Recovery Enhancement Practices *for* Psychosis (REP):

A TREATMENT APPROACH INFORMED BY COGNITIVE BEHAVIORAL THERAPY FOR PSYCHOSIS

A Mental Health Provider's Guide to Working with Psychosis

Promoting Innovation. Restoring Lives.

Produced by the Best Practices in Schizophrenia Treatment (BeST) Center,
Department of Psychiatry, at Northeast Ohio Medical University

BEST PRACTICES IN SCHIZOPHRENIA TREATMENT CENTER
A NEOMED CCoE

NEOMED | COORDINATING CENTERS *of* EXCELLENCE

Recovery Enhancement Practices for Psychosis (REP):

A treatment approach informed by

Cognitive Behavioral Therapy for Psychosis

A Mental Health Provider's Introductory Guide to Working with Psychosis

Developed by

Harry Sivec and Val Kreider

Best Practices in Schizophrenia Treatment (BeST) Center
Cognitive Behavioral Therapy for Psychosis Program

DRAFT

BEST PRACTICES
IN SCHIZOPHRENIA
TREATMENT CENTER
A NEOMED CCoE

Recovery Enhancement Practices for Psychosis (REP):
A treatment approach informed by
Cognitive Behavioral Therapy for Psychosis

Table of Contents

Section 1

Introduction to Recovery Enhancement Practices for Psychosis (REP)

Part 1: Psychosis and an Approach to Care

Objectives:

1. **To describe psychosis and the schizophrenia spectrum**
2. **To provide an overview for an approach to care**

This guide is written for the frontline providers who work with persons who experience psychosis and want to know how to make a difference. The foundation for this work was developed primarily from work with individuals diagnosed in the "schizophrenia spectrum." We believe that many features of this approach are broadly applicable to psychotic symptoms occurring outside of schizophrenia spectrum diagnoses, but as a matter of good practice, we encourage you to consult with your supervisor and trainer for case-specific adaptations.

It is our hope that this guide will provide a simple and clear explanation of common psychotic experiences. This guide will share tips and strategies that have been developed over many years by clinicians, researchers, and persons with lived experience of psychosis.

Recovery Enhancement Practices for Psychosis (REP) are based on a deep **respect for the dignity of individuals** combined with a strong belief that people have the capacity to better their lives. These practices are informed by elements of Cognitive Behavioral Therapy for psychosis and guided by advances in the recovery movement. While schizophrenia is a challenging illness, individuals who experience this condition also have tremendous strengths that will become increasingly apparent (and may already be apparent to you) after doing this work.

It is important to be gentle with yourself as you learn to work with psychosis. This work takes time, it is challenging, and it is also wonderfully enriching. Once you learn to welcome the uncertainty and vulnerability required of the work, you will discover new ways to encounter individuals who experience psychosis that will enhance your professional work (see McCraw and Brabban, 2002 for an excellent discussion of insights learned from working with psychosis).

Introduction: What is Psychosis?

Psychosis is a term that is often not well understood and for some it is associated with danger and fear. Psychosis refers to a state of mind in which perception and cognition is impaired. The root meaning of the word "psychosis" is psyche (soul or mind) and "osis" (unusual or abnormal state). So, we might say psychosis reflects an **unusual or altered state of mind**. For a variety of reasons, our brains are prone to misperceive information and when this happens to the extent that it causes serious distress and/or impairment, we refer to the experience as psychosis.

To help understand what this means concretely, it may be helpful to consider what we mean by "reality." Robert Francis, an author and person with lived experience of psychosis, describes the distinction between consensus and private reality as a way to think about psychosis. **Consensus** or "shared reality" refers to experiences that you and I (or individuals with a similar background) share in common. For example, we see two people walking in our neighborhood and we can agree we see two individuals. **Private reality** refers to one's private interpretation of a situation. For example, I may consider the appearance of two individuals in the neighborhood as worrisome while you may not be concerned about it at all. With some explanation of past encounters with these individuals (maybe they were rude to me in the past or disrupted the yard, etc.), you can understand my perspective even though you do not hold the same belief or concern.

When private experiences become more unusual, illogical, or lacking in objective evidence (for example, I see two people that are not seen by others and I believe they are aliens who intend to hurt me) AND this causes impairment and distress, we move into the space that we would call a psychotic symptom. The experience is very real and distressing (private reality), but this experience does not fit with common experience or knowledge of others (consensus reality). Likewise, hearing voices that intend harm (that no one else hears- private reality), accompanied by distress (fear), and interfering with important life roles (e.g., run and hide in the house for days), we would characterize this as psychosis (private, non-consensual reality, causing distress and impairment). In contrast, a person may describe a spiritual experience that lacks objective evidence (private reality) but does not cause distress or impairment and is consistent with person's cultural background (shared or consensus reality)- this would not be considered a symptom.

A couple of key points to remember about psychosis:

- While we may not immediately understand a person's experience, we should not discount it. It is often **very personal and frightening** for the person who experiences it.
- It is not just having an unusual experience that qualifies it as psychosis. A person must also experience **distress and interference with daily living** (remember we all experience unusual things at times, and we all have idiosyncratic beliefs).
- The person's ability to consider his or her psychotic symptom from another perspective is often impaired. In other words, when a person seems unaware that their experiences are atypical, their lack of perspective is less about willful opposition and more about **impaired cognitive processing ability**.
- Finally, the meaning of any experience is substantially influenced by one's culture and background. Be sure to understand the person's **cultural vantage point** before labeling the experience as psychotic.

SCHIZOPHRENIA: is a diagnostic label for individuals who exhibit symptoms of psychosis and who experience a sharp decline in their ability to function. See table 1 for descriptions of behaviors commonly observed in individuals with this diagnosis. A brief experience of any one of these symptoms does NOT constitute schizophrenia. The experiences must occur over time and significantly disrupt a person's life. While psychosis is a more generalized term for a type of human experience, schizophrenia is a diagnosis based on a set of criteria.

Like the term "psychosis", schizophrenia as a diagnosis is often feared and misrepresented. Despite decades of research, this diagnosis is still poorly understood and defies easy categorization. It is important to realize that schizophrenia does not present in just one way. This is why we often refer to **schizophrenia "spectrum" disorders**. There are multiple "causes," different underlying mechanisms, and different presentations. Also, an individual may show symptoms of psychosis and not be diagnosed with a schizophrenia spectrum disorder (e.g., some mood disorders and personality disorders also show psychotic symptoms).

Table 1. Symptom Description

Symptom Name	Definition	How this may look in the field
Hallucinations	A sensory experience (hearing, seeing, smelling, feeling touch, taste) experienced by an individual that is not perceived by others or where there is no clear evidence to support the experience	Person talking to themselves Person looking around as if responding to something others cannot hear or see Complaints of feeling probed by others Person reports a voice is talking to them
Delusions	Strongly held beliefs that are not supported by evidence, logic, or not within the range of consensus	Person states that they are a king or prophet Person states that the devil is probing
Thought disorganization	Extreme difficulty or inability to think in a linear and organized way. There may be intrusions of different thoughts	Person speaks in rhymes or nonsensical language. May repeat phrases that don't make sense in the context May miss or be late for appointments, not complete paperwork effectively, may not recall content of meetings or may appear distracted
Negative Symptoms	A cluster of symptoms that represents certain essential functions that are diminished or "taken away" from the individual Limited speech; Flat affect Avolition: Not able to get started to do things	Person may stay in their room all day Appearance may be unclean, room disorganized, not engaging in activities Emotions may appear to be absent; appears bored or as having no energy

Understanding the causes of schizophrenia

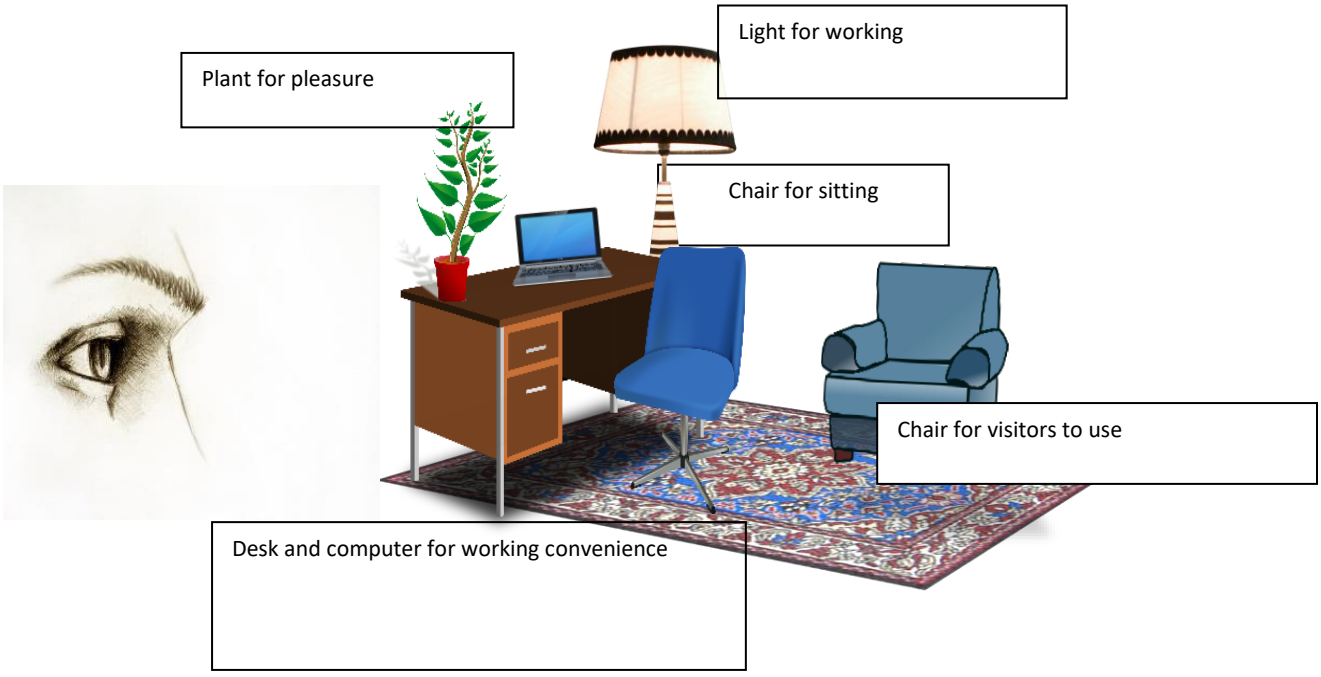
Schizophrenia is a term that does not help us to understand the physiology of schizophrenia or psychotic symptoms. It translates to "split mind" and is a term coined more than 100 years ago. People diagnosed with schizophrenia can present in vastly different ways. For our purposes, it is helpful to briefly consider some factors that contribute to psychotic symptoms. Dopamine is a neurotransmitter that has been identified as having a primary role in psychosis. We discussed earlier that psychosis often involves misperception and an altered state of mind. Dopamine plays a role in helping us to determine what to pay attention to in order to respond appropriately. If there is too much dopamine or dopamine is not effectively regulated, the brain may misinterpret situations as dangerous or "very important" even though others in the same situation see them as relatively neutral. These types of unusual events, when they recur frequently, can form the basis for certain delusional beliefs. Dopamine, along with other underlying mechanisms, is also thought to influence the experience of hearing voices. Let's look at how dopamine, perception and thinking combine to make unusual experiences.

Common Perception and Interpretation

"These things are connected because they all belong in an office or den of some sort. Thank goodness my computer is here."

When these items are in a room together, they ignite a memory called "office," and that memory helps to generalize all these items to "office items." No item is particularly more important than another (neutral salience). Though, if one were looking for a laptop, the laptop in this picture would have more salience based on a specific want or need.

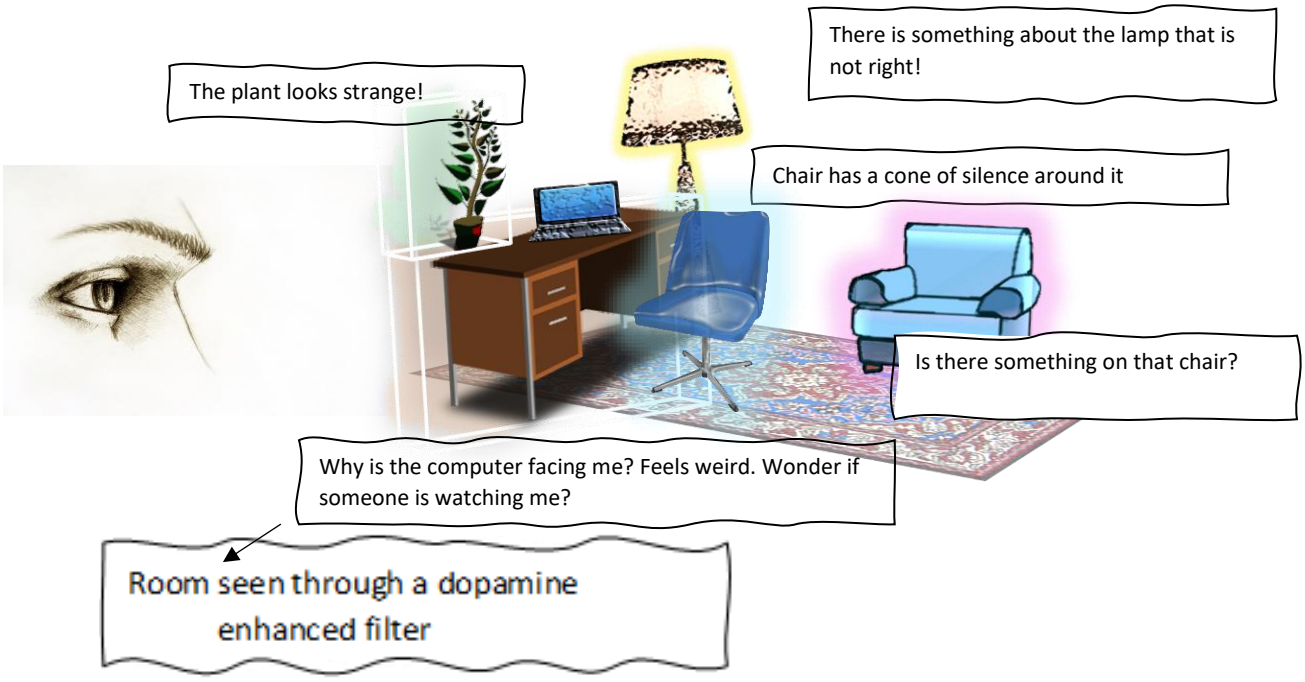
Dopamine modulates learning and guides ongoing behavior by rewarding our brain with some sense of certainty about what is happening and why.



Misperception that Develops into Symptoms

When dopamine is heightened or not well regulated, several items in the visual field become "highlighted". Because it is not clear why objects stand out, the person may think, "I can't figure out the connection between any of these things. All of these items seem important, but I don't know why". Trying to make sense of the experience, the person arrives at an explanation that is distressing, "This must be an experiment of some kind. I think someone is watching me, playing with my emotions and my thoughts."

With heightened salience, objects (or even ideas or emotions) feel unusually significant. The salience drives a need to explain or account for the experiences. They can be explained by a supernatural force or a belief about one's special abilities (which can lead to delusions of influence or self-significance) or could be explained by the deliberate, but hidden actions of others- this thought process can lead to suspicion or delusions of persecution.



See van der Gaag et al., 2013 for additional description

Since the 1950s treatment for schizophrenia has included some type of antipsychotic medication. The effectiveness of this type of treatment has brought about important improvements in the care and management of individuals suffering from these disorders. Notably, most of the early medicines affected the dopamine system. However, psychosis is not always caused by dopamine irregularities. Other neurotransmitters may be involved. In addition, psychosis can be caused by a variety of mechanisms (e.g., trauma, medical illness, inflammation, or other neurological processes). This is why medicines that block dopamine don't always work (because the psychosis comes from another primary source (as described above). This may be one reason why some people seem to get better quickly with medication while others do not seem to improve much on similar medicines.

Even with a better understanding of medication options, in many cases, medication alone still does not provide adequate relief (Gould, Mueser, Bolton, Mays, & Goff, 2001; Morrison, Hutton, Shiers, & Turkington, 2012). Other factors, like the role of trauma, need to be considered when working with someone who experiences psychosis.

Another important concept to remember when working with someone who experiences psychosis is the stress-vulnerability-resilience model (discussed in detail in Section 3). In short, the idea here is that a person develops psychotic symptoms when there is a combination of current stress that affects an underlying vulnerability (e.g., genetic predisposition or trauma experienced early in childhood). The greater the vulnerability, the lower the degree of stress that can be effectively managed. Understanding the ways that stress affects psychosis is important to developing effective ways to promote recovery.

Besides medicine, what else might help?

Cognitive Behavioral Therapy has been adapted for clients with persistent psychotic symptoms (CBT-p) and has shown benefits in treating individuals with schizophrenia spectrum disorders (Wykes, Steel, Everitt, & Tarrier, 2008). For example, this treatment has improved outcomes related to the positive and negative symptoms of schizophrenia as well as overall well-being.

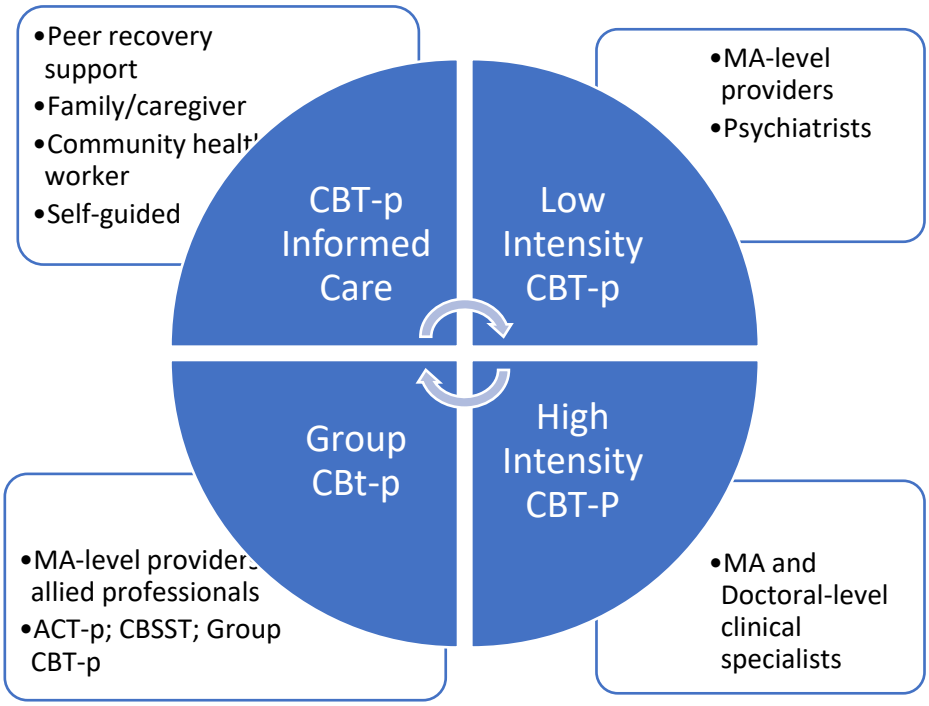
Unfortunately, very few individuals with schizophrenia receive CBT-p in the United States. This form of therapy requires advanced training that is not widely available. In an effort to address the lack of access to evidence-based practices, one area that has received very recent attention is the delivery of so-called "low

intensity" CBT interventions (Bennet-Levy, et al., 2010). There are several characteristics associated with the designation of "low intensity":

- Short amount of time (not a full therapeutic hour)
- Provided by frontline staff, many of whom are not licensed therapists
- Content and activities are "lower intensity;" (e.g., simple coping strategies; self-help materials and self-directed learning)

Mental health nurses (not traditionally licensed therapists) delivered brief CBT (six sessions) to individuals with a schizophrenia spectrum illness in the United Kingdom (Turkington, Kingdon, and Turner, 2002) who reported improvements in symptoms and positive satisfaction ratings. In more recent years, Pinninti, et al. (2010) also described a small pilot study in which they successfully trained members of an Assertive Community Treatment (ACT) team (case managers and other non-experts) in CBT. Waller et al. (2013) reported positive results in a small exploratory study in which frontline workers applied lower intensity CBT methods such as behavioral activation and graded exposure to individuals with schizophrenia spectrum illnesses. In another exploratory study, Turkington and colleagues (2014) trained case managers to provide low intensity cognitive behavioral techniques and found that clients responded with improvements in areas such as hallucinations, depression, and social functioning. Although variably defined, low-intensity CBT-p has demonstrated benefits for positive symptoms (Hazell, Hayward, Cavanagh, & Strauss, 2016; Naeem, Farooq, & Kingdon, 2014).

The above results suggest that techniques derived from CBT-p can be applied in non-traditional ways with benefits to the client. Therefore, if more providers could deliver a range of CBT-p related services within a community mental health agency (see table below), more individuals who experience psychosis could receive care (see Kopelovich, et al., 2019).



CBT-informed interventions are characterized by more straightforward strategies that require less time, and that can be delivered in the context of a mental health worker's other duties. Three skills are foundational for effective work with psychosis (this approach is loosely modeled after the United Kingdom's Psychological Well-Being Providers):

1. **Skillful engagement and information gathering** - developing a supportive working relationship and learning about the person.
2. **Skillful information giving** - providing information in a way that is instructive, normalizing, and hopeful.
3. **Shared decision-making** - working together in a way that empowers the person with choices and supports the person's ownership of successes.

This guide will focus on a CBT-p informed care approach we call Recovery Enhancement Practices for Psychosis (REP). This term is used to not confuse or mislead the provider or receiver of services that CBT-p is being provided. This approach can be provided by non-licensed staff who have received intensive training, ongoing consultation and have undergone a review of work samples. REP techniques are considered the foundational skills for working with anyone who experiences psychosis, so it fits a wide range of providers. To ensure quality care, this model also requires that individuals employing REP strategies are supervised by individuals who are independently licensed and who are qualified at the low-intensity CBT-p level of the continuum.

Training an entire team in this approach is the best way to apply the full spectrum of CBT-p services. Counselors, therapists, and others who are licensed to provide therapy would be responsible for high- and low- intensity psychotherapy interventions. Other members of the team (case manager, supported employment specialist, nurse, recovery specialist, etc.) provide REP within the context of their job duties and that is appropriate to their scope of practice. In this way, the team can be unified by a common language and model for intervention. Team members can also support one another in developing and coordinating interventions based on the CBT-p model.

The core goal of the stepped-care approach to CBT-p is to engage individuals at the most appropriate level to assist them in a process of defining and improving their personal quality of life.

Treatment in a larger context

Recovery Enhancement Practices are not a standalone approach; instead, they can interact with a number of other interventions. A person with schizophrenia would do well with access to a variety of services (See Section 1 Highlights). Notice that REP fits well with the other services in this model. Please note that the person (i.e., client) is at the center of the model to indicate the critical importance of his or her choices. Outcomes are improved with an integrated, specialized team-based approach.

Section 1 Questions

Care for psychosis

Describe/define psychosis as you would to a friend:

Who are the people you consider part of your team when working with someone who experiences psychosis?

Section 1 Introduction to Recovery Enhancement Practices for Psychosis (REP)

Part 2: Schizophrenia and Recovery Mindset

Objective:

1. **To describe the recovery mindset**

MINDSET

SCHIZOPHRENIA: Consider the first thoughts that come to your mind when you see or hear that word. Some of the more common impressions are listed below. Do any of these impressions sound familiar to you?

- People with schizophrenia are dangerous.
- They will never be well.
- They need someone to take care of them.
- They need medicine or nothing will help.

The attitudes listed above contribute to the stigma associated with schizophrenia. Some of these attitudes are shaped by media and news outlets. Some attitudes are formed by personal experience. What is important to consider is that **attitudes set the stage for actions**. Common responses to the above attitudes may include avoidance, exclusion, coercion, and control of individuals who are labeled with this condition. Another common tendency is to believe that the best way to care for someone with schizophrenia is to do everything for the person. These negative and inaccurate attitudes about schizophrenia can lead to ineffective interventions and practices.

For far too long and too often, schizophrenia has been viewed primarily from the lens of biology. Biology is important, but this perspective is incomplete. When biology becomes the exclusive way of thinking about schizophrenia, it narrows the range of treatment options. For example, symptoms may be viewed as categorically abnormal (e.g., if I hear a voice, I am mentally ill) and interventions become limited (e.g., medicine). In the past, clients were discouraged from talking about their symptoms (voices or delusions). When addressing the client's concern, the primary focus of treatment was to dispute the person's ideas and to focus mainly on taking medicine (e.g., "This is a brain disease and you have to take your medication"). If one believes that psychosis cannot be helped, with or without medicine, this may lead others to "take over" and attempt to do everything for the client. If someone made most of your decisions for you, what effect would that have on your self-confidence? For more detailed information, go to the resources at the end of this section and complete self-study exercises 1 and 2.

A singular, biological view has mostly fallen out of favor in other areas of physical health concerns (think about diabetes or hypertension) where specific

lifestyle adjustments are now more strongly advised. This type of holistic approach for schizophrenia is much less common.

The recovery-oriented perspective makes a different set of assumptions about a person who is living with schizophrenia. This perspective emphasizes the **dignity of the person** and the belief that individuals who are struggling **can better their own world** (see Deegan, 1997). Related to this point is the fact that people with schizophrenia ***can*** and ***do*** recover. Contrary to popular misconception, the **recovery rates** for individuals with schizophrenia range between **60-80%** (APA curriculum; Harding; 2003). From a recovery perspective, there is also a greater appreciation that distressing experiences, like hearing voices, may be linked with past or current stress.

From the recovery viewpoint, it is more essential to ask, "**What happened to you?"** and **"What do you need?**" rather than, "What is wrong with you?" (See Read, 2018). It was once thought that delusions were fixed false beliefs which, by definition, would not change. The recovery view suggests that delusions are strongly held beliefs and, like all beliefs, are understandable when viewed in the context of the individual's experience, and beliefs vary on a continuum of different dimensions (e.g., how strongly someone holds the belief, how much they think about the belief, how much the belief interferes with their life, how much distress the belief causes). This perspective allows providers to work within the person's belief system, rather than confronting or disputing the belief.

Biology	Recovery
□ **Schizophrenia is a brain disease with no cure** □ **Goal is symptom reduction** □ **Must be on medicine before therapy can begin** □ **Help client to orient to reality and educate about schizophrenia** □ **Do not talk about or explore symptoms** □ **If you talk about symptoms, either try to change the client's mind or convince him/her to take medication** □ **Do not expect much progress**	□ **Many with schizophrenia can and do recover** □ **Explore symptoms with a focus on listening and understanding and reducing distress** □ **Identify a common area to work on together; ask questions to clarify understanding** □ **Medicine is one of several ways to reduce distress and improve functioning** □ **There are many ways to improve quality of life** □ **Recovery is about living well whether symptoms are present or not**

A recovery-oriented approach conveys a message of receptiveness to hear the other person's viewpoint, no matter how strange it may sound. The goal is to understand his or her perspective before moving to help the client make changes. Additionally, from a recovery perspective, there are many possible pathways to improving one's life.

What do individuals who experience psychosis want in a provider?

When individuals with schizophrenia were asked about the qualities they preferred in their mental health providers, **"friendliness"** was the characteristic most clients chose. (Coursey, Keller, & Farrell, 1995). Workers who are friendly, kind, and who listen to the clients' concerns were most desirable. Other research involving clients who showed long-term recovery in schizophrenia identified positive associations for three factors: self-sufficiency, community integration, and having someone who "believed in me" (Harding, 2003). Taking the third point (someone who believed in me) one step further, one recent study found that case manager expectations of clients had a direct impact on employment status (i.e., clients of case managers who were more optimistic about their client's internal resources showed better employment status compared to those with low expectations for their clients

(O'Connell & Stein, 2011). How we treat those we work with and the attitudes we hold about them matter.

The cognitive symptoms inherent in a psychotic illness often result in poor concentration and difficulty with decision-making. This often leads mental health workers to think it is easier to "do for" clients (i.e., make decisions for the client or solve problems for the client). From the recovery perspective, the **value is placed on sharing decision-making.** In other words, to "**do with**" clients and empower and teach them to make their own decisions.

How do these recommendations fit with the preference of individuals living with schizophrenia? In a recent review of the importance of values and ethics in treatment, Brabban and colleagues (2017) list the following things that are **important to persons who receive treatment for schizophrenia**:

- To be listened to
- To have experiences validated
- To be seen as a person
- To be given hope
- To be given information and choice/collaboration about treatment
- To regain a sense of self and rebuild one's life with optimism

With increased awareness of the importance of how we think about individuals with mental illnesses, there has been an increased effort to clarify what is meant by recovery. Consider the following elements of *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery* (U.S. Department of Health and Human Services, 2012).

Recovery is "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p.3).

We next provide a description of the 10 principles of recovery and ways to apply these principles in your practice. Can you think of other ways?

SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery

Recovery Emerges from Hope
Defined: The belief that recovery with schizophrenia is real and possible
Applied: Familiarize yourself with outcome literature showing recovery rates of 60-80% for individuals with schizophrenia. Acquaint yourself with recovery stories within your own agency. Look for opportunities to communicate hope to clients, e.g., "we can do this!"

Recovery is Person-Driven
Defined: Individuals are encouraged and empowered to guide their own process of recovery. According to Deegan (1997), empowerment is based on the belief that others can act to better their world. The philosophy of REP is to identify opportunities for individuals to act on their own behalf in a way that contributes to recovery.
Applied: Letting the client identify short- and long-term goals is *one* aspect. Work with individuals to maximize their input and choice in *daily* interactions (asking frequently for their input, preferences and interests and also asking permission to offer suggestions put them in charge of receiving this information).

Recovery Occurs via Many Pathways
Defined: There are many ways in which individuals improve their quality of life based on their unique talents/strengths occurring within a variety of different contexts. Methods for dealing with illnesses include but are not limited to formal therapies, medicine, family and community supports, work, exercise, and meaningful activities.
Applied: When working with individuals with schizophrenia, be open to a variety of healing pathways. Encourage them to explore a range of interests and options to find the methods that work best for them.

Recovery is Holistic
Defined: A process that encompasses the whole person: mind, body, spirit, and community.
Applied: Discuss a wide range of interests and help clients to integrate and coordinate care offered in different aspects of their life (not just symptoms and appointments but attending to physical, social, spiritual, as well a sense of larger purpose).

Recovery is Supported by Peers
Defined: Learning about recovery is often facilitated by hearing from individuals who have a lived experience of psychosis and who are willing to share their recovery stories and help guide recovery.
Applied: Does your agency have peer support specialists who can consult with teams? Are there options for peer-led or operated services?

Recovery is Supported through Relationships and Social Networks
Defined: Support from and interaction with others is essential to increasing knowledge, skills, a sense of belonging, and community.
Applied: Look for a variety of ways that individuals may give and receive support along the way to pursuing their recovery goals. For example, many clients volunteer in areas of personal interest. Look for ways that family can be more effectively engaged in supporting the client.

Recovery is Culture-Based and Culture-Influenced
Defined: Cultural background includes values, ethnic and faith traditions, and beliefs. A person's culture is important to determining his or her journey and pathway to recovery.
Applied: Make it a point to learn about the background, culture, beliefs, and values of clients and the importance of these elements in the person's life. Identify important parts of the client's cultural background that may help the client to make sense of his or her experience or provide a sense of belonging. Identify cultural experiences that can open opportunities for meaningful activities.

Recovery is Supported by Addressing Trauma
Defined: The experience of traumatic events often precedes or is associated with substance use or mental health problems. Trauma-informed care involves an awareness of the potential short- and long-term effects of trauma, as well as understanding methods for fostering safety and trust in working toward recovery.
Applied: Does your agency have a process for identifying trauma history? Organize your sessions and interactions to promote a regular, safe routine that allows the client to have choices and the ability to guide treatment collaboratively. When appropriate and the client agrees, offer evidence-based treatments that address trauma. As mentioned early, another way to think about psychosis is to ask *what happened to* the individual that may contribute to his/her experience.

Recovery Involves Individual, Family, and Community Strengths and Responsibilities
Defined: Recovery is promoted when it is based on strengths and resources that are available. While symptoms and experiences can be challenging, individuals are responsible for their own recovery. Families and communities are also responsible for providing opportunities and resources to support recovery.
Applied: In your work with clients, *focus on what is strong rather than what is wrong*. Ask clients to identify strengths. Regularly point out strengths that you observe when working with clients. Respect clients' choices and decisions.

Recovery is Based on Respect
Defined: Recovery is promoted when individuals are treated with dignity and respect.
Applied: Every interaction is influenced by the way that we view and interact with the clients we serve. Actively listening is one way that we show respect to others. Asking for the client's permission to inquire about topics, offer opinions, and select action steps are all ways to communicate respect. The language we use in our electronic notes and the way we refer to clients in team meetings are also important areas to practice respectful communication.

Section 1: Self-Study Exercise 1

Attitudes about Psychosis

Early in training it is helpful to take a look at your views about psychosis. Consider the following statements and circle the degree to which you agree:

Delusions can be very understandable.

1	2	3	4	5
True/Agree		Unsure		False/Disagree

Hallucinations, odd beliefs, and/or disorganized thinking can happen to anyone under enough stress.

1	2	3	4	5
True/Agree		Unsure		False/Disagree

Some symptoms of psychosis (like paranoia) are actually not uncommon in the general population.

1	2	3	4	5
True/Agree		Unsure		False/Disagree

People with psychosis can and do recover.

1	2	3	4	5
True/Agree		Unsure		False/Disagree

The statements above were identified by a panel of experts as attitudes important for individuals who practice CBT-p (see Morrison & Barratt, 2010). Statements that are endorsed in the direction of *"True/Agree*" reflect the mindset of expert practitioners of CBT-p and indicate a way of thinking that is consistent with recovery.

The purpose of this survey is for you to get a better idea of your views about psychosis and recovery.

As a personal self-reflection exercise, consider the following questions:

How do my views about psychosis and recovery impact my interactions with individuals with schizophrenia?

What does the research say about recovery and schizophrenia? What does that mean for the individuals that I work with?

Section 1: Self-Study Exercise 2

Mental Health Provider Qualities

In order to help you to think about how to work with individuals who experience psychosis, consider the following exercise:

To the best of your ability, imagine that one day you began to experience your world very differently. You have been experiencing a variety of stressors in your life and you start to have problems focusing your thoughts. You are bothered by many intrusive thoughts and ideas. You start to hear voices that you find very distracting. Slowly, you withdraw and stay to yourself and become increasingly fearful. While bothered by all the changes, you are also annoyed that family and friends are insisting that you get help. When you try to explain your concerns, you find that people either dismiss you or tell you to go to the doctor. You are eventually forced to get treatment and notice that while you feel less fearful, you also feel less like yourself, more blah, and have found that you have gained weight and feel physically unwell. Today, you meet your new mental health provider.

How would you like your mental health provider to approach you? Write your response here:

What qualities of a mental health provider do you believe to be the most important when working with an individual who experiences psychosis?

*Exercise inspired by Wright et al., (2014)

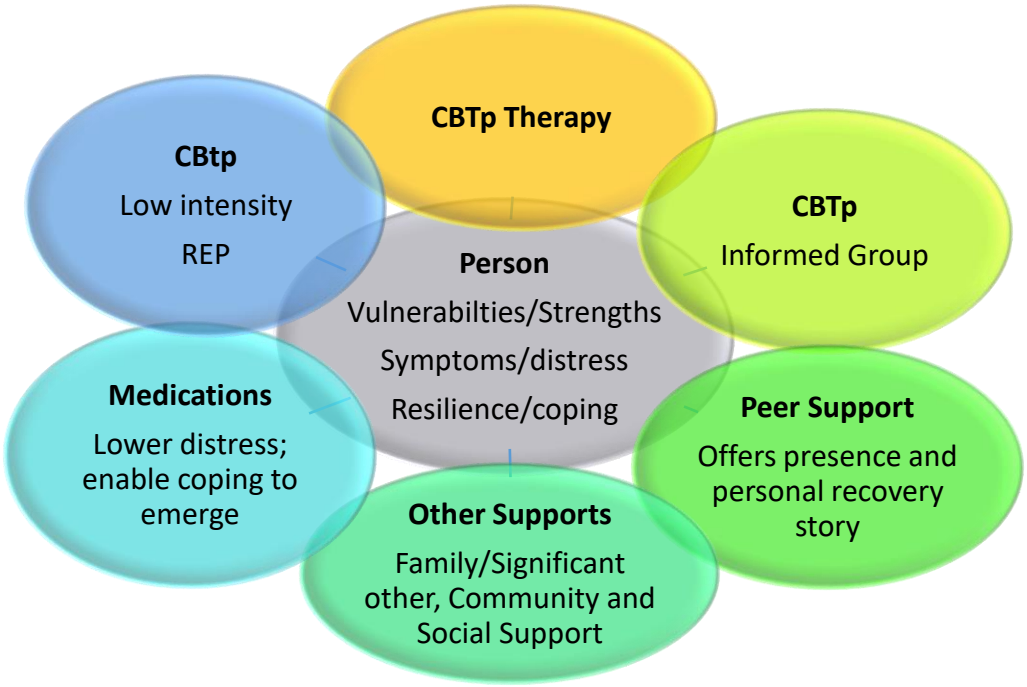
Section 1 Highlights: Schizophrenia is Often Misunderstood

- ***Bottom line: Recovery happens!***

What do we need to know?

- Starting point is dignity/respect/choice for the person experiencing psychosis
- Interventions informed by CBT-p and Recovery can help
- You can make a difference!
- The best approach is to work as a **TEAM!**

Team model



As a new learner:

- Be kind to yourself - welcome uncertainty!
- Check with your trainers, supervisors, and peers often for feedback and support

Section 2: Relationship Building/Engagement

Part 1: Developing a Collaborative Relationship

Objective:

1. **Form a positive, supportive, trusting relationship**

Developing a Collaborative Relationship

The most important task in promoting recovery is to build trust and to really get to know the person with whom you are working. It is in the context of this relationship that you will be able to introduce Recovery Enhancement Practices for Psychosis and instill a sense of realistic hopefulness about recovery. The trust and support of the relationship are what enable new learning to happen. As providers, we must understand the challenges that psychosis presents to forming relationships and to learning new information. The symptoms of psychosis (such as hearing voices and feeling fearful/ threatened) make it difficult to talk with others, pay attention and effectively integrate new information. For these reasons, we first provide practical considerations for working with psychosis. In short, it is important to identify situations and contexts that maximize our chances of having positive encounters (see Table 1).

As a general principle, it is important to engage clients in topics that they want to talk about, to reflect back what you have heard, and to frequently ask clarifying questions to fully understand the clients' perspective. Patience is essential. "Resting" in engagement (or staying in this phase for a time) is necessary for the client to feel heard and to get the sense that he or she is part of a team working on something together. The idea is to be present to the client and not rushed. At the same time, this is a very active phase in the sense that the mental health provider regularly looks for ways to improve the relationship by empowering the client with choices, helping with practical things, and providing a safe place to share their experience without pressure or judgment.

Location	Consider the best place to work with the client. If you are in an office, try to make the office space calm and clean. Clutter can cause confusion and distraction. Bright lighting can be overwhelming to someone with perceptual difficulties.
	Make the best possible use of time no matter where you are. In the car, walking, having coffee, at their home.
	Consider personal space and eye contact, paying attention to what the client is comfortable with.
	Allow the client to decide the seating arrangement and notice how much distance is preferred.
	Ask for feedback to develop a safe and positive interaction.
Distractions	The home environment may be the most convenient meeting place, but it can have a lot of distractions. Try to limit the distractions in the space.
	Keep in mind that some clients may prefer low background noise which can reduce the intensity of the interaction.
Timing	If possible, negotiate a time of day that works well for both you and the client.
	Is your client naturally a morning person, or does he/she prefer to meet later in the day?
	If the client has a problem with alcohol or drugs, consider meeting during the time of day when risk of using substances is lowest.
Duration	Although most encounters typically last 30-50 minutes, this may vary, depending on how your client is feeling that day or other factors. Some encounters may be much shorter or a bit longer.
	Pay attention to the client's comfort level and *watch for any signs of distress or loss of focus*.
	If the client shows distress or loses the ability to concentrate, *consider shortening the meeting*, rather than persisting and risking damage to the relationship.
Respect	Be holistic in your approach to working with the person. Show respect by offering choices and following their lead- this is a way to share power.

Early on, engagement consists of two parts:

1. Befriending/socializing (developing the relationship; knowing the person)
2. Effectively listening and responding to psychosis

Befriending/Socializing

Individuals who experience psychosis often find social conversation to be quite difficult. A person may be bothered by internal sounds or may misperceive social cues, misread faces, etc. Cognitive symptoms may make it difficult to initiate conversation and to recall what has recently been discussed. So… one of the first strategies is simply to make conversation light and easy. It is helpful to have a collection of "conversation starters" for early sessions. Some people are naturally gifted in this respect and others benefit from good preparation. Common "starters" include:

- Checking for areas of interest, hobbies, sports, favorite music, movies, shows, activities, clothing, or pets.
    - Once interest is identified, follow up by asking the person to teach you about their interest

- Asking about the ride in for the appointment and the weather are always safe bets.

- Additional prompts and starters:
    - If someone wrote a book about you, what would be in it?
    - Play a game - handy to have a deck of cards available
    - List favorite songs or music groups

During these early conversations, it is important to find as many things as possible that you can genuinely relate to with the person. Once an area of interest is identified, please spend some time genuinely exploring their interest. This is NOT wasted time. This is time well spent getting to know the person, what they like, what

they are good at, what is important to them. Remember that this individual has probably experienced unusual physical sensations, their viewpoint may have been dismissed or they may have been told to do things they may not fully understand. They may feel very disconnected from their "old" self and alienated from others. By helping them to talk about their interests you help them to re-connect with others.

Another early strategy is to provide the person with choices and options by frequently asking permission. For example, "Where would you like to sit?" or "Would you like to go for 30 or 40 minutes today?" "Would it be okay if we completed the paperwork this time or would next time be better?" Making choices in this way subtly conveys the idea that, "I am a person who has the power to make decisions to improve my life."

Another early befriending strategy is to notice and affirm strengths (e.g., "that was a lot of appointments to juggle, nice job handling that"). Find an area of interest and learn from the person. For example, "Pretty cool that you know so much about film, I don't know much about film, would you be willing to tell more about what you know about films?" Put another way, a common recovery guideline is to, "***focus on what is strong rather than what is wrong***."

It is also important to consistently express hope and optimism. For example, "We can figure this out together;" "Once we finish this step, we will move onto the next," etc.

Section 2 Questions

Collaborative Relationship

Identify three conversation starters that you might use with clients.

List actions that would help to improve the collaborative relationship with two of your current clients.

Section 2: Relationship Building/Engagement

Part 2: Listening and Responding to Psychosis

Objectives:

1. **Learn ways to engage clients who experience psychotic symptoms - how to listen and understand concerns and hopes**
2. **Learn how to respond to different levels of insight**
3. **Learn the importance of collaboration and shared decision-making in working with psychosis**

Understanding and Communicating with a Person who Experiences Psychosis

The symptoms of psychosis are the most common barrier to typical social interactions and meeting goals. For example, the client's thought process may be frequently interrupted by intrusive thoughts or sounds or his or her thinking may be disorganized. Some of the things we take for granted, such as adequate attention and memory skills, may be significantly lacking. Also keep in mind that individuals with psychosis are often excluded, avoided, and treated disrespectfully. As a result, they may develop an expectation to be treated the same by you (we sometimes call this a "blocking belief," because the expectation (belief) that others will be unhelpful or dismissive, blocks the person's willingness to interact with you or engage in new behaviors). It is important to create a "space" that is safe to share whatever is on the person's mind. It is very important to be patient, kind and non-judgmental in response to statements, even if the statements sound bizarre or outlandish. There are specific behaviors that may help the person improve his or her ability to interact and take meaningful steps to reach goals.

Two strategies for communicating about the experience of psychosis:

1. **Reflect** what you hear so that the person feels heard.
2. **Explore** the experience in a neutral and curious way.

Reflect: Effective listening is the key to building any solid relationship. The goal of listening is to understand the other person's perspective. The way that we show this is by reflecting back (or paraphrasing) what we have heard as accurately as possible. This is one of the best strategies for building a relationship. Xavier Amador has developed an entire model for working with individuals with psychosis that begins with what he calls reflective listening (Amador, 2000). Amador (2000) explains that "the sole purpose of reflective listening is to understand and communicate back what the person is saying without reacting or commenting" (p. 74).

This goal is often difficult to reach because individuals with psychosis can say things that are shocking, improbable, or extremely disorganized. When this happens, we are prone to paraphrase or interpret for the person what they have said and, by doing so, we do not really listen to them. So, you may have to step out of your comfort zone a little bit to listen with the intent of understanding the person's perspective, regardless of how unusual the content may seem. To do this effectively, it is important to both paraphrase what the person experienced and connect the emotion that the person is experiencing. When this is done well, the person really feels heard. This skill is learned through practice, so please rely on your instructors and mentors to guide you.

When a person truly feels heard by another, trust and connection grow. So, one of the phrases we use often is, "***Reflect to Connect***" to remind us to make sure we understand what the person has said and experienced in order to strengthen our connection.

Missed reflection- collusion

In an effort to validate the client's experience, we have to be careful that we don't directly or even inadvertently collude with the belief system. In other words, we need to be careful NOT to strengthen a delusional belief. For example, if the client reports, "I'm frightened because the devil is after me, weird things have been going on, he is doing things to me!"

- *Colluding statement: Sounds like the devil is after you!*
- *Reflective statement: Sounds like you have had some distressing experiences, you mentioned weird things happening and you think to yourself 'the devil is after me' and you feel very afraid. Am I understanding this right?*

Remember the goal is to really listen to the client, but at the same time to neither agree nor disagree with the stated belief. Rather, the task is to observe and describe the experience. Once the client feels heard, then you can begin to explore what is happening in a neutral and curious way.

Missed reflection- avoidance of content

Another common misstep involves avoiding the psychotic content while reflecting what was said:

The client says, "the voices constantly tell me I am possessed, the Devil is in me, maybe I am the Devil… I just hide under my blankets"

- Missed reflection- "sounds like you're feeling some stress about things you are hearing" (vague reflection without acknowledging content)
- Reflective listening: can I see if I got this right? sounds like… (insert psychotic content) you heard a voice saying you were possessed and the voices say the devil is in you, and then you hid in your blankets- did I get that right? this sounds very frightening".

Explore- in a neutral and curious way. As mental health providers, we often want to be helpful and solve problems. However, if we move too quickly and try to solve problems for the person or impose our preference in a situation we often: 1.) do not have all of the important information, and 2.) inadvertently disempower the person. We may send the message that "We are right and will take care of things" (*potential implied message*, "You are wrong and cannot do it for yourself").

In addition to actively listening, the second component of exploring concerns in a neutral and curious way is also essential to working with psychosis. It is important to gather more information in a respectful and curious way so that we understand the experience from the client's perspective first. Sometimes the content is difficult to understand and may not make sense to us. When we don't know what or how to ask, we might say, "I don't fully understand, would you be willing to tell

me a little more about that?" We sometimes call this, "**Tell me more to explore**" questions. In order to do this well, we also have to suspend judgment and resist the temptation to point out what appears to be gaps in logic or the impossibility of a stated belief. We give them the benefit of the doubt and try to hear them out. Rather than contradict the individual, the aim of exploratory questions is more about trying to understand how the experience came to be and how they have managed the experience so far.

A note on "insight"

You may have heard the phrase, "the client has no insight," which is often thought to mean the person has no realization that they are ill. This is to some extent accurate but has some additional meaning. Insight refers to the level of awareness a person has about their symptoms, behaviors, **and** illness. David (1990) breaks insight into three areas:

1. The extent to which a person is able to recognize that there is something **unusual** about their **behavior** or experience (e.g., that it is outside of the norm (or consensus reality) and/or interferes with their functioning)

2. The extent to which a person is able to recognize that the atypical experience/behavior is **related to an illness** or traumatic event

3. The extent to which a person is **willing to receive treatment** for the causes of the unusual experience or behavior.

When insight is particularly low, the person may be experiencing ***anosognosia;*** simply put, the person's brain does not automatically or effectively update information about their experience (See Amador, 2000). The person may not fully realize the aspects of their thoughts and behavior that are out of the ordinary (or not part of other peoples' "consensus reality" that we mentioned in the first section). For example, a person may not shower for a long time and may not realize that others

would notice this as a problem. ***Because this behavior is related to underlying difficulties the brain experiences in processing information, it is better viewed as a cognitive difficulty rather than a personality problem. In other words, when a person shows signs that they do not believe they are ill, it often has more to do with injury and processing problems than with defiance or denial*** (See Amador, 2000 for a more extensive discussion).

<u>How to respond to differing levels of insight</u>:

It is always best to begin with the person's understanding of and language for their experiences. For example, if the person reports that they have been diagnosed with an illness called "schizophrenia," it is helpful to first get an understanding of what they have been told and how well they understand this information.

If the person states, "There is nothing wrong;" it is not helpful to directly challenge their statement. It may rather be more beneficial to learn about what brought them to services and to learn about things they would like to do (back to befriending and socializing). You are looking for something in common, something you may be able to work on together. Again, it is important to not directly contradict or confront a strongly held belief or experience. In fact, it is often helpful to substitute the word "experience" or "event" in place of words like symptom, hallucination, or delusion. Consider the following additional examples:

<u>Suggested phrasing about a psychotic experience</u>:

- "Could you tell me a little more about…"(experience/event/symptom)
- "Where do you think that (experience/event) comes from? How do you explain it?" When did you first get a sense this was happening?
- "What is happening at this moment for you right now?"
- Do other people also have this experience or is it only you?

****Good references for reflective listening and engagement with psychosis**

- Amador, X. (2000). *I Am Not Sick I Don't Need Help: How to Help Someone with Mental Illness Accept Treatment.* New York: Vida Press

- Beck, A.T., Grant, P., Inverso, E., Brinen, A.P., Perivoliotis, D. (2021). *Recovery-Oriented Cognitive Therapy for Serious Mental Health Conditions.* NY: Guilford Press.

Collaboration and Shared Decision-making:

Probably the best way to summarize effective recovery-oriented practice for psychosis is to engage in an ongoing process of collaboration and shared decision-making. The underlying assumption is that both you and the person you are working with are equals. You both have some knowledge about the struggles and barriers to success and you both have something to offer about how to move forward. It is in figuring it out together that seems to make the difference.

Jean Vanier (1998), an advocate for persons living with disabilities, wrote that we discover who we are through mutual vulnerability and learning together. Learning occurs because we do not know something. Learning new ways to make sense of things helps to build a person's self-identity. Power and cleverness (the provider with all the answers for problems) may lead to admiration, but also separation and distance (I am not like the person with all the answers). Being able to sit with not knowing the answer (vulnerability) invites closeness and a shared space where learning to rebuild one's sense of self begins. So, gathering information *together*, making sense of things *together* (reflect and explore) and figuring out solutions *together* are all part of recovery in psychosis. In other words, the task for the person with psychosis is to learn to be an active agent in his or her life by using self-reflective skills and new ways to make sense of situations (see Lysaker and Roe, 2016). Providers help this learning process by allowing themselves to be open and to not know the answers, to listen to the perspective of the person with psychosis and to collaboratively figure out meaning and solutions.

Section 2 Questions

Listening and responding to psychosis

How might you respond when a client makes the following comment:

"I heard the devil's voice through the radio and he told me that people were following me. I looked outside and I saw someone walking by- they are following me!"

- Possible Reflection/paraphrase response:

- Possible Curiosity/exploratory question:

Review your responses with your trainer, supervisor or peer mentor

When individuals with psychosis sometimes lack awareness of their symptoms and their functioning, what may be causing that and what are some ways to work with someone who has low "insight"?

Section 2: Relationship building/Engagement

Part 3: Recovery Goals and Structure of Sessions

Objectives:

1. **Developing recovery-oriented goals**
2. **Learning a way to structure sessions**

Recovery Goals

Once a degree of trust and working relationship is established, the next essential task is helping the person to identify and begin to pursue something important and meaningful to them. It is important to not move too quickly to "accomplishing goals." Sometimes, individuals really know what they want to do (e.g., a job) and sometimes they need some help figuring out or remembering what is meaningful for them. If the person has been ill for some time and probably socially excluded, he or she may have a hard time believing that they can do anything meaningful. The person may have developed what is called "defeatist" beliefs about their abilities. In other words, they do not believe they can be successful and so they do not bother really trying. The negative beliefs (about their abilities and chances of success) adversely affect their motivation.

This is why we start with a person's interests and strengths and tie these interests to broad underlying values and long-range dreams or aspirations (which are often motivating and have less associated performance pressure). Once the person is willing to discuss interests and values, they access a more positive way of thinking (Beck and colleagues (2021) have coined the term "*adaptive mode*" to describe this empowered view of oneself). This "can-do" mindset tends to be more conducive to increased energy and to the ability to come up with specific, reachable goals. With energy combined with specific goals, the provider can then help the person to develop small steps toward the goal and eliminate barriers.

One additional way to help clients to tap into a mindset that is more hopeful and motivating is by exploring their values. Values are an expression of qualities, actions, situations and things that are most important to a person. Additionally:

- Core values tend to be relatively stable, but the way we act on values is dynamic.

- Acting according to one's values tends to be intrinsically reinforcing
- Values may serve as a compass to guide behaviors and choices

Because values are broad in scope and not tied to right or wrong (and not so closely tied to performance expectations), helping clients to identify their values and act according to these "deeper" motives is a bit safer than striving for goals (less "achievement risk") and provides a higher likelihood of positive return (I value kindness… I was kind to someone I didn't know today… I acted according to my values- success!). See Hayes, et al., 1999 and O'Donoghue, et al., 2018 for a more complete discussion of these concepts.

Once you have activated motivation to action, it is also helpful to provide two other forms of assistance to help a client realize success:

Assist 1: Teaching the person that long-range **goals are more reachable when they are put into a sequence of small steps.** Individuals who experience psychosis often experience difficulties in thinking that make it very challenging to identify, plan, and enact a series of steps to a desired goal. This is where you come in! Your role is to help the person activate the "can-do" mindset and then work with them to establish a plan of small steps to reach their goals. The small steps in a way become more important than the goal, because success in reaching the small steps provides additional energy and confidence to keep going… this is where they begin to believe that a recovery goal is possible!

Assist 2: The other most common challenge to reaching goals are **negative thoughts** (often in the form of doubt and lack of confidence) that often block their desire to try a new action. Helping the person to identify and check out the "blocking" thought that is slowing them down or leading to avoidance is very important. This is where we **ASSIST WITH ACTION**- highlight the underlying aspiration/ value and help them overcome doubt with small action steps. It is important to help them to show that

they can do more than they may anticipate. Later in the manual, we will discuss different ways to check negative thoughts.

Summary of Goal Setting

1. **ACTIVATE** Motivation
    a. with interests and values

2. **ASSIST with PLANNING** small steps on the way to the goal

3. **ASSIST with ACTION: by helping them to SHOW that they can do more than they may think**.

See below for different ways to identify and plan for goals.

PATH 1 Use client personal interests or strengths to lay the groundwork for exploring values that are needed in the creation of goals
• First, identify the types of things you like to do or would like to do: **   ○ Have a pet; work with animals; learn an instrument • What are you good at? mechanics, technology; music

• Next, identify value/interest (big picture hopes and dreams) linked with the interest or strength
  ○ I like pets because they are cute, lovable, accepting and I like to provide care and to be helpful
  ○ I can play piano

• Next, identify goals based on this activity - value connection that is simple and achievable
  ○ Volunteer at pet shelter- meets the value of providing care
  ○ Adopt a pet - providing care and being generous - giving a home
  ○ take music lessons; meet with others who like the same music

• Finally, identify VERY small steps that would lead to this larger goal Search for places to volunteer; develop a plan for completing applications, etc.

**One of the effects of psychosis is a slowing of thinking and difficulty generating ideas. If the person you are working with has trouble coming up with things they like to do, consider using a values card-sort to provide a wide variety of options for the person to choose from (see the link with materials from Moyers and Martino, 2006). The person then can identify and prioritize things that are most interesting in active and engaging ways that do not result in too much mental strain. Use your creativity to make the activity fun and energizing.

PATH 2 Going from small steps to bigger changes and guiding self-reflection
Goal setting from *Cognitive Behavioral Social Skills Training for Schizophrenia* Long-term goals can be thought about in terms of **months**, short-term goals in **weeks** and steps to short-term goals in **days**. Granholm and colleagues (2016) use the number 7 as the focus: 7 months for long-term goal; 7 weeks for short-term goal; and 7 days to complete the small steps.
• <u>What is your desire/aspiration</u>? Have a boyfriend/girlfriend
• <u>What is a small goal</u> that you would be willing to start with that would help with your desire to be in a relationship? Short term goal 1 - Hygiene; improve social skills
• <u>Steps to support short-term goals</u>: Shower every-other-day; practice introductory greetings
• <u>Reflect upon progress: what does that say that you were able to take those small steps? What feeling does that give you?</u>

PATH 3 Working around barriers to find aspiration and action items

• What is your **aspiration**?
  ○ Can't do anything because of voices
  ○ I always fail, so why bother trying

• **"Magic Wand" Question***: If we could wave a magic wand and this obstacle (hearing voices) disappeared, what would you be doing? Or conversely, if we could wave a wand and you were able to do _____ (e.g., big thought like-control the weather); what would be different? What would you be doing? What would others observe about you? * see Granholm, et al., 2016
• **Catch/Check/Change "it" (negative thought)**: example: "I always fail",
  ○ Catch it: I understand you've been through a lot and makes sense your concern about not succeeding AND this thought may keep you from trying
  ○ Check it: I wonder if there are small successes you've had along the way, it is easy to miss them, or maybe willing to take a small risk now and try this one activity?
  ○ Change it: I wonder if we could frame this thought differently? like, "this may be hard, but I can certainly try some things to see what I can do"…

• **Action steps:** Develop goals based on these thoughts/unmet needs/desired outcomes

Once a plan for working toward a goal or target is established, it is important to routinely discuss the identified goals and values and to relate all actions back to the aspiration or value. The most common barriers to reaching the goals are "defeatist beliefs" ("I don't believe I can do that" or "nothing will help"); practical limitations related to lack of resources (no transportation); and/or cognitive symptoms (difficulty organizing self; limited attention and concentration). The use of a visual aid, such as a goal sheet that can be referred to often may help with the cognitive challenges and provide an opportunity to identify any self-defeating beliefs. There are lots of ways to organize this information. See Goal Sheet and DIALOG Assessment tool in the Tool Kit (Preibe, et al., 2013; 2015).

A word about tasks and targets/aspirational goals. When a person states that their goal is "to complete my SSD application." This not so much a goal or target but a task. It is important to pay attention to three things here to find the target/goal of your work while completing the task:

1. **Identify** what **aspiration** the task will help with. If the task is completed, what does the task (in this case an application) provide? It might provide resources, and with resources, the person will be more independent and can volunteer. Value-based goal category= independence; volunteering.
2. **Identify** any **barriers**. What gets in the way of the person completing this task on his or her own (voices, concentration problems)? The barrier is often the "target" of your work. This information will also likely fulfill the requirement to specify medical necessity when writing notes (E.g. "worked with client to overcome cognitive symptoms and anxiety associated with completing necessary paperwork").
3. Make sure that when working on a task it is **done together with a focus on developing skills**. Ask yourself: "What is the person's role and what is my role as a provider?" What skill could be taught and practiced on the way to this goal? Will my actions help the person develop confidence and be able to do the task independently next time or am I doing the task for the person? A common framing of the work may be, "Let's work together on the skills of completing the application (list skills) so that it will help you reach your desire to be more independent and to volunteer." As a team, you share decisions about how to do a task and then review the outcome in order to reinforce learning and to improve self-confidence.

Section 3 Question: Goals and Structure for Session

Think of someone you are working with currently. What are some interests and values that might be developed into goals?

Insights from the Field

"I think the best advice to give to people learning the techniques is to find out what's important to the client, because once you find that out, it'll be an easier task. It's got to be something that you know you can both work on and both agree on and then allow them to do the work."

"As they see that they're making these accomplishments, they're feeling better about themselves. They become more self-sufficient and actually believe that there is recovery."

Structuring Sessions

The next section will discuss a method for organizing your time with clients. There are a few important reasons to provide structure for meetings. 1. Structured and focused meetings are more productive (guides the provider and receiver of services in a process for working together) 2. The structure becomes predictable and internalized (so may increase comfort level knowing what they will be doing each time). The method here is referred to as the START method. START is an acronym for Socialize, Target, Action, Review, and Take-Home work. This acronym is intended to help you remember the order and key points of sessions.

START

For each meeting, use the START Method as outlined on the next two pages.

S	**SOCIALIZE – *Support and safety is the mindset for the beginning of each visit.*** It is important to start the meeting with a very casual conversation. You can talk with the client about recent events or the ride in or interests of the client. It is helpful to talk a little about the events that have occurred since the last encounter – what has the client been doing, or whether he or she needs you to help with anything (e.g., doctor appointment, benefits). The goal is to set a relaxing, supportive tone. This makes it "safe" to talk because the client learns that you are interested in listening to him or her and that you will not be giving unsolicited advice or lectures.
T	**TARGET – *Set an agenda at the beginning of the meeting by asking the client what he or she would like to discuss today – that is, explicitly identify a target to work on that is important to the client. One way to transition to "work mode" is to ask about the previous time's home practice or Take-Home work. This helps to build connections between meetings. If you are in the early stages, the Target may be mainly to learn more about the person's life and what they experience.*** Once you begin the conversation about things to work on, the client may provide several areas to address or may be quite vague in what he or she wants to accomplish. Help the client prioritize target areas and limit the number of things to work on in one meeting. While there is great emphasis on working on the client's goal, it is also important to ***include tasks/goals that you feel are relevant in the list of priorities.*** For example, your role on the team may include some very specific tasks (e.g., housing, benefits, school, and job applications). These activities are also part of what is prioritized during this part of the encounter.

A	**ACTION – *This is the primary work of the session.*** Action may include a number of skills: • Listening and reflecting; exploring content; • It may include identifying goals and setting up a plan to reach the goals; • Teaching a skill (copings skill or practical skill): e.g., how to catch, check and change a negative thought) • It may also include activities important for living (filling out applications; getting groceries; going to appointments). • When the Action is a task of living; the way to make these common daily actions consistent with recovery-oriented practices is to emphasize **shared decision-making** (doing it together); encouraging the person to take ownership of the task (filling out an application).
R	**REVIEW – *Check the client's understanding of the encounter and ask for feedback.*** Always take the time to ask the client what he or she understood from your conversation, what was important to him or her, and what was helpful or unhelpful about your meeting. This will help you to identify what stood out for the client. This also invites feedback and provides opportunities for the client to shape the time you spend together (empowerment).
T	**TAKE-HOME WORK – *Talk with the client about what he or she would like to work on between this meeting and the next.*** It is important to make sure the client clearly understands what needs to be done for the next encounter. Work with the client to identify a reasonable amount of work to complete and check for barriers to completing the work. In the spirit of collaboration, it is helpful for you to see if there is something you can also do in between sessions.

A note on reviewing meetings and asking for feedback (R from START card example)

In order to assess how the interactions are going when working with someone who experiences psychosis, it is important to ***1) ask the client about the experience of the meeting and to ask for feedback*** and ***2) respond in a supportive and constructive way to the client's statements or observations.***

Consider asking the client the following questions:

- What stood out to you most from our meeting today?
- How do you like our meetings so far?
- Are the sessions going too quickly or too slowly? What changes would you make to improve our time together?
- Am I understanding your concerns? Are we working on the things that are important to you?

This strategy respects the client's ability to shape and guide the interaction as well as develop the overall approach for reaching a goal. This helps the person to have some control over how they spend time with you (remember choices support empowerment).

Note: **Feedback is a two-way street.** ***If the client says something you don't understand, it is helpful to ask for clarification.*** Remember that the client may have experienced other people ignoring or dismissing them. So… a gentle request for more information conveys a genuine interest in what the client has to say and helps the client to focus and clarify his or her own thinking. Think about having a conversation with a friend, if they veer too far off-topic and you do not understand where they are going, do you just let them go, or do you ask them to clarify?

Example of a meeting that follows the START structure

S	**SOCIALIZE** **Mental Health Provider (MHP)**: Hi, Joe. How was the ride in today? **Joe**: It was all right - a lot of traffic, but I got in okay. **MHP**: Glad the traffic didn't hold you up. Last time, you mentioned you were going to visit with family. How did that go? **Joe:** It was fine. I saw my cousin and that was nice. **MHP**: Is that the cousin you mentioned last time as someone you were close to?
T	**TARGET** **MHP**: So, Joe, we have talked about a few things that you might like to try to do differently. Do you recall what we talked about? **Joe**: Yeah, getting out more and maybe volunteering; I also need a new place. Can you help me with my neighbors? **MHP**: Do you mind if I just list these ideas to make sure I have them? So, getting out more, new place, and trouble with neighbors. Is that right? If you had to pick one of these for us to work on today, what is most important? **Joe:** How about my neighbors? **MHP**: Okay, how about we start with understanding the situation with your neighbors. I also wondered if we could save a little time to finish the benefits application we started last time. Would that be okay? **Joe:** Sure, I almost forgot about that.

A	**ACTION** **MHP**: So, tell me, what is going on with the neighbors? **Joe**: They keep making noise all night, shouting at times, calling me names at times. When I tell them to be quiet, they just say that they haven't done anything, and I hate when they lie like that. **MHP**: Let me see if I understand. (Reflect back and then ask for some additional details: When does it happen? Do other neighbors complain? What other actions has he done to address the situation?) …So, this is what I understand so far (summarize)… Did I get that right? What do you think would be a useful next step? (Process with the client leading to one action) … So, if you collect some more information and continue to do some relaxing, distracting activities when you hear all the noise that we talked about, we can review how it went next time. **Joe**: Okay. **MHP**: Would it be okay to move on to the benefits application needed for the transportation program we signed you up for? What part of the application would you like to do and what part could I do?
R	**REVIEW** **MHP**: We are about out of time today. What was helpful today for you? **Joe**: I liked telling you about the neighbors and I'm glad the application is done. **MHP**: What was most helpful about that? **Joe:** Just venting. I felt less upset.
T	**TAKE-HOME WORK** **MHP**: Between now and the next time we meet, what would you like to do about the neighbors? **Joe**: I'm just going to ignore them for now and do some of my other activities. **MHP**: Anything from today's meeting you might want to try? **Joe:** Well, I can write down the times it happens and what I do. **MHP**: Sounds good. If you want to write any other notes when you write down the times that might help me to understand the situation better.

Relationship Building & Engagement Highlights

Relationship building is about…

- ✓ Respect
- ✓ Having conversations: topics_____
- ✓ Finding as many common interests as possible - let them teach you about their interests!
- ✓ Noticing and affirming strengths
- ✓ Asking for their input and providing choices and options
- ✓ Expressing hope and optimism
- ✓ Have patience – this work is often slow and repetitive, that is perfectly normal
- ✓ Allow your kindness and compassion for others to shine through, you may be the only example of kindness and compassion this person may see

Find a comfortable and safe location Be flexible with time and routine

Goals: Let's find something that matters!

- **ACTIVATE** "Focus on what is strong rather than what is wrong"
  - Start with interests-values-strengths
- **ASSIST** with **planning and monitoring**
  - Identify a long-range plan
  - Help with identifying small steps
- **ASSIST with ACTION- CATCH** and **CHECK** thoughts that block progress
  - Work together to reduce barriers

For all content:

- Approach with an open and curious mind
- Reflect what you hear and ask for clarification
  - "This is what I heard you say… Can you tell me more so that I understand better?"
- Collaboration: Let's work on this together
- See resource section: Goal Sheet, DIALOG

<u>Finding goals and treatment paths can be like going on a journey!</u>

Where would you like to go? The things you want to do

What is attractive to you about going there?

What is important about going there?

We can work together to get to your goals? What strengths do you bring?

What are some things I can do?

What is one thing we can do today?

Section 3: Teaching and Learning Together

Part 1: Normalization

Objectives:

1. **To describe "normalization" as a strategy**
2. **To provide information that can be used to educate regarding psychosis and how to provide this information**

Strategies for Teaching and Learning Together

In the first two sections, we spent a lot of time focusing on getting a better understanding of schizophrenia and learning ways to effectively relate to individuals who experience psychotic symptoms. **A trusting relationship is a solid foundation for learning**. In this next section, we will provide some ideas about how to help individuals who experience psychosis to learn, remember and create meaning. One way to think about your role is as a co-investigator or collaborator in a shared work project. When client and provider work together as a team, both become students and teachers. Both are learning, remembering, and creating. When it comes to the experience of psychosis, you work together to explore and better understand the psychotic experience in a way that leads to improved coping. There is no single answer, but there is always a task, activity, goal, or challenge to work on together.

In order to achieve this state of teamwork, it is vitally important to overcome the negative, preconceived ideas we may have about working with psychosis. This is sometimes referred to as the stigma of mental illness. As we discussed in earlier sections, many providers fear asking a person about their experiences or have a limited and inaccurate view of what someone with psychosis can achieve. Many clients believe that experiencing psychosis means they are bad, broken, or can't accomplish things on their own. Therefore, it is important to find ways to reduce the impact of stigma

One method to reach this objective is to provide information about psychosis in a way that makes it easier to talk about and that is more accurate. The key starting point is that we all share certain experiences in common (see the poem by Maya Angelou at the end of this section). And, the

fact is, that when pushed to extremes by stress or biology, any one of us would begin to show signs of distress and symptoms. We also have strengths and resilience. We will describe three approaches for reducing the negative connotations associated with schizophrenia and promoting new ways of coping:

- Normalizing techniques
- Stress-vulnerability-resilience model
- Cognitive model

One technique used to reduce stigma and associated distress is called the "normalizing" rationale for unusual experiences (see Kingdon and Turkington, 1991). To normalize symptoms means, 1.) To point out the common aspects of symptoms (e.g., many individuals have suspicious thoughts at times) and, 2.) To help clients view their experiences from a perspective grounded in evidence rather than grounded in emotion and misunderstanding.

The goal of the normalizing rationale is to offer a way to discuss experiences that builds a different understanding of psychosis. Remember, this does not mean that clients should be encouraged to believe distorted beliefs or to follow the instructions

of the voices or anything like that. **Instead, individuals with psychosis are encouraged to consider that their experiences are not uncommon, that the thoughts/experiences they have do not automatically lead to negative outcomes, and that all thoughts are products of the mind and therefore are subject to change**. As a result, they can learn the advantages of sharing their thoughts, checking the accuracy of their thoughts, and developing coping strategies for distressing situations.

Examples of Normalizing Techniques

- ***Education: Commonness of symptoms***. For example, voice-hearing and suspicious thinking are more common than we may realize (see below). For example, Hayward and colleagues (2012) reported that 8% of participants in a survey conducted in the US reported, "hearing things other people could not hear like noises or voices". While symptoms are more common than perhaps many realize, it is important to be careful when normalizing not to minimize the distress of severe voice-hearing. Just because other people experience it does not make it necessarily less frightening in the moment.
- ***Education: Commonness of thinking and decision-making errors*** (i.e., at times, we are all prone to jump to conclusions or misinterpret information). Thoughts are often affected and indeed misled, by emotions. Common unhelpful thinking habits include:
    - Catastrophic thinking- anticipate the worst to happen
    - Discounting the positive- don't recognize positive things you do
    - Emotion reasoning- I feel anxious, so must be danger nearby
    - Spotlighting- doing something and thinking everyone is watching (when in fact most of the time others are not looking or care).
- ***Education: Hearing voices is not only associated with schizophrenia. It can occur for other reasons***:
    - Bereavement

- Sleep deprivation
- Traumatic experiences
- Substance use
- Physical illness (e.g. high fever, viral infections)

Education: Famous individuals who have heard voices (e.g., Anthony Hopkins, Brian Wilson). It is helpful to see other well-known individuals who have dealt with a similar experience.

- ***Education: Recovery happens-*** It is important to let the client know that while the experience of psychosis can be quite frightening, it is also accurate to indicate that many people in fact achieve recovery. For example, across many studies recovery rates range from 60-80% depending upon the study and location. Recovery is common!
- ***A note on self-disclosure***: It is not appropriate to share your problems with people you work with. However, it is often helpful to share information about yourself that indicates how common it is to experience certain things. For example, it may be appropriate to share that a mental health provider also procrastinates when it comes to completing some tasks or has trouble sleeping after feeling really stressed. When these experiences are shared, they can help to reduce the already strong feelings of alienation and isolation felt by many who deal with psychosis.

Effective Information-Sharing Strategies

You probably noticed that most of the above examples involve sharing information. The act of educating is central to REP. And, as Pat Deegan, a well-known psychologist, advocate, and person with lived experience of psychosis, has stated, "Information is power, and information-sharing is power-sharing." At the same time, it is important to recall the essential quality of a co-equal partnership in learning. Neither person is the ultimate expert, each partner offers ideas for consideration. In this sense, REP-based information-sharing is **less like**

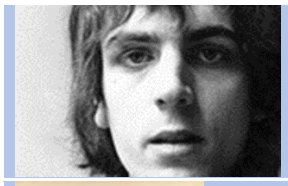
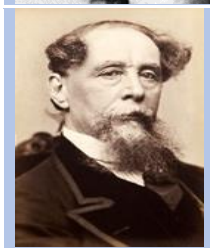
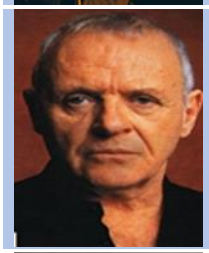
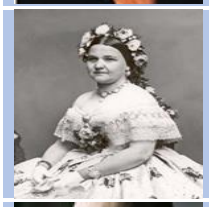
1. “This is the answer, these are the facts”- people who take medicine hear voices less. (While based on evidence, this approach to presenting the information may feel imposed or too confrontational)

And **more like**,

2. “Did you know?” or “I wonder if you were aware that… some people hear voices when they experience bereavement; or “some who have taken medicine and use other strategies have experienced fewer problems with voices.” Followed by, “what do you make of that”?

Notice that in the second framing of information there is much less social pressure to accept the information as presented AND the follow-up question allows individuals the chance to consider what this information means to them. They have the choice to dismiss it if they want or to consider whether or not it applies to them. It is very important for them to make their own decisions about new information. This is how we all take ownership of new learning. In the next few pages, you will find information that you can share to aid in normalizing. Remember that how you share the information is just as important as the information shared.

Famous and Successful Voice Hearers

Syd Barret	Founder of Pink Floyd	
Charles Dickens	Author	
Peter Green	Founder of Fleetwood Mac	
Darrell Hammond	Comedian, Cast member on Saturday Night Live	
Anthony Hopkins	Actor	
Mary Todd Lincoln	First Lady of the United States	
Rufus May	Clinical psychologist, currently in practice and doing well	
Brian Wilson	Co-founder of the Beach Boys	

Research Studies on "Normal" Populations with Unusual Thoughts and Beliefs

Study of 304 students from a four-year university endorsed the following beliefs (Wilson, 2018)

Psychic powers	23.6%
Psychokinesis	23.8%
Mind reading	38.2%
Witchcraft	29.0%
Astral projection	33.6%
Monsters	21.9%
Space aliens	24.2%

Abduction by aliens involuntarily 22.6%

The U.S. government has technology from space aliens in a secret base called Area 51 in Nevada 35.7%

Study of 60,000 British Adults (Cox and Cowling, 1989)

Believed thoughts could be transferred between people	50%
Believed it was possible to predict the future	50%
Believed in ghosts	15-25%

Freeman, 2005

Reported "need to be on guard against others" at least weekly	52%
Reported "people deliberately try to irritate me" at least weekly	27%

Voice hearing

Report current hallucinations 4-5% (Tien, 1991)

Report sensory perception of a person who is not physically present 10-27% (Stevenson, 1983)

Report often heard a voice speaking their thoughts aloud 17.6% (Bentall & Slade, 1985)

Report hearing a voice calling one's name aloud (36%) and hearing their thoughts being spoken aloud (Posey & Leisch, 1983)

Stressors known to induce unusual experiences:

Bereavement

Sexual abuse

Trauma

Sleep deprivation

Sensory deprivation

Hostage situations

Example Transcript for Providing Normalizing Information

Thank you for sharing with me your thoughts about schizophrenia. Would it be ok to share my thoughts about this diagnosis? ***(Asking permission; to avoid imposing provider's view)***

I hear what you are saying… you have been dealing with this for a long time and that others in your family have had this experience. You are not alone- it's not uncommon for families to have more than one person who have these experiences. ***(Reflect person's experience so they feel heard)***

This speaks to the genetics and biology involved. In this sense, it is really no one's fault. Our current understanding is that schizophrenia involves a combination of genetics, biology, and stress. Stressful events are very influential in what and how a person experiences this illness. The good news is that there are treatments and approaches that can address both the biology part and the stress part. If you are interested, I'd be happy to say more about this. ***(Education provided with an invitation to explore more)***

Also, did you know that most people who live with this experience recover and live satisfying, meaningful lives? Wonder if you might be interested in learning about some of these individuals? ***(Provide hopeful perspective and invitation to explore further)***

I appreciate you giving me this chance to talk about schizophrenia. I'm wondering what you think of what I've said? What parts make sense to you? Is there anything we could discuss or explore further? ***(Gratitude and invitation for the person to respond to information and opportunity to explore further)***

In the next section, please read and reflect on the poem, *Human Family*, by Maya Angelou to further explore our common human experience.

Human Family by Maya Angelou

I note the obvious differences
in the human family.
Some of us are serious,
some thrive on comedy.

Some declare their lives are lived
as true profundity,
and others claim they really live
the real reality.

The variety of our skin tones
can confuse, bemuse, delight,
brown and pink and beige and
purple,
tan and blue and white.

I've sailed upon the seven seas
and stopped in every land,
I've seen the wonders of the world
not yet one common man.

I know ten thousand women
called Jane and Mary Jane,
but I've not seen any two
who really were the same.

Mirror twins are different
although their features jibe,
and lovers think quite different thoughts
while lying side by side.

We love and lose in China,
we weep on England's moors,
and laugh and moan in Guinea,
and thrive on Spanish shores.

We seek success in Finland,
are born and die in Maine.
In minor ways we differ,
in major we're the same.

I note the obvious differences
between each sort and type,
but we are more alike, my friends,
than we are unalike.

We are more alike, my friends,
than we are unalike.

We are more alike, my friends,
than we are unalike.

Source: https://www.familyfriendpoems.com/poem/human-family-by-maya-angelou

Questions for Normalization

How common is hearing voices?

What are two common scenarios that might lead to voice hearing?

When is it ok to share a little bit of personal information during a meeting?

Section 3: Teaching and Learning Together

Part 2: Stress-Vulnerability-Resilience Model

Objectives:

1. **To describe the stress-vulnerability-resilience model**
2. **To discuss ways to use this model and worksheet in order to help individuals better understand their experience and ways to cope**

The Stress-Vulnerability-Resilience Model

One of the most important things that you will do is to help a person to understand or "make sense" of what they are experiencing. In this part of teaching and learning together, we explore what leads a person to experience symptoms of schizophrenia. ***The most common way to think about the onset of schizophrenia is that it is caused by a combination of "vulnerabilities" (chiefly related to biological factors like genetics), certain stressful events experienced early in life (e.g., traumas) that also predispose a person to experience psychosis, and then exposure to stressful events in late teens and early adulthood that are thought to precipitate or activate a psychotic episode.*** This model was originally referred to as the stress-vulnerability model. The concept of resilience was added to this model to better represent the strengths that individuals bring to coping. This model can be applied to most any illness, condition, or stress reaction, thereby offering some normalizing qualities by its broad applicability - it is not just a model for mental illness but something we can all use. To go one step further, this model helps an individual to develop a workable model for schizophrenia and related experiences. That is, it offers a common-sense understanding and a way to improve coping to improve quality of life.

Vulnerability

Some individuals are born with, or acquire very early in life, a tendency to develop problems in certain areas. While our understanding of the biology of schizophrenia is limited, we do know that the chances of an individual experiencing schizophrenia are greater if he or she has a close relative who has

been diagnosed with schizophrenia. So, we suspect that genes are involved in developing schizophrenia. However, it is also important to remember that some individuals who have no family history of a psychotic disorder also develop schizophrenia (so genes are important, but certainly not the whole story).

Several additional factors are thought to affect underlying vulnerability or predispose a person to experience psychosis. For example, brain injuries and early exposure to viruses also increase vulnerability to psychosis. In addition, **early events that are highly stressful and/or traumatic (such as physical or sexual abuse, bullying) may also influence a person's vulnerability or predisposition to experience psychotic symptoms later in life.** Also, recent research suggests that frequent and excessive use of cannabis in early adolescence will also likely increase a person's vulnerability to developing schizophrenia.

Stress

Stress can set in motion the onset of psychotic symptoms and/or make them worse. Individuals experience stress very differently. What is stressful to one person may not be stressful to another person. There is no way to completely avoid stress and live a stress-free life. Therefore, it is beneficial to try to understand what is stressful to the person you are working with. **For example,**

- Having too little to do
- Having too much to do
- Having arguments and receiving criticism
- Experiencing major life changes

- Experiencing financial or legal problems
- Feeling sick or physically unwell
- Abusing any alcohol or drug (particularly marijuana)
- Experiencing a traumatic event (victim of crime, abuse, etc.).
- Living in poverty or having poor living conditions
- Experiencing racism or discrimination

Resilience or Protective Factors: One's ability to recognize strengths and use them to bounce back from adversity is called "**resilience."** In addition to personal strengths, resilience is also about having access to supports (friends, family, and community) who help you to work toward health and wellness. Often, individuals who have experienced psychotic symptoms for a long time have lost sight of their strengths and may fear they cannot count on their supports. It is important to review strengths and social resources as part of developing a recovery plan.

Visual Aid

A good way to communicate the stress vulnerability model to clients is to use a visual aid and metaphor of "The Stress Bucket" developed by Allison Brabban (see Brabban and Turkington, 2002). Encourage the person you are working with to think about a bucket as representing the capacity to hold stress (vulnerability). The amount of stress can be seen as water flowing into the bucket. Everyone's vulnerability (bucket size) and stress (water) are different. See the image and subsequent explanation to teach and learn together about their experience.

Daily Practice: The Stress Bucket

Interpersonal Stressors

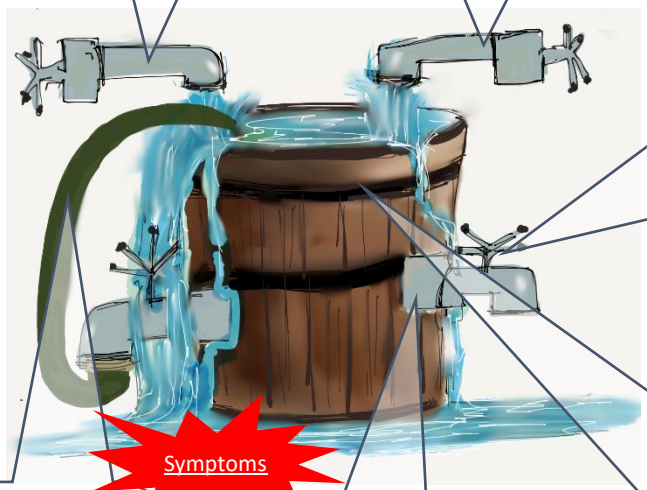
_____
_____
_____
_____
_____
_____

General Stressors

_____
_____
_____
_____
_____

New Coping Skills

_____
_____
_____
_____
_____



Unhelpful coping strategies. What do you need to work on?

_____
_____
_____
_____
_____
_____
_____

Vulnerabilities

_____
_____
_____
_____
_____
_____
_____

Resilience

_____
_____
_____
_____
_____
_____
_____

Stress

Stress is water flowing into the bucket. It can be identified as streaming into the bucket from different sources. For example, one source may be family relationships; another may be lack of housing. By breaking stressors down into separate areas, the client can learn to identify where he has more ability to control the amount of stress that goes into his bucket. You can also rate the degree of distress from each stressor on a scale from 1 (low) to 10 (high). This will help to identify the high-volume stressors.

Vulnerability

Vulnerability is the size of "The Bucket," which represents the client's ability to manage stress at any given point in time. The size of the bucket is largely determined by genetic and biological factors, but other factors like certain experiences can affect the size of the bucket. Consider the following physical example to help understand vulnerability.

Example: Think of sun-tanning: some people can spend hours in the sun and tan very well (large "bucket" to respond to the sun's rays). Others can spend only a few minutes in the sun before getting a sunburn (small "bucket"). A lot of this has to do with our genetics. Also, certain life experiences can predispose a person to a certain kind of reactivity to the sun. For example, an individual who was left alone in the sun as an infant and experienced a terrible sunburn (early stress or trauma) may also contribute to a vulnerability or predisposition to adverse reactions to the sun later in life.

Overwhelmed State (symptoms)

When the bucket overflows because of too much stress, problems and symptoms can arise.

Some ways to help the person see the link between symptoms: To directly ask what happens when he/she has experienced a lot of stress (e.g., hearing a lot of voices, feeling depressed, not sleeping, feeling anxious). What are the ways the person notices his/her stress getting worse? It is sometimes helpful to provide cues: Do you notice physical problems (e.g., stomachache) or changes in emotions (e.g., anxious, sad, tearful)?

Resilience

Resilience is represented in the stress bucket by bands wrapped around the bucket - the characteristics that hold us together and that have helped us to persevere under stress. Items in this category may include specific talents or traits like a good sense of humor, intelligence, musical ability or having a strong support network.

Consider the following questions to identify areas of resilience:

- What are you doing when you are happiest and at your best?
- What keeps things from getting worse?
- When things get tough, what seems to help?
    - What drew you to that particular activity?
    - How does it help?
- Tell me about skills or strengths that others see in you that you may not see in yourself.
- Would you mind telling me about something you are proud of? What skills or abilities helped you to achieve that?

Exploring the idea of resilience naturally conveys an affirmation of strengths that can also re-inspire motivation for participating in the world again. This discussion is also a good place to have a conversation about coping strategies. In this way, we start with what is strong and build from there.

Coping

The holes or faucets in the bucket represent coping skills. A person can learn to manage the amount of water (stress) that stays in the bucket in a variety of ways. For example, you can:

- **Lower stressors**
    - For example, reduce workload (i.e., slow the flow of water to the bucket) or help parents/others to reduce pressure at home
- **Improve coping/faucets**
    - Identify strategies that help one's body/mind work at its best
        - Discuss with prescriber medications that work best
        - Avoid drugs and alcohol
        - Take care of physical health (go for regular check-ups, exercise daily)
- **Identify strategies that help to reduce stress (work with your provider)**
        - Engage in meaningful activities and things you like to do
        - Develop relationships with supportive people
        - Take steps to improve sleep
    - The **hose (unhelpful coping)** going into the bucket represent strategies that can lower stress initially but ultimately lead to stress being returned to the bucket (e.g., using drugs or alcohol to cope with symptoms). This part of the model can be particularly helpful when the person you are working with identifies these areas. This creates an opportunity to have

conversation about topics that can otherwise be challenging to bring up without defensiveness.

Once the stress bucket worksheet has been filled out, there are many helpful ways to use this model.

- You can focus on better understanding the stressors in a person's life and making adjustments where possible (water in the bucket).
- You can focus on strengthening and adding coping skills (the faucets).
- You may focus on the strategies that are not helpful in the long run and help the person find other more helpful ways to cope (the hose putting water back in the bucket). If drug or alcohol use is an issue, consider the type of drug the client typically uses. This may give you an idea of the state of mind the client enjoys or is seeking. Marijuana and alcohol generally produce a state of relaxation, so finding a way to obtain that experience without the use of drugs or alcohol is what you will want to discuss with the client. Cocaine, meth, and amphetamines tend to be activating, so finding ways for the client to be (naturally) active and inspired may be the focus.

Action items:

- Fill out a stress bucket for yourself
- Practice explaining and filling out the stress-bucket with a co-worker
- Practice explaining and filling out a stress bucket with someone you are working with.
- Be sure to remember to get feedback from the person about what was and was not helpful and how you may modify this tool to suit them better.

Questions: Stress-Vulnerability-Resilience model

What are some factors that *predispose* a person to psychosis (or make it more likely for them to develop psychosis)?

What are some stressors that could increase the severity of psychosis?

Describe how stress and vulnerability can lead to schizophrenia- write out a brief description that you might share with a client.

Section 3: Teaching and Learning Together

Part 3: The Cognitive Model

Objectives:

1. **To provide an overview of the Cognitive Model as a way to understand experiences**
2. **To provide one strategy for helping persons to learn about how changing thoughts can influence emotions**

Explaining the Cognitive Model

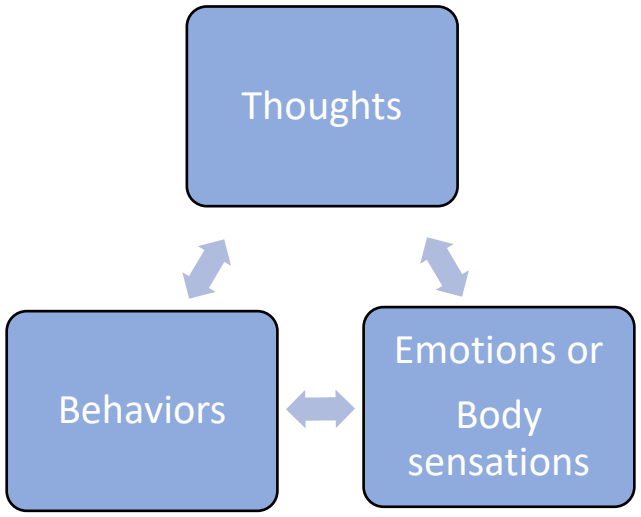
The techniques and approaches discussed in this handbook derive from a popular form of psychotherapy referred to as **Cognitive Behavioral Therapy (CBT)** (Ellis and Beck). As the name implies, this form of psychotherapy focuses on both cognitions (thoughts) and behavior. The first part, the cognitive part, refers to how a person interprets the world around him or her. From this viewpoint, **it is not what happens to a person, but how the person thinks about what happens that is** most **important.** The second part, **behavioral, refers to the importance of one's actions on his or her mental health**. In other words, the actions we take will influence our moods and thoughts. Helping people to understand the factors that influence their reactions to situations is central to CBT. This is most often accomplished by teaching them about the cognitive model.

The Cognitive Model

Albert Ellis, Ph.D., was one of the earliest writers to help clients to link events to certain outcomes (e.g., emotions and behaviors) by way of individual beliefs. This helped to explain why two people could respond to the exact same information very differently. The cognitive model was developed, popularized and expanded by Aaron Beck, M.D. The basic components of the model (thoughts, feelings, behaviors, physiological experiences) are described on the next page.

An event – for example, a problem or difficult situation to which a person responds (e.g., like hearing voices). The response to an event can be understood by examining the following table:

Cognitive Model Component	Definition	Example
Thoughts	How do you think about the event? What goes through your mind when it happens?	You hear a voice calling you a bad name and you think "It is the devil, I am cursed, I will make others sick"
Emotions	What emotions do you experience as a result of the event?	Afraid, angry
Behaviors	What behaviors did you exhibit in response to the event?	Shout at the voices, hide from others
Body Sensations	How did your body respond to the event?	Muscle tension, lethargy



Each component of the model influences every other component

The cognitive model provides a way of looking at events in our life to see how our thoughts influence the way that we feel and what we do. By making changes in the way we think about events, we can influence our reactions.

Recovery Enhancement Practices include helping clients to become aware of how their thinking influences their emotions and behaviors. While the major work of helping a person modifying thinking patterns is often facilitated by a trained therapist, frontline providers can help prepare individuals for this work.

Strategy: Education about thoughts

- Thoughts come and go
- Sometimes we think of things on purpose, other times thoughts just happen
- Thoughts can lead to feelings, sensations, and memories
- Some thoughts are inaccurate or sometimes we misinterpret situations
    - We all misread situations at times, like jumping to conclusions before we have all the information. It is part of being human.
- There is often more than one way to think about situations or events that leads to different outcomes (see below)

- **Situation**: "I am late for my appointment!"
    - **Thought 1**: They will be so mad, I am irresponsible----→ **Outcome**: Feel anxious, tense, beat myself up
    - **Thought 2**: They may be upset, but they will understand → **Outcome**: mildly nervous, prepare a reason for lateness.

Once there is a realization that there are different ways to interpret situations, it is helpful to practice thinking about situations in a variety of different ways.

- I can see how you see it that way, but I wonder if there is another way to look at it? Remember the time we talked about how different thoughts lead to different outcomes? I wonder if we could practice it in this situation.

Action items: Think of one or two situations this week and practice identifying your thoughts in these situations

Situation 1: _____

Thought: _____ → Outcome: _____

Alternative Thought: _____ → Outcome: _____

Situation 2: _____

Thought: _____ → Outcome: _____

Alternative Thought: _____ → Outcome: _____

The main idea here is to help the person you are working with to be able to notice that the ways they think about situations affect how they feel and react. If you find that the person you are working with is open to this method of working with their concerns, consider making a referral to a counselor or therapist who is trained in CBT-p within your agency for more in-depth work. Additionally, you may be working with a client who is also seeing a CBT-p trained therapist and your role may be to support some of the work that is done in therapy.

Understanding that thoughts can influence our behaviors is very useful when working with clients who think that they cannot accomplish anything. Remember that earlier we talked about the negative, defeating thoughts that stop people from even trying to reach for goals. One thing we can do is to work with clients in order to "Catch, Check, and Change" negative thoughts (the 3 Cs) Granholm et al., (2016).

- ***Catch it:*** I will never be able to do anything (catch that thought)
- ***Check it:*** I wonder if that is always true? are there times you can do some things? when you think that way what happens? Is it helpful to think that way?
- ***Change it:*** is there another way to think about this that is more accurate and/or more helpful. If your best friend said this about themself; what would you say to them?

One of the most valuable things a provider can do is to help the person to look at a situation from different perspectives, to think about it differently, and hopefully choose a more accurate and helpful perspective.

Section 3 Highlights: Managing Stress

Stress is normal – we all experience it

Too much stress is like too much water going into a bucket. When there is too much, the water overflows. When we have too much stress minds and bodies don't work well. We may:

- **Hear voices**
- **Feel really nervous or paranoid**
- **Not see things accurately, jump to conclusions**
- **Break out in hives; get headaches; stomachaches**
- **Not sleep well**

The good news is that we can learn ways to lower stress!

What are my stressors today?

What are the skills that will help me most?

1. **Take a break from the situation (reduce stressors)**
   _____
2. **Take a breath and rethink your skill selection**
   (Am I using old behavior (the hose) too much?)
   _____
3. **What new way of managing stress could I try out?**
   _____

How to work with thoughts

Event	Thought	Outcome	Alternative Thought	Outcome
I'm late for my appointment	They will be mad. I am irresponsible.	Tense, Stressed out	They may be upset, but they will understand	Relief

REMEMBER:

- **There is often more than one way to think about things**
- **Sometimes we all make mistakes in our interpretation of things**
- **Sometimes we think things on purpose, sometimes thoughts just happen**
- **Changing our thoughts leads to changing our emotions and behaviors**

Section 3 Questions

The Cognitive model: Review the situation below and fill in the chart below

George enters the store and notices the security guard looking at him. He begins to feel nervous and says to himself, “what is he looking at, he must think I am going to steal something. Everyone knows.” George forgets what he came to the store for and leaves immediately.

What is the “event” or situation?

What are the thoughts?

What are the outcomes (emotions/behaviors)?

What are possible alternative thoughts/Outcomes?

Event	Thought	Outcome	Alternative Thought	Outcome

A Final Note

You have completed this brief review of some of the foundational principles for working with psychosis. Remember that this work is challenging and very necessary. Doing this work will lead to stress, and frustration as well as growth and satisfaction. It is essential to practice this approach under the direction of a qualified supervisor and ideally supported by peers working within a team-based model. Be sure that you stay within your scope of practice and competence (check-in frequently with your supervisor and team).

Do not underestimate your potential to have a positive impact on somebody who is experiencing psychosis. At its core, this approach requires honesty, humility, and kindness. It also requires a willingness to walk alongside someone and not give answers, but instead to be willing to learn (to make sense of situations, to figure out options) together. Remember, recovery involves both becoming (developing a positive view of self) and belonging (to a wider network or community).

References

References

Amador, X. (2000). *I Am Not Sick I Don't Need Help: How to Help Someone with Mental Illness Accept Treatment.* New York: Vida Press

Beck, A.T.,Finkel, M.R., Beck, J.S. (2021). The Theory of Modes: Applications to schizophrenia and other psychological conditions. *Cognitive Therapy and Research*, 45, 391-400.

Beck, A.T., Grant, P., Inverso, E., Brinen, A.P., Perivoliotis, D. (2021). *Recovery-Oriented Cognitive Therapy for Serious Mental Health Conditions.* NY: Guilford Press.

Bennett-Levy, J., Richards, D.A., Ferrand, P., Christensen, H., Griffiths, K.M., Kavanagh, D.J. . . . Williams, C. (Eds.). (2010). *Oxford Guide to Low Intensity CBT Interventions.* New York; NY: Oxford University Press.

Bentall, R.P., & Slade, P.D. (1985). Reliability of a scale measuring disposition towards hallucination: a brief report. *Personality and Individual Differences, 6*(4), 527-529.

Brabban, A., Byrne, R., Longden, E., and Morrison, A. (2017). The importance of human relationships, ethics and recovery-oriented values in the delivery of CBT for people with psychosis. *Psychosis, 9*, 157-166.

Brabban, A and Turkington, D. (2002) The Search for Meaning: Detecting Congruence between Life Events, Underlying Schema and Psychotic Symptoms. In: A Casebook of Cognitive Therapy for Psychosis (ed. A.P. Morrison) pp. 59-75. Hove: Brunner

Coursey, R., Keller, A.B., and Farrell, E.W. (1995). Individual psychotherapy and persons with serious mental illness: The client's perspective. *Schizophrenia Bulletin, 21*, 283-301.

Cox, D. & Cowling, P. (1989). *Are you normal?* London: Tower Press.

David, A.S. (1990). Insight and psychosis. *British Journal of Psychiatry, 156*, 798-808.

Francis, R. (2019). *On Conquering Schizophrenia: From the Desk of a Therapist and Survivor*. Indiana: iUniverse.

Friedman-Yakoobian, M., Gottlieb, J., Hollow, L., Pinninti, N., Carther, C. (2007). *Cognitive Behavioral Therapy (CBT) guide for case managers: Client Workbook.* Unpublished manuscript.

Freeman, et al., (2005). Psychological investigation of the structure of paranoia in a non-clinical population. *British Journal of Psychiatry, 186*, 427-435.

Gould, R.A., Mueser, K.T., Bolton, E., Mays, V. & Goff, D. (2001). Cognitive therapy for psychosis in schizophrenia: An effect size analysis. *Schizophrenia Research, 48*, 335-342.

Granholm, E.L., McQuaid, J.R., Holden, J.L. (2016). *Cognitive-Behavioral Social Skills Training for Schizophrenia: A Practical Treatment Guide*. New York: Guilford Press. ** Source for the Magic Wand question and the Life Documentary Question and 777 goal setting.

Grant, P.M., Reisweber, J., Luther, L, Brinen, A., and Beck, A. (2014). Successfully breaking a 20-year cycle of hospitalizations with recovery oriented cognitive therapy for schizophrenia. *Psychological Services, 11*, 125-133.

Harding, C.M. (2003). Changes in schizophrenia across time: Paradox, patterns, and predictions. In Carl Cohen (Ed) *Schizophrenia into later life: Treatment, research, and policy*.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* Guilford Press.

Hazell, C. M., Hayward, M., Cavanagh, K., & Strauss, C. (2016). A systematic review and meta-analysis of low intensity CBT for psychosis. *Clinical Psychology Review, 45*, 183-192. doi:10.1016/j.cpr.2016.03.004

Kingdon, D. & Turkington, D. (2005). *Cognitive Therapy of Schizophrenia*. New York: Guilford.

Kopelovich, S.L., Strachan, E., Sivec, H., Kreider, V. (2019). Stepped care as an implementation and service delivery model for cognitive behavioral therapy for psychosis. *Community Mental Health Journal*, published online first; doi.org/10.1007/s10597-018-00365-6.

Lysaker, P.H. and Roe, D. (2016). Integrative Psychotherapy for schizophrenia: Its potential for a central role in recovery-oriented treatment. *Journal of Clinical Psychology, 72*, 117-122.

McCraw and Brabban, (2002). From a position of knowing: The journey into uncertainty. *The Case Study Guide to Cognitive Behaviour Therapy of Psychosis*, Eds (D. Kingdon and D. Turkington).

Morrison, A., Hutton, P., Shiers, D., & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? *British Journal of Psychiatry, 201*(2), 83-84. doi:10.1192/bjp.bp.112.112110

Naeem, F. et al (2016). Cognitive Behavior Therapy for psychosis based on Guided Self-Help delivered by frontline mental health professionals: Results of feasibility study. *Schizophrenia Research*, 173, 69-74.

O'Connell, M.J. & Stein, C.H. (2011). The relationship between case manager expectations and outcomes of persons diagnosed with schizophrenia. *Community Mental Health Journal, 47*: 424-435.

O'Donoghue, E.K., Morris, E., Oliver, J.E., Johns, L. (2018). *ACT for Psychosis Recovery. A Practice Manual for Group-Based Interventions Using Acceptance and Commitment Therapy*. Oakland: Harbinger

Perry, Y., Varlow, M., Dedousis-Wallace, A., Murrihy, R., Ellis, D., & Kidman, A. (2012). *Moving forward: Introduction to Psychosis. A Reference Manual for Mental Health Professionals*. Australia: Foundation for Life Sciences.

Posey, T.B. & Losch, M.E. (1983) Auditory hallucinations of hearing voices in 375 normal subjects. *Imagination, Cognition and Personality, 3*(2), 99-113.

Pinniniti, N.R., Fisher, J., Thompson, K., & Steer, R. (2010). Feasibility and usefulness of training assertive community treatment team in cognitive behavioral therapy. *Community Mental Health Journal, 46*, 337-341. doi: 10.1007/s10597-009-9271-y.

Pinninti, N.R., Cather, C. Gottlieb, J., Friedman-Yakoobian, M., Hollow, (2007). *Cognitive Behavioral Therapy for Individuals diagnosed with schizophrenia spectrum disorders: A treatment manual for case managers*. Unpublished manuscript. The General Hospital Corporation.

Priebe S, Kelley L, Golden E, McCrone P, Kingdon D, Rutterford C, McCabe R (2013) Effectiveness of structured patient-clinician communication with a solution focused approach (DIALOG+) in community treatment of patients with psychosis – a cluster randomised controlled trial. *BMC Psychiatry, 13*:173

Priebe S, Kelley L, Omer S, Golden E, Walsh S, Khanom H, Kingdon D, Rutterford C, McCrone P, McCabe R (2015) The effectiveness of a patient-centered assessment with a solution-focused approach (DIALOG+) for patients with psychosis: A pragmatic cluster-randomised controlled trial in community care. *Psychotherapy and Psychosomatics, 84*:304-303

Read, J. (2018). Making sense of, and responding sensibly to, psychosis. *Journal of Humanistic Psychology*, 1-9. https://journals.sagepub.com/doi/10.1177/0022167818761918

Stevenson, I. (1983). Do we need a new word to supplement “hallucination”? *American Journal of Psychiatry, 140*(12), 1609- 1611.

Tien, A.Y. (1991). Distributions of hallucinations in the population. *Social Psychiatry and Psychiatric Epidemiology, 26*, 287-292.

Turkington, D., Kingdon, D., & Turner, T. (2002). Effectiveness of a brief cognitive-behavioural therapy intervention in the treatment of schizophrenia. *The British Journal of Psychiatry, 180*(6), 523-527. doi:10.1192/bjp.180.6.523

Turkington, D., Munetz, M., Pelton, J., Montesano, V., Sivec, H., Nausheen, B., & Kingdon, D. (2014). High-yield cognitive behavioral techniques for psychosis delivered by case managers to their clients with persistent psychotic symptoms: An exploratory trial. *Journal of Nervous and Mental Disease, 202*(1), 30-34. doi:10.1097/NMD.0000000000000070

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration. (2012). *SAMHSA’s Working Definition of Recovery: 10 Guiding Principles*

(Publication ID PEP12-RECDEF). Retrieved from http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of- Recovery/PEP12-RECDEF/

Van der Gaag, M., Nieman, D., and van den Berg, D.(2013). *CBT for Those at Risk of a First Episode Psychosis. Evidence-based psychotherapy for people with an "At Risk Mental State'*. London: Routledge.

Vanier, J. (1998). *Becoming Human*. New York: Paulist Press.

Waller, H., Garety, P.A., Jolley, S., Fornells-Ambrojo, M., Kuipers, E., Onwumere, J., . . . Craig, T. (2013). Low intensity cognitive behavioural therapy for psychosis: A pilot study. *Journal of Behavior Therapy and Experimental Psychiatry, 44*(1), 98-104. doi: 10.1016/j.jbtep.2012.07.013.

Wilson, 2018). Reducing Pseudoscientific and Paranormal Beliefs in University Students Through a Course in Science and Critical Thinking. *Sci & Educ. 27*, 183-210.

Wright, N., Turkington, D., Kelly, O., Davies, D., Jacobs, A., Hopton, J. (2014). *Treating Psychosis: A clinician's guide to integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy & Mindfulness approaches within the Cognitive Behavioral Therapy Tradition*. New Harbinger Publications, Inc.: Oakland, CA. See their website: www.treatingpsychosis.com for examples of mindfulness coping exercises.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive Behavior Therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin, 34*(3), 523-537. doi:10.1093/schbul/sbm114