Good afternoon, everyone. We are so glad that you can be with us on this Wednesday morning. I know that in parts of the country it's snowing, and in other parts there is ice. Hopefully some of you have some sun and are quite comfortable and warm wherever you are. Thanks for being here.

We are bringing you this Recovery to Practice webinar based on funding from SAMHSA, Substance Abuse and Mental Health Services Administration. My name is Melody Riefer, and I am going to be your moderator today.

I'm going to give you a couple of quick hints about how to navigate the room if you are looking at a computer screen or a tablet screen.

You probably need to know that the views and opinions and content in this presentation don't necessarily reflect the exact views, opinions, and policies of the Center for Mental Health Services of the Substance Abuse Mental Health Services Administration or the U.S. Department of Health and Human Services. However, we do have experts presenting information to you.

For the room that you are looking at, there are a couple of pods or boxes that you want to refer to. Tech & Topic pod is where you should put any questions that you have about the technology. So if you are having a difficult time with sound, or echoes, or volume, you can put those questions there.

If you have questions for our presenters, which we would love to entertain, please type them in that very same box. So questions for the presenters go in the topic pod.

If you want to speak with other attendees, you may add that information to the Participant Chat pod. Say hello, say where you're from, maybe what you do. It's a great place to share ideas about the webinar topic with each other. You might want to share information about your thoughts on the information or other resources that you have.

Now finally, you can get credit for the time that you are spending on this webinar. So if you need a continuing education certificate, at the end of the webinar, please follow the link that will be provided and you will be able to complete a survey and a short quiz in order to get that certificate and use it for continuing education credit.

Now, finally, if you need captioning for any reason at all, this would be real-time captioning, it's available by clicking the link in the pod just below the presenters' pictures. A separate window will open and provide that information for you.

This is the third webinar in a series looking at recovery-oriented cognitive therapy. And we have two great presenters who are – who have been with us for the whole series. Paul Grant and Ellen Inverso, who are from the Perelman School of Medicine at the University of Pennsylvania. Both of these people have spent a great deal of time working on recovery-oriented cognitive therapy and developing the trainings that are associated with that intervention. So they will continue to educate us on CTR, and I would like to turn the webinar over to them at this point.

So Paul, Ellen, thanks again for being here, and we look forward to learning from you today.

Thank you very much, and –

Thank you.

We really appreciate it. Since we – we were last on the webinar, there has been some kind of change in – in the country. Our home city has been destroyed by a Super Bowl victory, so it's – it's a pretty interesting time for us. We're happy to be joining with all of you.

And we're happy to see that there is so – there's a lot of familiar faces – sorry, Paul – there's a lot of familiar faces to us in folks that we have worked with and see who I see are joining us today, and so we want to say hi to everyone who we know. Glad to have everyone here. And those who are joining us for the first time, we're excited.

Yeah. So today what we want to do is we want to pick up sort of from where we've been and sort of more forward into – to this point in time we've really been talking about the adaptive mode, and really talking about the ways that we can sort of meet up with the people that we are collaborating with to have, you know, their lived experience and some of the challenges that they are facing. How we can really meet up with them and really sort of start to energize and really help them build up their best self.

And so we spent the first two times talking about that, especially a focus on developing this adaptive mode and, you know, best self in terms of what does the individual want, what are they really looking to get in their life, including making sure that that is kind of richly expressed for them, and then really helping them actualize that with actual things they are doing so they have the feeling of the feelings. And then they see also the meaning, whatever the meaning is of volunteering, or going back to school, or, you know, getting a girlfriend or boyfriend, that kind of thing. All that kind of stuff. Really realizing it.

And then we also focused some on really how it is we can help – help with really drawing conclusions around, sort of strengthening these positive beliefs, and making the positive message more frequent and really the life being – the sort of life the person really wants to be having as they develop more and more autonomy and more, you know, just more of the life that they really want to have.

And we talked also in that context about shifting.

So today what we want to – want to shift to is really talking about some of the challenges that often have gotten the person into a particular level of care and the challenges that often come with – with – you know, go under the categorization of a symptom by a psychologist or a psychiatrist might put it in that category. But for the sake of what we are going to talk about, these are challenges to moving forward. And really, the focus with respect to any of the challenges is going to be around resiliency – sorry, empowerment. Real empowerment is what we're going for.

What we want to do towards the end of this session is really talk about how teams, treatment teams, community teams, hospital teams, can really sort of collaborate with an individual to really bring about some real impressive recovery and resiliency.

Ellen?

So I want to introduce for folks who are joining for the first time and to remind those who have been with us for the previous webinars, I want to introduce you to the mechanism by which we organize a lot of the ideas that we'll be talking about.

So in the download materials, in your reference materials, you will find a recovery map. And what that does is it is a tool for organizing exactly what Paul was just describing. And so the area of the recovery map – so, in general, it's about developing an understanding of how an individual is at their best and the beliefs that are really activated when someone is in a really great adaptive mode. But also it's a way of understanding when somebody is having a challenging time. Kind of what are the beliefs that are more activated in that time. And that gives us a really meaningful target for what we are going to be – what we can do as far as interventions do.

So this is a tool we'll reference at different points and kind of the point where we're going to be focusing on part of today is the – the challenges and thoughts. So what are the current things that are getting in the way of moving toward aspirations, and then what are some of those beliefs that are underlying those.

Now, one of the things that we'll be doing today is we want to try and provide a kind of light touch, for – with the amount of time we have, a light touch on the recovery-oriented cognitive therapy formulation for some specific and common challenges. And those are going to include lack of access to motivation, so when an individual has a really difficult time kind of accessing motivation. And also when somebody is expressing delusions and it's getting in their way of achieving the – their aspirations, things that are really important to them. When hallucinations are the obstacle as well as aggression and self-injury. Those are some of the topics we are going to try and do a light-touch formulation on. And then we'll provide some recommendations for strategies and interventions that are rooted in the CTR model.

And then as we talk about the treatment teams, we'll really emphasize how those can be addressed in a really recovery-oriented cognitive therapy and aspirations-oriented teaming or milieu at all the levels of care.

So as I was saying, obstacles – challenges that people experience are really only a problem if they are getting in the way of, you know, forming relationships, pursuing the things that are meaningful, or if they are contributing to other ways in which a person gets stuck.

So the experience of what might traditionally be labeled as a symptom is not in and of itself – if we have a – quote/unquote – symptom, that is not, in and of itself, an obstacle, and neither are similar factors such as not having insight into mental illness or things like that. A person doesn't have to identify it as a challenge to – identify a diagnosis or a symptom as a challenge in order to live a rich life. Right? So we really see that the obstacles come into play when they are exactly that, getting in the person's way.

And so we really want to think about how the obstacles work. And really that is going to be in terms of thinking about the beliefs. If you were present in the first session that we had, we talked about some of the beliefs that people have about themselves about being capable, incompetent or weak. Beliefs about others in terms of others being sort of malicious, or rejecting, or, you know, not understanding, that kind of thing.

Really what we want to do is see sort of how these – how these obstacles come up. Or challenges as we like to call them. Then really this is greatly about empowering the individuals to be able to really – really be able to not have that get in the way of really the life they want to be having, but that – that is sometimes what has happened. And so we will really try to be focusing on it in those terms. But a lot of the understanding is really – is really where a lot of – where the work is going to be.

And I would really say, too, that when we are working on understanding the obstacles, it's really going to involve enhancing the experience of the beliefs that can be activated when someone is at their best or in the adaptive mode. A lot of times those are personal things that counter the beliefs underlying obstacles. Similarly, the – as we're doing things that support the meaning of achieving aspirations, those are going to be the things that will really bring somebody into the – into more adaptive mode and can help to undercut the challenges, the beliefs that are underlying the challenges.

Yeah. And one other thing, too, we would say is that also this can help avoid unwitting sort of conflicts you might have with – with people. Because ultimately the challenges are going to be in the context of the life they want to be having, which can really minimize conflicts in terms of handling them. And I think this will be especially obvious when we are talking about things like anger and self-injury.

So we always like to start things as exciting as possible when we can. So negative symptoms are certainly the most exciting thing we run into. You know, sort of lack of things. So – and – but as I said on the first day, I think the negative symptoms are actually much more associated with disability and really a lack of getting the life they want than they might initially seem. You know, oftentimes somebody who has a lot of negative symptoms and not a lot else, just – just can fly under the radar a lot of times. Because they don't really have a lot of motivation, they might sit by themselves all the time. They often don't do a lot that really draws attention to them. So, the people that we are talking about that might be leading lives of quiet desperation. It might people who have a lot of this without some of the other challenges being present.

And what we found is – and what our work has shown, and our research has shown, is that there are beliefs that are connected to the negative symptoms. Which are publicly, you know, mis-named because they sound a little bit absolute, like no motivation, no sociality, no pleasure, no speaking, that kind of thing. But it really – it's really – I mean, the no motivation I think is really about a lack of access. Harder to access it. Social stuff is really about feeling really just wary about socializing so sticking to yourself instead. And with finding pleasure, it's really not engaging in pleasurable activity or finding low-level pleasurable activities don't give a lot of feedback. You need something a little bit stronger.

So this slide just illustrates some of the beliefs that we see as really proximal factors to the negative symptoms, so, like in the first – first box, you know, why bother? You know, partly the same feelings all the way. If you really have these beliefs and you endorse them firmly, you're probably not likely to engage in a lot of things that might be leading you towards the girlfriend, or leading you towards the volunteering, or that kind of thing.

Similarly, with the sociology, similar kinds of things. You don't expect people to like you. You don't expect to enjoy social experiences. So you might not – you might choose to just stay to yourself. And I think we see a lot of that. And it's similar to hopelessness and not expecting to enjoy things.

In terms of the limited speech, there's some pretty good research that shows that people over the age span, this one actually seems to grow the longer the person has, gotten – had the diagnosis, the more likely it is there is a deficit in speech. And I do worry – I think that maybe illustrates the language doesn't seem like other people care. And they just feel people aren't interested in what they have to say. So – so single-word answers are indicators of care about the social challenge.

May I have the next slide?

So the – what we've been talking about in terms of how to address language symptoms is really through experientially countering the beliefs that the people have that are – that are – that are keeping them quiet but ultimately isolated. We all might have beliefs about things that we don't well or that won't work out for us. But those – those are just limited to that area whereas for the individuals we're working with, it's often global. Everything.

So real key to countering the a – what is called the a-motivation is really to help the person experience success. See that they really are capable of doing things.

Similarly, you know, have beliefs about not being able to be socially successful. So having a positive experience with a staff member, and ultimately with other people, and then the community, where you see that it is better to do things with other people than do things by yourself. You like it better. That you can succeed. And if you can succeed at this particular task, you might be able to succeed in another kind of task. And then ultimately it leads up to sort of positive beliefs that – that I am a good person, I'm a capable person, and I have a future. And the resiliency comes in really when we're talking about sort of initially when you might feel like – and I think we all might have days like this – where you just don't feel like doing stuff, you don't feel like getting started. You realize, well, initially I don't feel like starting, but then I can really get going, and – and – and then it is much better than I expect I can be. That kind of thing.

Anything you would add to that, Ellen? Okay. All right.

In terms of – we told you this was going to be a quick – quick trip here, but you can pick up some stuff in the classroom.

And in terms of delusion, the way that – the way that we conceptualize delusions is that they really are sort of standing in for something that is deeper for the person. So, somebody who feels they are being poisoned. Or they might have the experience of conspiracy and things like that. It seems like they really care about safety. And they feel vulnerable. And they don't miss it, so they always feel like they're not going to be able to keep themselves safe. So, safety is an important value for them.

Similarly, somebody who – who might sort of boast and tell you that they own the hospital, or that they own the organization, all these kinds of things, it might be the case that they – that they don't feel like they are important. Or they don't feel like people are listening to them. Or something like that.

Similarly, some of the delusions can be related to really not having any sense of control. And the belief itself, the belief that you might – that you have power, that you're talking to important people, things like this might counter the sense that in your personal life you don't have a sense of control. And at the end of

the day, a lot of delusions can be about are connections. I'm going to ask Ellen to illustrate with an example or two.

Sure. We have some examples coming up. I'll actually just go ahead.

So, yeah, we've got a couple of examples. We'll do a couple examples coming up I think after we break down some of the understandings if that sounds okay.

Sure.

Cool.

Okay.

Cool. So there are some – what we're trying to do, is we're trying to get an understanding, right, of when it is that some of these experiences are more likely to come up than not. And that can give us a lot of good information as to what the beliefs are that a person is actually experiencing at that time.

So these are just some common times when we see delusions be more likely to show up. And I think that many of us can relate to the experience of social gatherings and in some of these situations we may have different reactions, that don't always get us closer to the things that we want.

So increased stress situations such as being in treatment. Those can be really stressful situations, you know, working with a team of providers, regression, all the different contexts.

Rejection. So, you know, in the pursuit of work, or pursuit of relationships. Even just in general interactions the perception of rejection can really stoke up a lot of vulnerability.

Disappointment.

Situations where I don't feel like I have a lot of control or freedom. And a lot of times we'll see that in situations of, you know, involuntary hospitalization or the approach of court dates can really stoke up a lot of those beliefs.

And then in times when someone is particularly isolated or feeling maybe really lonely, that can bring up a lot of beliefs like paranoia and maybe focusing a lot on kind of cues in the environment that contribute to just different feelings of vulnerability and so forth.

And these are – this is a very – it's not an exhaustive list, but when we are thinking about the common beliefs that underlie solutions, there are a lot of – these are kind of the more common ones, the things – this is where the cognitive model helps inform what we do and the interventions we'll ultimately decide to pursue. So beliefs about the self-esteem, you know, I'm helpless, or weak, or vulnerable, can really bring up a bit of these beliefs.

Similarly, if I don't find that other people are trustworthy, or that people are going to take advantage of me, I may want – I may kind of compensate for that by, you now, really giving myself a very important status or role, something to that extent.

And similarly for the future, the world being dangerous, or, you know, that I have to always be prepared for what's going to happen can really be – those can be some of the beliefs that underlie this.

And so what we want to try and do is figure out which of these beliefs are maybe most activated for somebody so that we can select an accurate target and intervention. And that's going to include a lot of action, and here is where we can give you some – some examples.

So one of the things that we want to do to try and better understand which of the beliefs it is that is – that is really activated for a person is we want to – we want to really be curious and develop a good

understanding. So we want to try to see things from the person's perspective. And get a really good sense for the meaning of what it is that a person is communicating.

So, for example, if somebody is sharing that they are a, you know, the owner of a hospital, for example, or the owner of an organization or a – a – a – has a particular status, I might want to find out, what's the best part of that? What's good about that? And when we ask somebody what's good about that, we get a – we get a really good sense for just what is it that the person is trying to achieve.

So if we all think about, and, you know, if you feel free to put this in the Chat box if you want, think about what would be good about, you know, owning a hospital? Or what would be good about, you know, being a rock star? There are a lot of things that we can get from that that inform us about what a person may feel like they are missing or lacking in their life. So maybe it's that I have control, or maybe that I have status, that people respect me. There's a lot of different beliefs that we can learn about getting an understanding – pop – rock stars are popular and have a lot of fun. That's a perfect possibility that someone might say to someone else – that someone might say that gives us a lot of good information about what is it that they feel like they might be lacking in their life and what is it that we can help target. Being in control of your life, or when you are getting discharged, things like that. These are – these are excellent.

So, you really want to ask questions that are going to get us – be curious enough to get us an understanding, what is the person looking for and what are they hoping to get.

Similarly, when we have individuals who are experiencing – we have individuals who are experiencing more kind of concerns about their safety and other people, or fear about being injured in some way, we can ask similar questions to get a good understanding, you know, what lets you know that this is happening? Help me understand so that I can hear – so that I can get an understanding from your perspective.

So, for example, we've had folks who believed that things were happening to them at night, or they were sharing that they were getting hurt throughout the night, and we would ask them, you know, what lets you know that that is happening and help me understand? And we would learn a lot about things like physical pain that they were experiencing. They were unexplained where when people come in and out of the room to do checks at night that I'm feeling really – that that's a really vulnerable position. I can hear them coming in. I'm experiencing physical discomfort. And I put those two things together.

So we want to get an understanding from the person because that's the – that's the target. That is something that we can then work with.

And what we want to do to help with the empowerment key is collaboratively engage the individuals in activities that are going to provide that exact meaning that someone might be looking for. Whether that's to feel valued, connected, safe, or in control, right? And so a couple examples. So we are – a couple of you guys put some great comments about these in the comments already, but we – there's an individual – a couple of individuals we work with I want to illustrate these points with. We're going to talk a little bit about what it looks like, some of the beliefs targeted, and then how the intervention came out of those beliefs.

So we did have, you know, an individual who often stated that he was a famous rock star. And was a famous rock star who would put on concerts regularly. And so when we asked him, you know, what's the best part of that or what would be good about that, we learned some really important information. We learned that for him the best part would be helping other people. That as a rock star performing, he would have money to give and help other people. And, actually, I'm going to hit on this. We've got a great question from Doug about – I want to – and I'm going to make sure I hit on it about inadvertently colluding with the collusion. I'm going to hang onto to that though and make sure I say it before this slide is up. That's a great question.

So, we learned that it would be – it would be something that he would be helpful with, that he would be important and connected to other people were the beliefs that seemed to be underlying that – that

statement that he would make. So that became our target because there are things that we can all do together on the day to day to be helpful, to have an important role, and to be connected to other people.

So the intervention for this particular individual involved helping staff organize a clothing drive to help people in the town in which they lived. And so by having a role in a project like that, the experience and the statement about being a rock star really didn't come up so much as he was involved in that because of having an important and meaningful role within that context.

Another example. We have several individuals that we have worked with who have indicated that they own the program in which they are in. And so the – the beliefs that were targeted in that case were the sense of being important and having control, as you guys – several of you commented on that might be an important part if you own – own the organization.

And so the intervention was providing an opportunity for the individual to have an important role where he also had a sense of choice and control in his experience, and that, for this person, involved being a – the resident tour guide. He gave tours of the residence to new people coming in as well as to new staff and helped to orient staff, which helped to also level a bit of the playing field between staff and the residents of the – the place. Less of a power struggle. Because they – they – you know, this person was able to share his expertise.

And similarly he had some – would perform some work on the unit in a janitorial kind of context that he was very proud of and would direct other people in how to keep the place clean and – and – and how to run things well. And so in that – within the context of that role, it actually helped him to connect more to other people and participate in a lot of the different events within the community in which he could really connect more with the broader community.

And then finally I want to share with you about an individual who frequently believed that he was being poisoned, and the beliefs that were targeted about that were really around disconnection and really perceiving that he was being rejected, and really focusing on that.

And so the intervention there then hits on those targeted beliefs of helping him to connect and the way in which he connected was to teach other people. Teach other people. He taught things like chess. Taught things like exercise. There were a variety of things that he taught to other people which helped him to expand his connections and be – not experience the rejection so much. And also he was able to really be a part of the community, and that really reduced his feel – feeling for being threatened or that people were out to get him.

So to quickly touch on that question about the difference between collusion and – and getting more information is we really want to understand we're not asking about the details of the delusion per se. So not getting a lot of details about, well, you know, where do you perform your concerts, and what songs do you plan, things like that. And then it's really more about, hey, what's good about that? What would be the best part about that? And hitting up the meaning underneath. So instead of kind of getting down that – that path where we can really spiral into focusing on the belief itself, instead we're focusing on what is the meaning for the person, and we're kind of going – circumventing that.

Yeah. What I would say, and it's just assumptions, but really what we're doing is we're figuring out what the – what the – what the delusion tells us what the person's need is. What they really want. Whether it's safety, importance, belonging, what that is.

And then what we think of – the approach we're talking about like for safety therapy. We're hoping that he gets that need into the light in a way that is actually much more concrete and immediate for them. And at least that's what really matters. It's not – well, we're going to the meta level - we're certainly not colluding. We're figuring out what matters. And the delusion has come up because their needs aren't being met. So, whether it be for safety, for importance, or both.

So that's how I would answer that. It's not so much that we're – we need to know what the delusion means to the person so that we can really help them communicate that meaning better.

And one of the things I would like to illustrate is you don't need to have something grandiose to replace a grandiose belief. And so there is still simple ways in which you are connected to other people in making a difference. Like that gentlemen who is using money within the community to go on outings and things of that source, can go a long way.

Hallucinations are the perceptions – perceptions of things that aren't there. And they are often really distressing and upsetting. They are also one of the – one of the experiences that we see that can lead to some of the dangerous behaviors because, of course, people can comply with what the voice is saying or similarly by what they are seeing and act on in it that kind of way.

I'm thinking we don't have on the slide but that could be useful to keep in mind is that hallucinations are something that brings to you and pretty much polls – Gallup-like polls from even all over the world will show pretty much 80% of people will say that they have heard persons when there's something not there or seen something when there is nothing there. And that 88% of people have hallucinations without having a diagnosis of any sort. And one of the features that seems to differentiate – oh, and you might find this interesting, too. People who are psychic often report hearing voices in the way that they see the future.

So what's different with the people we work with is on the slide. It's really their beliefs about the voices that seems to really lead to their distress and sometimes their compliant behavior. And the biggest one, I think, is that sense of control. The experience really seems like it's out of control. It seems like something comes and goes when it pleases. And oftentimes this is the reason that people who have hallucinations and go through lots of treatment are so demoralized. And so hallucinations in particular are associated with depression quite a lot and demoralization in a way that – that the users are more likely to be associated with anxiety for example.

The other really important issue is the credibility. Because physically there are all kinds of things in the world that they are talking about. But a lot of times the individuals believe what the voice has to say, and they think it is credible, and that's more of those fears that – or they will really be upset at what it's telling them, that other people are going to hurt them, or that they should do this, that, or the other thing to make the world a better place, and that kind of thing.

And, on to the next slide.

So empowerment, again, is a belief. And think of if hallucinations, I think that it's really a straightforward thing.

Sorry, I'm told I'm being muffled. I'm speaking directly into my thing. Sorry.

So, empowerment can be, I think, for the person, being able to refocus. Because a lot of times people feel like the hallucinations are keeping them away from the life that they want to be having or the stuff they want to do. So, if we can identify the aspirations and the things that you want to be having, then what you can do is you can start to focus away from the hallucination onto the things that you want. Oftentimes, and it's pretty easy to illustrate, if you do some kind of activity with someone that throws stuff back and forth, you might have a conversation, or you might play a game. And you might notice that during that time you can't hear the voices as much. And that what you are doing will help guide the person to see that what they are doing that actually makes it different.

I would advise, I'm a little bit wary about having people listen to headphones on their own, only because I think that really a lot of the power of recovery, and the power of what people want to be doing is with other people. And listening to headphones kind of isolates you a little bit. So, it might defeat the purpose a touch. But we'll see in a second a little exercise how you can utilize and other things that distort sort of once you understand, but basically it's really hard to talk and listen at the same time. And there's some neuroscience behind all of that. So any kind of activity really engaging the person outside themselves, emphasizes the fact that they have control. And that control is something they can draw upon at other times, and that's what we're really referring to.

So let me have the next slide. All right. This one is for you.

So this is just an example of an intervention that can be used to help draw someone's attention to the fact that they can actually have control over the experience of distressing voices. So I like to distinguish between it's not a tool for distraction, it is a tool – our mission isn't distraction, our mission is really about control. So that this isn't an obstacle so that you can then go do more. So refocusing and kind of moving – getting over the hump, so to speak, and then moving towards something else.

So this is an intervention called Look, Point, Name. And it involves kind of guessing a really rough gauge for how distressed somebody is. And this is something that can be used with folks who don't describe the experience as voices. It can just be described as if you're feeling stressed. You know, it seems like you are feeling stressed out. Would you say you're a little stressed, a lot stressed, somewhere in between? You can adapt it to the individual that you are working with. But what you do is you say, you know, I've got this kind of trick that some folks have used to help them feel a little bit less stressed, and, you know, what do you say we try it out.

And Look, Point, Name involves looking at something, pointing to it, and saying the name out loud. It helps to really interfere with those processes that Paul was just describing.

So you go back and forth and back and forth. Now step three here says you keep going until you run out of objects. My tip for you guys is you want to keep going until we see the person is really involved in the activity with you and not – and, you know, it's just really like, you know, animated. The affect is brighter. They're going a little bit faster. That's a good cue that someone has control in that moment, and so that's a great time to say, hey, how you feeling now? Better? Worse? You know, stress low, medium, high? And they give you the rating again. When they indicate that they feel better or they feel less stressed, or they are hearing voices less, depending on what they use, you can say, huh, you know, so do you have more or less control than you thought you did? Or, wow, doing something likes this really helps you get control over that stress you're feeling. I wonder if there are other times you can do this to help feel less stressed.

So it's a simple intervention that can be modified to an abundance-- many difference ways, but it's really a test for trying to get some more control over those experiences. And the importance is that the person notices that they were the one who chose to engage in the activity which really gives them that control. And you can say, "you helped me, you did it."

Go ahead, Paul.

Yeah, that's right. And that's right exactly. And so then they can see that they have the control and they can take it with them.

Yes.

Here's some of the conclusions, right, that we talked about. And they are similar to what we talked about last time. Just a little bit more in terms of sort of posing the questions to help them see that they are getting what they want and they are doing what they are hoping to be able to achieve. They are sort of strengthening their sense of control and efficacy.

So you want to move to the next one?

Um hmm. Oh, it should be – oh – Twenty.

Yeah. So – so we don't have a lot of time to talk about this, which it could be a whole webinar in and of itself talking about anger and self-injury. And I'm not seeing this slide by hopefully you are.

So – so essentially these are ones that really challenge staff in terms of really, you know – they are the things that really consume a lot of the resources and that kind of thing. And so we think – we think that if you look at these two things together, they are often quite similar. And a lot of the aggressive behavior, the hitting and other things that we see, often is really reactive kinds of things to these kinds of beliefs that are underneath what the individual, you know, what the individual walks through the world seeing. They

are looking to not be – it's like they are expecting to be rejected. They are expecting others not to like them. They are also in a situation where they are worried they are going to be weak. A lot of the examples are about being weak and that kind of thing.

So these are kind of really useful beliefs to think about in these situations. So these often lead to these really kind of – often, often really sort of challenging situations that we might see. And sometimes the same person has those.

I don't know if we want to illustrate that with a quick example or if not.

I think that we probably don't have enough time. I want to be sure we get to teams.

Okay. All right. Okay, so you want to move on to 21?

Okay. And so what we've found is that this is where the recovery image is really useful. And so – so the person who really has an image of themselves in the future, and we see them working as a nurse, or also – or in that kind of – they can bring that to bear when they are feeling challenged.

And the key to self-injury, it's often they get an urge to hurt themselves when they feel rejected or they feel like social things are not working right. And they can bring that to bear as a way of sort of martialing the positive emotions that they feel and then the resiliency that they have to be able to do something different and wait until the urge passes. And we had somebody say that to us. I know if I sort of focus on my art for a little while, the urge will pass and then I'm going to be moving more towards the job that I want to have.

And we find it – the positive beliefs, the more we get them activated, the better because in terms of really being able to help them not engage in these things which are ultimately getting in the way of what they really want to be doing.

So, go on to the next one.

So when we talked last time about resiliency, these seem to be factors we find over and over again that really seem to lead to these situations. So feeling rejection, disappointment, actual or – actual disappointment or things not working out right. Or just feeling overwhelmed. So the feeling overwhelmed often shows us exactly when somebody is going through some kind of transition, like into a new job, or into a new living situation, or that kind of thing. That's when resiliency comes to bear.

If you would show me the next slide.

This is – this is something you might think about in terms of how to work with somebody to really develop their confidence and their resiliency with regard to any number of challenges that we have. One of the things that we know is that a lot of times people are having a lot more success than they report. We often focus on the things that don't work so well. And so this is – this is a way to get them to sort of notice things that they could help other people with, item one. Two, maybe you look at places where they could do that themselves. And then look at some of the minor stressors they might be facing and them in doing role plays with them to sort of see how they could – how they could handle it when it comes up. And this can really prepare them for some real successful movement into whatever it is that they want to be doing.

So in terms of thinking about teams and things like this, this is a network of care we have been involved in. I'll talk more about this tomorrow with Arthur Evans tomorrow.

Next slide.

But we did just sort of looked at the levels of care where teams – you can find teams. These are some of the places we've worked.

Perhaps you want to jump into a little bit of a discussion of teams. And ultimately the approach we've used, we've really been able to promote the continuity of care with it. I was hoping Ellen could illustrate with maybe a couple of examples.

Oops, sorry. I was muted.

One of the things we have really been able to do with this approach is improve the continuity of care within the system, and that involves using tools such as the recovery map as a way to share understanding and have the things that we've learned about – about individuals that help bring them into the adaptive mode, or that really help them have a meaningful, valuable role. And also just even identifying – knowing what the meanings are behind their aspirations. Those are things that we have seen successfully communicated across providers and treatment teams to help support continuity from hospitals and into communities as well as from residences into new supported independent housing. And these kinds of things are also really useful and helpful in connecting with the families as well because they can be a really valuable resource for when is a person at their best? How do we understand it? And can share a continuity between loved ones and treatment providers as well.

So some of the ways that we have seen this translated across the different types of programs, we've been able to really help to develop programming that then meets the meanings that people are looking to experience and help them to experience steps so lead them toward the aspirations that they want. And this is kind of a cross setting. We've seen this in residential settings. We've seen this on act teams. We've seen this in hospitals as well and in outpatient providers who have really integrated activities for individuals to pursue interests, engage in aspiration-oriented activities, have meaningful roles, and really become a part of the community. And we have really found that there are a lot of beautify ways that people have connected in activities that they do in the treatment-oriented setting to activities that actually exist in the community. For example, people who have joined book clubs, and Bible studies, and building clubs. Things that might occur in any community. They can begin at any stage of this. So we have really worked with teams to knowing this formulation and this way of understanding individuals, really incorporate their individualized programming to provide the opportunity in-house, which provides the confidence and success to then lead into just living a really rich, full life. I do think that that actually summarizes kind of the next several slides of stuff.

And everyone, we do have access to the slides. I know we're up against time here, but everyone will have access to the slides for the details. That was kind of my summary.

Paul, do you want to end?

Yeah, sure. I was going to say, we didn't get a chance to really cover so much the treatment team. The treatment teams follow the same approach in the sense that you started off by accessing the person's adaptive mode. Then you sort of switch over to what aspirations that they are working on, and really how they are dealing with them. And then you can in some of the challenges towards the – as you move along, which really leads to a really productive and dynamic conversation which is ultimately one that they really want to be – be having anyway, and it really avoids a lot of the conflict, and I think becomes a better experience for everyone because treatment teams can be a little daunting.

So maybe at that point we should wrap up what we're talking about. And we can – we can address some of the concerns that we didn't discuss just now in the questions-and-answers if that would be helpful.

Thanks, you guys. I know there were both some technical difficulties and there's just such rich information here that I think any one slice of this could be talked about for a long time, which is why you have a full training available. And so I want to, you know, be sure and make note of that. That we – we know we're just sticking our toes into the water on this topic, and I appreciate your working with us in this format.

I do have some questions that were presented and sent by the audience.

One of the questions was, I find that there is some resilience in the delusion that supports survival and often harkens back to early childhood trauma or other toxic stress. What are your thoughts about this?

Um, yeah. I think that – I'm thinking of several examples. Within the delusion, you can see some strengths, and I do think the person is often doing as well as they can do. Obviously sometimes the delusion creates a social liability for the person because a lot of other people don't really – don't really, you know, appreciate it. They don't see it as true and things like that. But I do see that there's often some real – some real strength in there. And what we're really trying to do is to try to see if we can harness that so that the person can actually get more of what they want. Because certainly when you are really paranoid and afraid, it's very hard to really make a difference in the world, which is what a lot of people want to do.

Similarly, if you are really thinking that you have billions of dollars or think you are a deity, it's much harder for you to actually concretely do some of that stuff. But I do think that – I do think that even within the other – the other – some of the other challenges that we've discussed, there's usually some real strengths there that you can grab onto.

I don't know, Ellen, if you want to say anything about that.

No, I think that's great.

Another question was kind of trying to get a little clearer about how you select the intervention based on the type of hallucination, perhaps, that someone is hearing. So if someone is hearing voice commands, for instance, would you select a different intervention versus another type of – of voice they were hearing?

Sure. I think that it really – that's where the formulation and understanding kind of what might be stoked up for a person is really helpful. So I think that there are – excuse me – I think that for some, like we talked about where it's maybe that they are just hearing a lot of negative things or hearing very distressing things and it's not necessarily commanding them to do anything but it's – it's – it's just a really stressful experience. Getting a sense of control and also interventions that will help with maybe having – giving that person successful experiences to demonstrate that the voices are not actually credible, they don't tell the truth.

Then for someone who might be experiencing a command hallucination, I think of an example of a gentleman who heard voices that he needed to – he needed to hit someone. But the reason that he needed to hit one person was because if he didn't hit that person, then several other people would be hurt. So that right there gives us a clue that the desire to comply with that voice might be because the person actually really wants to help other people. And that maybe he was afraid or that people are in danger. And so I think that that would inform the intervention in a way that how can we maybe counter some of the beliefs that a person is having that would stoke some of those voices up in a way.

I don't know if that's a helpful explanation. But it's absolutely right that you want to target it and tailor it to whatever either belief seems to be especially activated and provide an experience that was going to counter that.

Um hmm.

But I also think it's really important to emphasize that we want to do that in the context of their aspirations.

Aspirations.

Really the kind of things that they want to be doing. It's – it's getting rid of the stress is only part of the equation. You want to do it – it's easiest, I think – not easiest, but it's much more effective if you do it in the context of helping the person really get to some meaningful life experiences, that they really are connecting it with their values and their aspirations.

And so I would want to take this opportunity to remind people who perhaps weren't on sessions one or two that they can learn more about the role of aspirations in those earlier webinars. And that it does really

build on itself. And so just the same way successes build on themselves for us to be able to do more and more, the – the content for these webinars do the same.

The other part that I was reminded of is how much, and how important it is that – that any intervention be seen as an art rather than a science. I mean there's a – there's a – there's a structure, and you all have done a fabulous job, like with the recovery map and things like that, to identify a structure to hold things up. But that the nuances are art. And so the – the more you know someone, the more you are able to determine if you should pursue a voice command or not.

And I'm afraid that leaves us with our need to close up, and in doing so, what I want to do is first of all thank you all. I want to remind the audience that we will be back on – not tomorrow – but in two weeks, on February 21st, with Dr. Grant. And we will have Dr. Arthur Evans joining us for the final session of this webinar series.

Ellen, it has been great to get to know you through these first three sessions, and I look forward to having you kind of hanging out in the wings next week as well.

We couldn't do any of this without the support of SAMHSA, and that it's SAMHSA's recovery-oriented practices that are the foundation of everything that Recovery to Practice does. And so practices like these and our other webinars are designed to help the whole field, regardless of discipline, become better at what we do. And for all of us to become better in our own recovery.

So Recovery to Practice, if you don't know, is an initiative that is designed to help the various disciplines come together and put into practice the principles of recovery. And have it not just be something that is theoretical or intangible, but to make it very tangible and that we can act on it.

We want you to be able to continue your learning, and so with that we have available some additional resources as well as additional resources provided by the trainers, and so I hope you will take the time to check out these links, and read the articles, educate yourselves as providers.

We also have a newsletter that is published roughly quarterly, and we would want you to know that there is additional information specific to recovery-oriented cognitive therapy in our most-recently released version of the newsletter.

If you do not already get that, you can by visiting the samsha.gov website and going to Recovery to Practice.

As our mentioned, our final webinar in this series will be presented on February 21st, 1:00 Eastern Time. Please adjust for your time zone. You can click on this link to register, and we hope that you do. These have been in high demand, and so registering early, and calling in early, is well advised.

If you would like to get your continuing education credit, and I know that there are a lot of you who do want that, you will be able to click on this link, and you will be taken to a page where you will complete a very brief questionnaire, and you can then take the quiz to get your continuing education credit. This credit is brought to you by NADAC (SP) and is approved for a number of disciplines. So know that it is likely to cover yours. I hope that you will take the time to pursue this continuing education credit, and also let people know about this webinar series. And we have a great year coming up, and we want you to be able to get the kind of support that you need. If you cannot make the actual time, you can still register, and that way you will get a link for when the recording is available.

So with that, Paul, Ellen, thanks for your wisdom, your education, your science, and providing that to us. We will see you all in a couple of weeks. Everybody, have a great day. That concludes this webinar.

Thank you.

Thank you.