when
613 structural inequalities pose barriers to obtaining basic needs⁸⁹. Indeed, the RAISE-ETP study
614 showed that treatment based on a coordinated specialty care intervention for early psychosis
615 that adopts a strengths and resilience based approach only improved symptoms and quality of
616 life in individuals at the top 25% of the socioeconomic distribution^{296, 297}.

617
618 Finally, the bulk of research to date on resilience factors for psychosis has focused somewhat
619 narrowly on clinical outcomes such as diagnosis and relapse, with resilience in non-clinical
620 domains remaining largely unaddressed. Relatedly, conceptual models of resilient outcomes
621 that guide current research might not necessarily align with those of individuals with lived
622 experience of psychosis.

623

624 **[H1] Summary and future directions**

625 Resilience models stand to enhance, refine, and complement what has been learned from
626 traditional risk-based approaches to psychosis. Moreover, understanding modifiable factors that
627 lead to resilience in the face of psychosis risk will be central to therapeutic innovation. Existing
628 research highlights several promising modifiable protective and promotive factors in the context
629 of psychosis risk, including health behaviors, psychological strengths, attitudes, and abilities,
630 social interactions, support, and cohesion, and access to green space. Future research must
631 now bridge the critical gaps we identified in the current literature.

632

633 First, future research should test a comprehensive set of (ideally modifiable) potential protective
634 and promotive factors to identify factors with the strongest associations with positive outcomes
635 both individually and when considered in concert with other factors. Relatedly, future work
636 should test whether putative associations are moderated by psychosis risk, which would
637 distinguish protective from promotive factors. Such research can then be used to identify
638 promising targets for novel and cost-effective interventions. Identifying promotive factors could
639 support the implementation of broad, public health-informed strategies to shore up factors that
640 increase positive outcomes for emerging adults in general²⁹⁸. Identifying protective factors could
641 inform clinical staging interventions that acknowledge the 'pluripotential' nature of psychosis
642 risk²⁹⁹⁻³⁰², whereby the identified individuals are at heightened risk for a variety of psychiatric
643 outcomes. Indeed, an increasing number of clinical high-risk research groups are moving
644 toward transdiagnostic clinical staging approaches that focus on youth mental health more
645 generally²⁹⁹⁻³⁰². In addition, future work should examine the co-occurring influences that might
646 moderate the impact of protective and promotive factors. Knowing what factors are associated
647 with positive outcomes, when, and for whom, is central to understanding at what level of a

648 biopsychosocial-ecological system resilience-promoting assets and activities yield better
649 individual-level outcomes, to developing tailored interventions, and to understanding
650 heterogeneity in outcomes.

651 Second, future research should re-imagine positive outcomes to be broader than the mere
652 absence of psychological distress and diagnosis. Resilient outcomes are multifaceted, and
653 future work in this field would benefit from considering a wider range of measures that include
654 academic performance, work outcomes, physical health, social functioning, and purpose in
655 addition to mental health. Furthermore, researchers should consider positive outcomes at
656 broader levels of the social ecology and the ensuing impact on individual outcomes—for
657 example, how individual activism might promote transformation of social institutions that in turn
658 engenders more rights and opportunities for those living with mental illness.

659 Third, given the inherent multisystemic nature of resilience, diverse teams that include
660 multidisciplinary scholars as well as individuals who have traditionally been excluded from
661 academic discourse will be critical for gaining a broader perspective on potential protective and
662 promotive factors and on defining positive outcomes. This includes individuals with lived
663 experience of psychosis, families, teachers, and community and religious leaders who often
664 encounter people experiencing or at-risk for mental health emergencies along their pathway to
665 care. Furthermore, more cross-cultural work is needed, as positive outcomes and resilience
666 promoting processes are inherently shaped by culture. Looking beyond the biomedical models
667 of mental health that have dominated scientific discourse might allow us to reshape or refine our
668 conceptualization of positive outcomes, which could potentially uncover additional resilience-
669 promoting factors.

670
671 Finally, several methodological considerations will likely enhance the study of resilience to
672 psychosis risk. First, mixed methods approaches that link qualitative and quantitative research
673 can provide a springboard for generating testable hypotheses regarding factors that might
674 confer protection against psychotic symptoms and related distress. Second, resilience is best
675 represented as a positive trajectory and therefore not fully captured by a single moment in
676 time³⁰³. Thus, longitudinal studies are critical for characterizing this trajectory and determining
677 causal relationships between factors and outcomes, particularly as compromised access to and
678 engagement in the promotive and protective factors might be direct consequences of illness.
679 Indeed, prospective longitudinal studies have provided critical data regarding factors that
680 contribute to the development of a psychotic disorder and poor clinical outcomes among high-
681 risk individuals³⁰⁴⁻³⁰⁷. Third, more is not always better, and researchers should consider non-
682 linear relationships between outcome metrics and both risk and protective and promotive
683 factors. For example, stress is typically considered a risk factor, but might have inoculating
684 effects in small doses³⁰⁸. Fourth, natural and passive monitoring approaches, such as
685 ecological momentary assessment and mobility tracking can greatly enhance ecological validity
686 and provide richer assessments that capture the complexity of participants' daily lives³⁰⁹. For
687 example, geospatial location and geographical information systems can objectively measure
688 how often and for how long people are exposed to natural or built features of the environment,
689 and how these durations relate to mental health^{261,310,311}. Finally, it is paramount to expand
690 beyond help-seeking samples. Individuals identified at clinical high-risk are already experiencing
691 significant clinical distress related to attenuated psychotic symptoms, social and functioning
692 difficulties, depression, and other sources³¹². Identifying individuals in the general population
693 who are at-risk for psychosis owing to attenuated psychotic symptoms or genetic risk but who
694 do not present with a need for care might provide insights into factors that help avert the
695 functional decline that leads young people at-risk for psychosis to seek help in the first place.
696

697 In conclusion, our Review suggests that the 'ordinary magic'³¹³ that constitutes human resilience
698 promotes positive adaptations in what is generally considered to be the most severe of mental
699 health conditions³¹⁴. Such findings are particularly important given antiquated, but still influential,
700 notions of schizophrenia as a progressively deteriorating illness³¹⁵ with its basis in irreversible
701 etiological factors that manifest later in life³¹⁶. The factors reviewed here are modifiable, thereby
702 reinforcing the notion that illness course can be changed. The identified modifiable resilience
703 factors provide valuable data that can inform therapeutic development, including individual
704 prevention and intervention efforts, institutional programs, and broader policy.

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The results of this article provide important insights into what might reduce the chance of persistent psychotic experiences leading to poor psychological outcomes.

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Table 1. Summary of reviewed protective and promotive factors.

Level	Factor	Key findings	Considerations for prevention and intervention
Biological	Sleep	<p>Better sleep quality is associated with greater well-being^{110,111}</p> <p>Sleep quality interventions decrease psychotic-like symptoms¹¹²</p> <p>Sleep quantity shows a non-linear relationship with well-being^{114,115}</p>	<p>Cognitive behavioral therapy (CBT) for insomnia³¹⁷ is the first-line treatment for sleep disturbance and can be effectively delivered using scalable web-based programs³¹⁸</p> <p>Sleep hygiene recommendations as stand-alone interventions without personalization are unlikely to be effective³¹⁹</p> <p>Expand beyond the level of the individual and consider how social and environmental determinants might be modified to improve sleep health³²⁰</p>
	Physical activity	<p>Low to moderate exercise is associated with mental health benefits¹¹⁶⁻¹¹⁸</p> <p>Physical activity in childhood is associated with a lower likelihood of developing psychosis later in life¹²⁴⁻¹²⁶</p> <p>Physical activity is associated with positive clinical and functional outcomes and subjective well-being in individuals with psychotic disorders¹²⁷⁻¹³¹</p>	<p>90 minutes of moderate to vigorous exercise per week can improve mental and physical health³²¹ among individuals diagnosed with psychotic disorders³²² and individuals at clinical high risk³²³</p> <p>Supervised exercise in group settings (versus solitary exercise) maximizes adherence to the exercise intervention in individuals diagnosed with psychotic disorders³²²</p> <p>Strategies for addressing barriers to exercise include establishing an incentive structure, using augmented reality, varying the exercise routine, and social support¹³⁰</p>

	<p>Homeostatic regulation of the autonomic nervous system</p>	<p>Higher heart rate variability and respiratory sinus arrhythmia (within the normal range) are associated with better mental and physical health¹³⁵⁻¹³⁸</p> <p>Heart rate variability and respiratory sinus arrhythmia are lower in people with psychotic disorder and individual differences relate to clinical symptoms and daily functioning¹⁴²⁻¹⁴⁶</p> <p>Biofeedback training to enhance heart rate variability is associated with improved clinical symptoms^{153,154}</p>	<p>Heart rate variability and respiratory sinus arrhythmia are modifiable through biofeedback training, breathing retraining, mindfulness practice, and physical exercise in the general population^{147-152,324}</p>
<p>Psychological</p>	<p>Traits and personal characteristics</p>	<p>Adaptive coping is associated with less severe psychotic and psychotic-like symptoms in the general population^{157,158,165} and clinical populations¹⁶⁰⁻¹⁶⁴</p> <p>Higher self-esteem is associated with reduced psychotic and psychotic-like symptom severity^{168,169,173}, improved quality of life¹⁷⁰ and general mental health in clinical populations^{170,171}, and reduced distress associated with psychotic experiences¹⁷²</p> <p>Regaining internal locus of control is a major component of recovery in individuals with schizophrenia¹⁷⁵ and is associated with a lower likelihood of developing psychotic symptoms¹⁷⁶</p> <p>Trait emotional stability, extraversion, and agreeableness are associated with better quality of life in individuals with schizophrenia¹⁸⁰⁻¹⁸²</p>	<p>Fostering coping might be a mechanism of symptom improvement in CBT for psychosis³²⁵, although CBT does not lead to improvements in quality of life, subjective distress or functioning³²⁶. There is no evidence to favor any specific preventative treatment of psychosis (including CBT)³²⁷.</p> <p>Individualized Resiliency Training is a psychosocial intervention to enhance well-being among people with psychosis that focuses on education and skills training to foster adaptive coping strategies³²⁸.</p> <p>Face-to-face or scalable web-based CBT and reminiscence-based interventions that focus on reflecting upon autobiographical memories are associated with improved self-esteem³²⁹.</p>

	<p>Attitudes and orientations</p>	<p>Stigma resistance is related to well-being and quality of life in individuals with psychotic disorders¹⁸⁷⁻¹⁸⁹</p> <p>Spirituality might confer mental health benefits in the general population^{193,194}. Religion and religious practices might act as both a vulnerability factor^{193,197,202} as well as a protective or promotive factor^{196,203-205}.</p> <p>Among individuals diagnosed with a psychotic disorder, spirituality relates to adaptation in the face of adversity¹⁹⁶, is associated with better social functioning in young people at risk for psychosis¹⁹⁷, and might buffer against the distress associated with psychotic experiences^{172,198}</p> <p>Ascribing meaning to anomalous experiences might buffer against the distress of psychotic experiences^{210,211} and promote well-being in individuals diagnosed with schizophrenia²¹²</p>	<p>Stigma reduction strategies that either attempt to alter stigmatizing beliefs and attitudes or enhance stigma-coping skills through improvements in self-esteem, empowerment, and help-seeking behavior are effective in reducing self-stigma³³⁰, particularly when they include a psychoeducation component³³¹</p> <p>Religion and spirituality might offer resources for support and meaning and/or exacerbate psychological distress. Thus, they should only be incorporated into psychotherapy after careful consideration. Incorporating religion and spirituality into treatment might be particularly important for individuals from underserved and minoritized backgrounds who have higher rates of religious beliefs and greater use of religious coping than the general population²⁰⁶⁻²⁰⁹ and for whom religious and spiritual resources might be more accessible than other resilience-promoting factors^{332,333}.</p>
	<p>Abilities</p>	<p>Higher social competence is associated with reduced risk of relapse in patients with psychosis²¹⁶ and with reduced risk for and severity of psychotic-like experiences in at-risk individuals^{217,218}</p> <p>Better neurocognitive abilities are associated with decreased risk for psychotic symptoms in at-risk youth^{219-221,223}, a better clinical course in individuals recently diagnosed with a psychotic disorder²²², and might buffer</p>	<p>Cognitive Behavioral Social Skills Training³³⁴, Social Cognition Training³³⁵, and Social Cognition and Interaction Training³³⁶ involve live instruction, role plays, behavioral assignments, and/or computerized programs³³⁷ to foster skills in emotion and social perception, theory of mind, and social problem solving in individuals with psychotic-spectrum illness.</p> <p>Cognitive remediation improves cognition and daily functioning in individuals with schizophrenia^{338,339}</p>

		against distress associated with psychotic symptoms ¹⁷² .	and in individuals at high risk for psychosis ³⁴⁰ , particularly when they include an active and trained therapist, repeated practice, structured development of cognitive strategies, and techniques to maximize transfer of cognitive improvement to real-world settings. Delivery in group and individual settings is equally effective.
Social	Social support and relationship quality	<p>Greater social support is related to reduced psychotic experiences in young adults with significant psychosis risk^{124,223,225-227}, and to reduced symptom severity^{203,228,229} and improved functioning²²⁹ in people diagnosed with a psychotic disorder.</p> <p>Mutually beneficial exchange of support (relationship reciprocity) is higher in individuals with persistent psychotic experiences that do not have a need for care versus those that do²³⁰.</p> <p>In individuals with schizophrenia, better relationship quality is related to reduced symptom severity²³¹ and predicts better functional outcomes three years later²³². In individuals at clinical high risk for psychosis, better quality of relationships and number of relationships are related to reduced severity of psychotic experiences and better functioning²³³</p>	<p>Group and individual interventions in adolescents and adults aimed at enhancing the availability of social support through social skill development or increasing the degree of perceived support through cognitive restructuring show preliminary effectiveness. But results are mixed and methodological limitations preclude a definitive interpretation of these results³⁴¹</p> <p>Family interventions aimed at improving family support are protective against relapse²¹⁶.</p> <p>One-to-one peer support improves support provided by personal relationships when adjunctive to usual care for psychosis³⁴²</p> <p>Targeting families of children at higher risk for psychosis by increasing parental social support and parent training can enhance the quality of familial support provided to the child^{343,344}</p>
	Social network size and social interaction	<p>Social interaction promotes positive mental health outcomes in the general population²³⁴.</p> <p>Interactions with close relations is associated with</p>	<p>Social participation interventions aim to build social networks and improve community integration for individuals with mental illness through activities that facilitate social interactions. The limited evidence available suggests</p>

		<p>improved psychotic symptoms²³⁵⁻²³⁷</p> <p>Number of relationships is associated with a reduced risk of developing schizophrenia 15 years post-baseline²³⁸ and with reduced symptom severity in individuals diagnosed with schizophrenia²³¹.</p>	<p>potential benefit of social participation interventions for social networks. However, further work is needed³⁴⁵.</p>
	Social roles	<p>Engagement in activities related to valued social roles reduces clinical symptoms and prevents relapse^{237,239}.</p>	
	Broader social environment	<p>High ethnic density²⁴⁰⁻²⁴², neighborhood social cohesion^{124,223,227}, and neighborhood social capital²⁴⁹⁻²⁵¹ are associated with reduced risk of developing a psychotic disorder.</p>	
Built and natural environment	Built environment characteristics	<p>Characteristics of the built environment (for example, walkability and housing quality) contribute to positive mental health outcomes in the general population²⁷¹⁻²⁷³.</p> <p>No studies have directly examined the impact of aspects of the built environment on positive outcomes in the context of psychosis risk.</p>	<p>Environmental modifications aimed at increasing public access to green space (for example, planting street trees and greening vacant lots) might broadly improve health outcomes³⁴⁸⁻³⁵⁰.</p> <p>Neighborhood walkability increases physical activity in individuals with schizophrenia²⁴²⁻²⁴⁴</p>
	Exposure to natural space	<p>Exposure to natural green and blue space during childhood is associated with reduced psychosis risk in adulthood²⁵⁷⁻²⁵⁹</p> <p>Exposure to green space is related to decreased severity of clinical symptoms in individuals diagnosed with schizophrenia²⁶¹ and might buffer against stress of urban environment²⁶⁴</p>	<p>Group and individual interventions to increase time spent in green space promote mental and physical health^{265,266}, including among individuals hospitalized for psychosis²⁶⁹ and even in simulated or virtual formats^{267,268}.</p>

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Figure legends

Figure 1. Trajectories of psychosis risk and resilience. Example trajectories for psychological distress (top), psychotic and psychotic-like experiences (middle), and subjective well-being and psychosocial functioning (bottom) in individuals at risk for psychosis. Risk factors include the circumstances that increase the likelihood of being diagnosed with a psychotic disorder, the distress associated with the experience of psychotic symptoms themselves, and secondary events associated with a diagnosis of psychotic disorder (for example, poor physical health or discrimination). Blue represents an individual presenting with risk factors but not protective or promotive factors. The grey, yellow, and green trajectories represent different resilience-promoting processes. Adaptation (grey) occurs when the individual changes in ways that permit positive outcomes despite the impact of risk. Recovery (yellow) occurs when the individual initially experiences negative outcomes in response to risk, but later returns to a previous level of functioning. Finally, resistance and persistence (green) occur when the individual maintains their current trajectory despite risk. These trajectories are highly schematized and simplified examples and do not encompass all possible trajectories of an individual with psychosis risk factors. Rather, they are intended to provide an illustration of how resilience-promoting processes might be enacted in the context of psychosis risk factors.

Figure 2. Protective and promotive factors across the biopsychosocial-ecological system. Potential protective and promotive factors in the context of psychosis risk identified in the Review are organized within levels of a biopsychosocial-ecological system. The factors placed at the border of adjacent levels indicate that different aspects of these factors are best conceptualized as operating at multiple levels of the biopsychosocial-ecological system.

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Box 1. Beyond semantics in the shift from risk to resilience

A shift away from risk and towards resilience could be perceived as merely semantic—that a focus on strengths and protection is more hopeful-sounding but conceptually identical to a risk-focused approach to prevention and intervention. But resilience scholars have presented several arguments supporting the idea that a shift from risk to resilience is more than an inversion of language⁸⁷. First, a high ‘dose’ of a particular variable that buffers against the effect of risk exposure might do so via different processes or mechanisms than those by which a low ‘dose’ of that same variable exacerbates the effect of risk^{22,87}. For example, physical activity (generally considered a promotive factor) has a non-linear relationship with mental health, such that more physical exercise is related to improved mental health up to a threshold, after which it increases the likelihood of poor mental health³⁵¹⁻³⁵⁴. Those aspects of exercise at low to moderate ‘doses’ that confer benefits are likely not the same aspects that confer vulnerability at high doses.

Second, context matters: a particular factor or process that has protective or promotive effects in one context, group, or individual might operate as a vulnerability factor in another⁸⁷. For example, participating in high school sports is protective against alcohol use in Black girls, but is associated with increased alcohol use in Black boys and white girls and boys³⁵⁵. Third, the ‘active ingredient’ by which a particular factor confers benefits might lie in the positive end of that factor. For example, in women raised in institutional care, being in a supportive marital relationship was related to improved parental quality as compared to women who were not in a supportive marital relationship; however, parenting quality was equivalent in women raising a child without a partner and women raising children in the context of a poor marital relationship. In other words, a supportive marital relationship was a protective or promotive factor, but there was no analogous vulnerability caused by a poor marital relationship³⁵⁶. Thus, focusing on the protective end of a variable— supportive marital relationship, in this example—might elucidate the mechanism or process by which variation in exposure to a given factor might buffer the negative effects of risk. Finally, outcome variables do not lie on a unidimensional spectrum. Presence of resilience factors is not equivalent to an absence of risk factors. In a similar way, positive and negative emotions represent different constructs³⁵⁷ and ‘feeling good’ is not the same as ‘not feeling bad’. Thus, a paradigmatic shift from risk to resilience represents a change in approach and framework, not just a matter of emphasis on language and terms.

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Box 2. The case of delusions

1794 Delusions (false and fixed beliefs that are not amenable to change despite conflicting
1795 evidence³⁵⁹) are a defining symptom of schizophrenia and are understood as harmful and
1796 dysfunctional. Delusions are also considered an important treatment target that is central to
1797 recovery from psychosis. Current explanatory models of delusions adopt neurocognitive
1798 approaches to belief formation, whereby delusions are thought to arise from normative
1799 reasoning in the context of anomalous experiences or reflect abnormalities in a normative belief
1800 formation process (for a review see ³⁵⁸). These approaches have led to the development of
1801 cognitive-behavioral therapy (CBT) for delusions ³⁵⁹, which treat delusions as beliefs that can be
1802 challenged through standard techniques of reality testing and evaluation. However, the efficacy
1803 of CBT for delusions appears to be modest and its therapeutic ingredients remain unclear ^{360,361}.

1804 Delusions are notoriously difficult to dispel. However, the current definition and
1805 operationalization of delusions are fraught with epistemic hurdles that make it difficult to
1806 determine the borders of pathology ^{362,363}. Framing delusions as harmful beliefs that must be
1807 eliminated to achieve recovery from psychosis fails to consider the lived experience of the
1808 phenomenon and the broader sociocultural and psychological context. Specifically, some
1809 delusions might serve an adaptive purpose, at least temporarily ^{364,365}. This proposition is not
1810 intended to romanticize delusions or to downplay their seriousness. Indeed, delusions—
1811 particularly persecutory delusions—are associated with tremendous personal distress ³⁶⁶, and
1812 anger secondary to delusions has been found to increase an individual's risk for violent behavior
1813 ³⁶⁷.

1814 To best grapple with these clinical realities, clinicians and researchers must consider that
1815 delusions might be an adaptive response in some cases, and notions of recovery and treatment
1816 must be reframed accordingly. Indeed, a meta-analysis indicated the improvements in positive
1817 symptoms (like delusions) with CBT were related to increases in hopelessness³²⁶. Quotes from
1818 a qualitative study wherein individuals with schizophrenia with a longstanding delusional belief
1819 were asked what their life would be like without their delusional belief further illustrate this
1820 point³⁶⁸:

1821 "It would all have been for nothing...it would be sadness...it would be wrong, I wouldn't
1822 accept it...that's futility - I would really miss it. A waste of a life, all my lives, all the way
1823 through."

1824 "I can't see that ever happening - psychic activity is part of my structure - my heart. If I
1825 lost it, I would be inert. I'd have to start all over again."

1826 An alternative phenomenological account of delusions incorporates the phenomenology of the
1827 variety of reality experiences to fathom how individuals with delusions might evaluate and
1828 discover meaning in these experiential alterations³⁶². Moving away from a purely mechanistic
1829 model of delusions that fails to acknowledge or incorporate the subjective, phenomenological
1830 illness narratives will be essential to defining recovery and positive outcomes in a manner that
1831 leaves intact the person's sense of self and ability to find meaning in experience^{365,369}. From the
1832 perspective of the person with lived experience, delusions are not necessarily an irrational or
1833 false representation of reality; rather, such beliefs might bring a sense of meaningfulness to
1834 their life ³⁶⁹—which might confer resilience.

1835

1836 **Box 3. Integrating risk and resilience factors**

1837 Our categorization of potential protective and promotive factors reflects the current literature that
1838 tends to study factors in isolation or within a small selection of other risk or resilience factors.
1839 However, this approach obscures the fact that it is the interactions between various assets and
1840 abilities together with risk factors that engender the conditions under which resilience can
1841 occur⁸³. First, interactions between various risk and resilience promoting factors can occur
1842 within levels. For example, the biological resilience promoting factors reviewed here (sleep
1843 quality, physical activity, and homeostatic regulation of the autonomic nervous system) influence
1844 each other through reciprocal interactions via physiological and psychological pathways³⁷⁰ and
1845 might exert their impact on positive mental health outcomes via a common process, such as
1846 reducing stress reactivity³⁷¹⁻³⁷³. Second, extensive interactions occur between levels. For
1847 example, physical activity is influenced by the walkability of the built environment³⁷⁴, self-esteem
1848 increases perceived social support³⁷⁵, and exercise promotes cognitive abilities³⁷⁶. Furthermore,
1849 these resilience promoting factors might also reduce exposure to stressors. For example, for
1850 individuals from minoritized ethnic groups, the protective effect of living in neighborhoods
1851 wherein their ethnic identity is well-represented might reduce the degree of discrimination they
1852 experience in day-to-day life²⁴⁶. Finally, the access or ability conferred by resilience promoting
1853 resources might be compromised by the illness itself. For example, qualitative studies indicate
1854 that symptoms and the sedative effects of medication pose barriers to engaging in physical
1855 activity³⁷⁷. Similarly, stigma and structural discrimination together with psychosocial disability
1856 might limit employment opportunities and thereby reduce opportunities to access resilience
1857 promoting resources associated with wealth (such as access to green space, which is less
1858 available in low-income neighborhoods³⁷⁸), and to engage in social networks.

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Table of Contents blurb

Psychosis research has traditionally focused on vulnerability and the detrimental outcomes of risk exposure. In this Review, Thakkar et al. consider an alternative resilience-based approach focused on resources and strengths that might help protect against negative illness course among people at risk.