Happy New Year, everyone. We are so glad that you can be with us as we kick off this 2018 series of Recovery to Practice webinars. And we have got a fantastic series to start us off during the months of April – I'm sorry. April, that's weird, that's my birth month. Of January and February. We're glad you are here and we are going to tell you all about those.

The first thing I want to do is let you know who I am. My name is Melody Riefer. I'm a Project Director at Advocates for Human Potential, and I get to work with all of the webinars under the Recovery to Practice series.

I want to show you around the room so you will be familiar with the screen and be able to use it to your advantage.

There are a couple of pods that you want to pay close attention to. We have a question-and-answer pod which is labeled Teck and Top Questions – Topic Questions, and it's right under the slides that you see. This is where you want to put any questions that you have regarding technical challenges, sound, image, things like that. Also, that's where you want to type any questions that you have for the presenters. If you put them there, we are able to sort them and make sure they don't get lost in the busyness of the Participant Chat box, which is just to the left of the Tech and Topic Questions. In the Participants' Chat box you are welcome to share information with each other, general comments about recovery, or the work that you do, or where you are from. This is a great networking area, and we want you to feel free to use that area while you are listening to and participating in the webinar.

If you look right above the Participants' Chat box, there is a captioning information pod. If you need closed captioning for any reason at all, you can click the link and a separate window will open that will contain the closed captioning in real time. We also make the text of the webinar available after the webinar when the recording is available as well.

And then right above that you see the faces of our presenters. And I'm going to tell you a little bit more about them in just a second.

Also remember that you can get Continuing Education hours for this webinar and your participation. At the end of the webinar there will be a link that you can click. Take the quiz and participate in that process so that you get some credit.

I would like to tell you a little bit about our topic. The next webinars, four of them, are all going to look at Recovery-Oriented Cognitive Therapy. We have presenters who are intimately knowledgeable about this evidence-based practice and are going to speak to us, two webinars this month, two webinars in February. So be sure and look for the time and dates.

Let me tell you about the folks who are going to be sharing this information.

Dr. Paul Grant is an Assistant Professor of Psychology in psychiatry at the Aaron T. Beck Psychopathology Research Center with the University of Pennsylvania. He is a primary developer of recovery-oriented cognitive therapy for individuals with persistent schizophrenia. And he is the lead author of the basic studies reporting this theoretical framework. So he is right at the top of this topic and field.

Dr. Inverso is the Director of Clinical Training and Education at the Beck Recovery Training Network and is also a trainer and consultant to mental health care providers in recovery-oriented cognitive therapy.

When you can go to the source of information, it is always helpful in bringing some deep understanding that we don't otherwise get. And so we have the source information, and I am excited that both Paul and Ellen are here to share their knowledge and experience with us. And I'm going to turn this over to them so that they can begin giving us an orientation to CTR.

So welcome you guys. Thanks for being here.

Hello. We're quite happy to be here, and we are thankful to SAMHSA for inviting us to be a part of Recovery to Practice.

Hi. I'm excited to see so many people from all over the place checking in. This is really fantastic.

We love it.

Okay. So let's get – let's get rolling.

Really, I think today's – today's webinar the focus is really going to be about how it is that evidence-based practice and recovery really are together. That we really do both of them at the same time and use evidence-based practice to achieve recovery. And so I'm going to actually spend some time really talking about some of the – some of the evidence that we have, really the way in which research plugs into the clinical work that brings about recovery.

We will probably focus on individuals who kind of have had more of a challenging course of things. They might have been institutionalized, they might have gotten in the criminal justice system, and oftentimes it is very difficult for them to really get the life that they want. So we are hoping, through the course of this particular webinar, that we get a sense for how to reach such people. But what we're saying is applicable at less – sort of a lesser degree of (inaudible) and also at different phases of – of sort of age range.

So what I like to start with, though, is just a little bit of background, which is that it has become pretty clear that negative symptoms, and this slide here really describes the primary ideas of negative symptoms, so the reduction in emotional responding. I would think that the problems with motivation individuals have often make it hard for them to access their motivation. And they often don't feel like being around other people and they often don't elaborate in their speech and things of this sort.

These particular – this cluster, which psychiatrists call negative symptoms, really is linked to the disability that a lot of the people experience. It's really connected to – it's linked to rehospitalization. It's linked to really – really not participating in the community, and those kinds of things. And so one of our – one of our focuses has always been to address this cluster of problems because it can really hold people back from what they – what they really want to be getting.

Now our guide in all of this is something that was developed by our boss and mentor, Dr. Aaron Beck. And he developed the cognitive model approximately 50 years ago – more than 50 years ago. But it has actually turned out to be a really good guide for figuring out, on the one hand, how it is that people might get stuck in trying to get what they want. But on the other hand, it can actually help us understand how they can really get what they want and how they really can recovery and develop resiliency.

And so there really are sort of clusters of beliefs that are often called the cognitive triad. And it has to do with negative views about the self, negative views about other people, and negative views about the culture. And really what we see for a lot of the people who have a serious mental illness or are stuck is really they see themselves as weak, vulnerable, ineffective, and worthless. These are the kinds of things that come out when – when they are really having a difficult time really being able to get what they want.

Similarly, they see others as controlling, dangerous, rejecting. And the future as uncertain and forbidding.

These kinds of beliefs we see as sort of the things that can kind of be really sort of challenges for them in terms of really being able to develop the life that they want. And we are going to talk a lot today about how – how to address these sorts of things.

But what I want to talk about now is how we – how we translate this actually just to show you that it can be translated into the negative symptoms that we just talked about. So I won't take you through this whole matrix, but just to give you a sense that we take something, there's a symptom that seems like it is difficult to be able to deal with, like amotivation or anhedonia, and turn it into something that seems much more approachable in terms of things you might do psychosocially, or you might - you might – you might promote them. So beliefs like I am broken, inadequate, inefficient, the task is too demanding, I will fail, all

these kinds of things, can lead to avoidance and not doing things. And ultimately somebody having a real difficult time really getting the motivation up to do much of anything.

So – so that's – that's – that's really our theoretical model. And what I want to talk about for just a little bit is the way in which we have used research approaches to try to see whether or not we could show that this is systematically true. More than just, I should say, we based a lot of our ideas on interviews with individuals with lived experience as well as interviews with family members and providers. And we have been – we have been doing this kind of work now for about almost 20 years.

One last thing. This is something I want to draw your attention to because I think the key to – the key to so much of the success that we have seen with individuals who have – who have found themselves not getting the life they want is related to this. There's pretty good evidence that we all have this need to want to belong to the group, to really want to be connected with other people in various different ways. And that – and so this – this is something that is powerful in everyone. But a lot of the individuals with serious mental illness, a lot of the people, they don't have that as much. And so when you go to congregate living situations or hospitals, often what is really noticeable is the way in which everybody is there but not really interacting that much. It is sort of the together alone, to borrow the phrase.

But I think the key to much of what we are going to be talking about over the webinars in terms of how it is that we – we reach individuals, connect – establish initial connection, and help them really find the life they want and get the life they want, is going to be through things like connection (inaudible). A lot of the work is social.

This is a very busy slide that I created, but the basic idea is that we can – we have a way of measuring some of the beliefs that we talked about. And we have – this is one of the ways that we can fine – fine-tune our understanding of exactly how things are linked together and whether or not people's community participation is really being impacted by a particular set of beliefs.

So I have just listed on here some of the skills that we have developed. Some of these are in press, if you will, in terms of the publications out there. Some of them are already out there. We can provide them if people are interested.

But the idea is we can – we can validate measures, there are methods for doing that. And we can utilize those measures to sort of try to answer some of the questions we have. And, again, we can also utilize them clinically to sort of understand better how someone is stuck or how someone is getting better.

These are just the kinds of studies that we have done over the years. You know, essentially what we are trying to do with what's called an association study, we're just trying to show do things go together. Do the negative beliefs go with the negative symptoms like we said? Do they predict them in the future kind of stuff. I'll show you one study that we did, just very quickly, about how you can actually run an experiment to sort of show a mechanism that might be involved in sort of better or worse outcomes. That kind of thing.

This is one of the early findings that we have. This is one of the things that, after talking with a lot of people, we found that a lot of times when you ask somebody why they no longer engage in some of the things they used to like to do, they would say things like taking even a small risk is foolish because (inaudible) likely to be a disaster. The other part leads to the same – the incomplete failure.

So we had a sense that there were these beliefs that people had, and we call them defeatist beliefs, that might be really getting in the way of the life that they want and that they are afraid of – they might be afraid of taking chances, afraid of failing, that kind of thing. So these beliefs will protect you against failure, but they also would hold you back maybe from really having that life you want, really being able to make a difference in the world, you know, have significant relationships, friends, that kind of thing.

So this was a paper that we published some years ago just showing that we could show that the beliefs were related to laboratory tests and they were related to negative symptoms. What is not on this slide is we also showed that they were related to community involvement and that kind of thing.

So what was nice about that is it looked like maybe we were right, the theory was right, and maybe these would be really good targets for some kind of intervention that would help people to really more or less get the life that they want.

This is kind of a neat thing. So a meta-analysis is sort of like a summary across a bunch of studies. It's an interesting methodology. But the reason I put this here is just to show that we found this (inaudible) for these defeatist beliefs, but it turned out that many other people have found that as well. And so it's not specific to Philadelphia, or to me, or to the people that I interviewed. It's been found all over the world. So it seems to be emerging as a sort of general thing. These sorts of beliefs being endorsed by people with serious mental illness who have negative symptoms and have a difficult time participating in the community.

And so this is another kind of belief we have that sort of holds people back from socializing. We call it asocial belief, so saying you prefer to be by yourself than doing things with other people. People think I'm shy when I just want to be left alone, that kind of thing. And we were able to show that that predicted their social functioning in the future. So, again, the beliefs predicting behavior.

But a more recent study that we've done – I'm going to skip over this slide because I think the next one shows it better. This is work that I did with a terrific early career psychologist, Liz Thomas from Temple University. And what we were able to show is that both kinds of beliefs impacted community participation separately. And so you could target each of them. And each of them had an impact on motivation. So that's what this – this slide is showing.

And community participation is a lot closer to I think what recovery means than some of the other things that people have measured over the years. So that's why this is kind of an exciting study, is to be able to link the beliefs to community participation which is ultimately what we want to help people do.

This is a – this is a – this is also part of the theory just showing that how someone sees themselves and how they think others see them is related both to delusional beliefs, as some psychiatrists call it, and also to their sense of motivation. So if you can help with self concepts, you can help with other things which might be getting in the way of the stuff that they really want to have.

Similarly, we have been able to link on the beliefs to performance on laboratory tasks to show that the beliefs impact them. And it kind of makes sense. If you don't think you are going to do very well on a task, you might not try that hard, and so that's – that's what we are seeing here. What we basically can show is that when the beliefs change, people do better at the laboratory tasks but not the other way around. And we also have shown sort of something that is a little bit more related to how you think about your thinking, so what some people call meta-cognition, also seems to be related to how people perform on laboratory tasks. And as you have more favorable beliefs, you do better on the tasks.

And this, I think, is kind of pulling it all together. This is work that comes out of UCLA by Felice Reddy and Bill Horan. And the neat thing that they show here is that you can show that the negative symptoms – people have elevated negative symptoms, and then they also have elevated defeatist beliefs, they just don't try as hard on the laboratory tasks. They just don't put in as much effort. And so they have a difficult time accessing the motivation and really marshalling the effort. And, again, what is nice about all of this, I think, is that you can see where you can reverse that kind of thing and really actually help – be able to help people with that.

This is something that – that we think is pretty exciting because – because what we have been able to do with the literature review, it really illustrates the way in which there are all these different factors that might be contributing to how people aren't really able to get what they want in the world, with community participation on the one hand and laboratory tasks on the other hand. And all of the factors that I have listed here, social exclusion, stress, mood, that kind of thing, those are all addressable psychosocial – all addressable by the way, you know, you can live your life. And so it suggests that a lot of people really can get the life they want and that recovery really extends to everyone because there's a lot of – a lot of stuff that can be done and it's not so much about there being something defective about you that's leading to some of – some of the challenges you might have.

This is some neat – neat work that Paul Lysaker in Indiana has done which is just showing that as people sort of start to feel different about sort of the defeatist beliefs that we talked about, as those start to go down, in particular two kinds. One related to whether you are going to be able to succeed at work. Another just about whether you are going to succeed generally. They really improve your life quite a lot. Again suggesting that they are really great targets for really improving people's lives.

And this is a big thing. I pointed out the connection things before. And this is also some research out of UCLA. Really showing that social exclusion seems to really exacerbate the defeatist beliefs as well as people not being able to perform the laboratory tasks. So, again, suggesting if we can reverse the social exclusion, we can help somebody really be involved and be able to participate in a meaningful way to them, we might really achieve a transformation for them.

So we developed a treatment based on these ideas. So basically all the stuff I just was showing you, and there's more there, but just sort of these basic ideas about trying to understand how things work for people. Then you can translate that, and we have done this, into a treatment approach. And Ellen is going to tell you a lot about the treatment approach, but I have worked with Dr. Beck for a little bit of time, and he always says, before you show people how – how you do it, you have got to show them that it works. And so I wanted to just give you a little sense of that here.

So we published a clinical trial a few years back. And in this trial we recruited people who had elevated negative symptoms. That seemed to be the thing that really was the limiter on the sort of life that they wanted. We randomly assigned them to receive recovery-oriented cognitive therapy, which we'll tell you about, as opposed to the treatment that they were already receiving in the community. So it could – it could involve day treatment. It could involve – obviously it often involved medication, that kind of thing.

And what we basically found at the end of treatment, which was 18 months, we had – we showed an improvement in functioning in the community, we showed an improvement in motivation, and to our surprise, we also showed reduced positive symptoms because we weren't targeting those in this. We were targeting the person's life.

We used functioning because that was – that seemed to us to be the closest we could get to measuring recovery at the time. I think we are improved on that.

But the numbers here in case you are interested and it's not familiar to you, basically what we are looking at here is that we show a shift in how well people are functioning, and that's what the number is trying to account for. That there has been a shift, so the whole group has moved up. And basically it's like someone goes from not really doing a lot or not having any – any social contacts to volunteering and having a friend or two, that sort of thing. So that's the kind of shift that that number is referring to. And similarly with the motivation. They just have more access to motivation.

So this was – this, of course, was very encouraging to us and has gotten us into a lot of work in the community.

But we also recently published, just earlier this year, in Psychiatric Services, we published a follow-up study where we showed that the improvements that we showed in the original clinical trial actually were maintained after the treatment was over. So it wasn't just – the contact with the therapist was good, it was a good thing, but it wasn't the only thing that was making it working. Those people learned some stuff. They had a change in lifestyle so their functioning was still better. Their negative symptoms were still improved. And their positive symptoms were also still improved.

And then the one thing that we really thought was kind of neat, and I realize this – this graph is exciting, but – and I apologize for how exciting this graph is – but here's – here's the take-home message for this. We had people who had – who had – had developed problems when they were teenagers, and now they were in their sixties. And what we could show is people with that longer – longer time, longer chronicity, took longer to improve but they did improve. They improved over their baseline by the end of the study. And the people who were sort of at an earlier episode responded more quickly.

But my message for this one, I think, is everyone can recover. And everyone has their rate of recovery. And there is nobody who is too severe, or has had these too long, that it can't improve and really get the life that they want.

This one is probably also really exciting. And really the metrics for this one here just this. What we could show is that on the – on your right, where there is a line that is going diagonally, what we are showing there is that we had a way of measuring the beliefs that people had, and we could show that that correlated with the improvement that they showed in functioning positives, and so they went together basically. So it looked like things changed together which means that how we thought it was working seems to be right.

We had a control thing, which was the performance on the tasks, which is on the left, and it didn't seem like it improved.

So basically we are just trying to show that our idea about how it works seems like it is right.

Okay. This is – this is – this is a study I think is really going to shape our thinking for a long time to come. Because what began this study is we had a study where we had people doing a task, and they – and we did an analog of therapy. So they collaborated with somebody to work on doing something better as opposed to a group that didn't collaborate while still working with somebody.

The main point about this is that what we found is that as people improved their performance on a laboratory task, the biggest predictor of that was their positive beliefs about themselves and also their positive mood. And we have seen this clinically, that the key to real recovery and resilience is actually really the strengthening of positive beliefs and mood. More, I think, than it is a reduction of the negative beliefs.

All right. So now I'm making a transition and hand things off to Ellen.

So, now I want to tell you a little bit about the way the treatment program works. So this is a slide that is trying to capture that.

So a lot of times we are working with people who are really withdrawn. And so they won't come out of their room, or they don't seem to want to do very much. Or they might be sitting in the corner, they might have a blanket over themselves, that kind of thing.

So any kind of thing that we do is going to need to – got to reach them where they are at, as some senior psychologist once said. So – so -so – but we also know that everybody, and Ellen will talk a little bit more about this, has a different mode of being. We call this the adaptive mode. And what our treatment is about is really trying to access that adaptive mode, so finding it in the person. How do you find it? We'll talk in a minute about how you do that.

But once you find it, you need to really to help them energize it because it's really not the mode of living that's really dominant. Often what is dominant is this avoidance. Or maybe somebody is hearing voices all the time. Or they are really focused on, you know, the fact that they let people (inaudible) and that kind of thing.

So, reaching – reaching into the adaptive mode, sort of accessing it, and really helping them energize it, and all this will be done through activity. It's a very active therapy.

And interestingly enough, accessing and energizing the adaptive mode hit one of the most recovery dimensions, which is connection. Right? Having connections with others. That is the way that you do that. You establish really good connection with somebody. Well, we can talk about some of the ways in which that happens. And then – and then as you sort of do things with them, as a family member, as a provider, you know, as a doctor, you are basically energizing the adaptive mode. And for a lot of the people, they are very – they are often very withdrawn and really out of the swing of things. And so it is hard for them to

access motivation. But as you do activities that they are interested in and you are interested in, as they start to help you, things of that sort, they start to develop the adaptive mode.

Now this isn't enough to get where you want to go. This is (inaudible) to like you on. And that's the middle one, the developing the adaptive mode. And what that is about is really the dreams that the people have, the life that they wanted to have. And we refer to that as aspirations. And this part of the model, the approach, is really where we get hope. That's the recovery principle of hope. Because a lot of people have given up on what they can do. They don't think they can do any more. They are afraid of failing. That kind of stuff. But you can really work with people to sort of think what do they really, really want in life. And it's going to be – I mean, so many years ago I remember being in a long-term hospital facility and sitting down with a gentlemen who was having such a hard time making his speech do what he wanted it to do. But at some point he just said to me, doc, you know I'm 52 years old. Where is my wife? Where is my house? Where is my job? Where is my car?

So – so I think aspirations are within everybody, and they are really achievable. And a lot of what we will talk about, and we'll spend the next webinar on this – a lot of this, is what is really key for aspirations is the meaning that they bring to the person. And more often than not, it is going to be a human connection through helping. And it doesn't matter what the person's past is, that comes up again and again.

The fourth – the fourth square there for you is actualizing the adaptive mode. What I mean by that is you are actually doing the things that are related to your values and your aspirations. So you are actually doing sort of thing. We don't talk – we can talk, but we do. We do lots of things. It's really making the meaning happen.

And when you are actualizing, that's the recovery dimension, I would say, of self-efficacy. Or sense of efficacy. A sense of purpose comes in at that stage because your experiences, your successes, show you how well you can do.

The final thought is really where people help – this is where we really deal with their beliefs very directly. This is where we help people see that they are really being successful because a lot of times individuals we work with don't notice that. One thing they often don't notice is social success in particular.

But also helping them develop resiliency with respect to stress and the things that sort of have sort of knocked them off of their path before, maybe gotten them hospitalized, got them in the criminal justice system, that kind of thing. So this is really the part where we really help them and partner with them to really – really become the powerful person they can be.

And one way to think about this is at some point they being able to learn from things that don't work out well and really learn from things that do work out well.

So, I'm going to (inaudible) and we're going to do for the rest of our time is think about the – how do we organize and understand both times when people are really doing well and also when things can become more challenging.

And so what I'm going to do first is to introduce you to a tool that we use to really help us organize our understanding. And this is – and then I'm going to lead into breaking down really the first section of Recovery-Oriented Cognitive Therapy, which is accessing the adaptive mode as kind of our first step. And that will take us through.

I want to let you know that the recovery map that I am about to go through is something that is available on the resource list as a principal document, so it is something that you guys have access to.

But a recovery map is a way that we organize – like I said, the ways in which people really get into the adaptive mode and what it means to be in that space. And gives us a really good tool as maybe – it's a tool that is often used by practitioners. I think I should probably caveat this with it's not something that we necessarily sit and do with an individual. It's more for our own way of organizing and understanding. I tend to use this just for – to keep myself thinking about based on what I know about someone and what

they are like at their best or when things are more challenging, what then can I do. It's about taking it and putting it into action.

So the components of the recovery map start off with how do we – this is related to the arrow – so how do we access that adaptive mode? What are the things that people are interested in? What do they like? What do they enjoy? What gets them excited?

And then related to that then, what are the beliefs about ourselves that have potential to be activated when we are doing those things that we really like? So, you know, what does it say about me when I am able to sing a song with my niece or nephew? Things like that. And just the sense of capability and connection that I can experience and the sense that I can actually create my own energy when I am in that adaptive mode. Those are the beliefs that can be tapped in at that time.

Next is those aspirations. What is it that a person wants? So things that are really exciting. The things that are worth getting up for in the morning. And then next to that is what would it mean for me to achieve that. And this is where I would say this is going to be – that part is going to be the focus of the next webinar. So that is really about it doesn't matter how big or far off something may seem, when we know what it would mean for the person it gives us a really good target for what they want.

The next part of the recovery map is what are the things that are more challenging? What does – what gets in my way of really moving to the things that I want? And that could be that I am spending, you know, I spend a lot of time away from other people or – or in my room. It could be that I am really just having a hard time interacting for a number of reasons. So any of the obstacles, and that will be the focus of the third webinar, will be the obstacles.

And then finally it's about positive action. So as Paul was saying, it's a very active approach. So it is about what are the things that we can do together that are going to increase those more positive beliefs about the self and get people in that adaptive mode. But then also what are the things that we can do that are going to counter some of the challenges. And those two are really often go hand in hand.

So. If you think about just yourself, your own experience, and when you are feeling kind of at your – just your – the point where you have the least amount of energy. Or you are the most frustrated. Or you are having a really hard time moving forward. These are some of the things that we often run into. A lot of isolation. Or not having a ton of energy. Or not feeling like you can – you can do much or connect to other people. So activating the adaptive mode is going to be one way to really bring about energy, connection, and tap into those parts of ourselves that either we haven't accessed in a long time because it takes a lot of energy to or things that we haven't yet experienced that we might want to do, things we haven't gotten a chance to do yet.

So, what I often like to think about is what are people like at their best? What is it that makes you feel like yourself, that helps you feel connected and energized?

So if you are feeling so inclined, these are just a couple of examples of when people are like at your best, you know, when you are – when you are connected to other people, you are doing events, when you are involved with sports. I would love to know in the Chat box, what are some of the things that make you feel like yourself? First, what are the things that make you happy or feel like you are in kind in your adaptive space? For me it's cooking lasagna with my mom before Christmas. Or listening to Michael Jackson. That's my – that's my jam. Those are the kinds of things that make me feel like I am at my best.

Helping other people get singing. I'm going to read some of these off. When people are traveling. When people are singing. Painting. Running. I love it. Going for a walk. Being with kids. Going out. Pets I see. Exercise. This is great. A lot of you guys have things in common.

Going out to shows. Going to the beach. Dancing. I love dancing. My exercise is Zumba because I have to dance. You can't see me but I'm moving right now.

Time with family. Spiritual practice.

Exactly. These are the things that really help people feel to like themselves and at their best. And what does it say about us? What we do is we – we want to think about when you are in that mode, and you are doing those things that you really enjoy, what can that say about us, right? That we are capable, maybe if it is cooking. If we are connected – that we are connected to other people.

Webinars. That's fantastic. That's fantastic. Well, hey, you know what? Sharing, and I'm – I'm smart, I'm knowledgeable, I'm able to give and receive information. I think all those things are fantastic. And so what it is is about kind of identifying for people what are the things that bring them out at their best. Because that's what makes us – that brings out our energy, our knowledge, our personality, and comfort. And being in those interactive spaces. So that's fantastic.

How do we get there, though? I know, as Paul said, we work with a lot of folks who have spent a lot of time particularly isolated or disconnected from other people, and so it can be really tricky where if you ask them do they want to do certain things, the quickest thing you get back is, no, I'm good, I'm good. Even if you knew they used to enjoy it. So that's why this is about doing rather than talking so much.

So we really encourage folks, whether it is your family member or a person that you are working with in a clinical capacity, I think that it is really helpful to just go in with instead of, hey, do you want to do – this, hey, what do we want to do, Uno or – Uno or Spades? Or should I play this song or this song? Or even just going in and saying, hey, you know, I know that you really like – well, I'm just going to use Michael Jackson because it is the fastest thing for me – Michael Jackson. You know, I heard this and thought of you, and start playing the song.

There are things that we can do to really quickly try and tap into, access those hooks.

And another way is, that I think is really, really useful, is so doing with. Finding things you are connecting with people on and doing them together. But then another really helpful thing is asking for advice and finding a way that we can connect that levels our playing field a bit. Because I think that it is really important to find things that, you know, we all don't know everything. And so it is a really good opportunity to connect with individuals and learn about things that they care about and know about. For example, I'm going to be going to a, you know, a family party, and I have no idea what to make. Have you got a recipe for me? Can you help me out?

These are things you can do across treatment contexts. You can do it at home with our loved ones, whichever the, you know, it can be done anywhere. But it really can tap into areas of knowledge and interest for people and get them really excited and start thinking about how they can help you and the best ways to do things.

I ask a lot of things related to pop culture and music because those are things I am really interested in learning more about. So anything that someone can teach you is going to be a really great way to access that adaptive mode.

(Inaudible)?

Sure. So sometimes the kinds of examples that we have seen is the young man who really feels estranged from his family. And one of the ways – and really doesn't feel like he belongs. And one of the ways that he is able to really reach with him and work with him is he helps fix the Alexa that is not working. And he is able – he knows how it works, when he gets it to work –

I don't even know what Alexa is. Something electronic.

And that – and that's the way – but it's a role. It's a way to belong. It's a way to contribute. I think the key thing for getting into the adaptive mode is ways in which people can contribute and be a part of things.

Yes. And so really when we are talking about academia adaptive mode, to kind of summarize this piece of it, is that it is something that is essential for building energy, for creating connection, and for finding ways that we can work together that are not based on just focusing on challenges. It's about really

emphasizing people at their best and thinking about what are the – how often is it that we can have that opportunity to – to give a person that experience. Because there is a lot of learning about ourselves that can happen during that time.

Let's see. Yes, so I see Lorie made a comment there about how this is the first of our webinars. The next webinar on this is going to be thinking about once someone is in the adaptive mode, how do we find out what it is that they really want and what is really important to them and how we use that. So in the meantime, I see this kind of neat action plan slide here. So what is it that people might want to do between now and maybe the next time we are all together to try and help activate people's adaptive mode?

Get up. Get out. Get involved. Get busy. I like that, Kim.

Yeah. Yeah, we were just thinking that it might be – might be interesting if some of these ideas are ones that you would like to try out if you haven't – you haven't done these as much, or sort of taking this slant on it a bit and giving it a try with someone you might be, you know, like a family member or someone you might be working with or that kind of thing.

Lots of people.

Yeah, lots of people typing. Yeah.

We – we find that this is a particularly nice way to be able to really connect with people. And actually from the perspective when we have talked with people who – who have lived experience, a lot of times they – this is what they like. They like this aspect. We were talking about things we care about. We're sort of focusing on my life. And I think it is much more healing, often to them, than focusing on the traditional targets that you can find in psychiatric treatment. Things of that sort. And so that's why we emphasize it at the start because we really want – and that's why it is at the top of the recovery map that we showed.

Yes. I see some of the cool things people are saying. Someone talks about – mentioned coffee. That's always a great way to start engaging someone around, you know, things they like to eat and drink and things they might know about.

And someone mentioned asking about volunteer opportunities. I think that is great.

And I love there's a comment about people not always seeing their strengths. And I think that's why this piece right here is so important because, exactly, this is – the Recovery-Oriented Cognitive Therapy modality is really focused on, you know, trying to find things that people either have, you know, long forgotten. Or a lot of times people will say, well, I'm not good at that anymore because I have this diagnosis now. Or I'm in the hospital, what do you mean like I – I have strengths? They can be really difficult to – to bring up. And particularly if people have been maybe isolated from others for a long time or really kept their distance from people, it can be really tricky. So I think it is really important to – that's why this is so important. It can give a way to reenergize some of the things that they – they have to do. But it can also provide opportunities to creating new things.

So why don't you tell the example from yesterday?

Yeah, yesterday I had a really great example. One of the things we do when we apply this therapy to things like group therapy is we want to get people really involved in it and engaged and energized, but that's tricky. So on an inpatient unit, one of the things we did was we started to involve like physical activity, like sports, in the milieu. And what we did yesterday was toss the frisbee around the room. And tossing the frisbee around the room did a few things. It – we had music on, frisbees being thrown, and we had people who were coming into the – into the day hall just kind of because they heard the music, weren't sure what was going on. And someone who really doesn't often engage with many people on the unit came out, and the frisbee got thrown his way. And he picks up and he starts throwing it around, and he was really, really talented. It turned out that he had been on like a – a frisbee league in school as a kid and did competitive frisbee. And we would have never known it had we not had the opportunity present

and available, and it started to get other people involved. And there was another gentlemen who would stay isolated because of disorganized speech, and he started throwing it around and started actually really being focused on the activity. It helped with organization there as well. So -

And they both taught other people how to do it.

Yeah. They taught me how to because I stink at (inaudible).

And brought people into the game.

Yeah. So we had connection, energy, and tapping into untapped potential – a potential that hadn't – things that hadn't been tapped into in several years. And it took some music and a frisbee. It doesn't take a lot of resources for access to be able to pull from them. Just some creativity at times.

We are at I think a 30-second countdown here for our part of things.

Yeah, so I think – I think in summary, we tried to present sort of a way in which we have done research over the years to really try to understand some stuff and understand how people are getting stuck and then really how to help them and collaborate with them. And then we tried to sort of translate that into how that would look and really sort of start to show the first phase of it. And then the subsequent – subsequently we are going to look in more detail at some of the key pieces to it.

Thank you for all the excitement.

Yes. That's great, you guys. I appreciate so much your energy, but also the energy of the participants. People have made lots of comments, and there have been some really great questions. And I want to spend our last few minutes together going through some of the questions, but also letting people know that this really is a – a serial event. So like a good show on TV where it – the story is going to build on itself, and the opening – what do they call it – the pilot spends a good amount of time just introducing the characters and building some of the framework. And then we are going to get into the storyline and learn more as we go.

So I hope that everyone on the call will join us for the – the sessions that are coming up. We are going to review those times in just a minute. But know that if we don't get to your question today, it's because it is going to be answered in one of the next sessions. And also please feel free to, if you can't be on the call in real time, they are going to be recorded, just as this webinar was. And you will be able to check out the recordings of the sessions that come up and get all of your questions answered.

But as for today, one person asked, and almost more of a reflection, if defeatist beliefs may have roots in early childhood toxic stress where their defeatist world view was reinforced repeatedly. And so rather than it being a belief, it's an experience. It's a – it was what they were taught. And how might you work with that in CTR?

Sure. So the first thing to say is there is definitely emerging evidence that these beliefs pre-date literally anything that you see that gets a lot – a lot more like what someone would give a psychiatric diagnosis to. So you can find it when people are eight and nine years old.

And I think whatever – the way I would answer is we all have beliefs, and so anything that – any of these sorts of things, when I'm saying that I can't do things or I can do things, that kind of thing, those are beliefs. And, sure, it might be the case that people learned them from people – well, in fact, I think that often happens. And I think it's actually kind of tricky sometimes. You can inadvertently help people sort of hold themselves back. Or you might do it because you are really worried that you don't want to see them fail, that kind of thing.

But what I would say is that – that they are largely – I mean, I think we all have certain beliefs that we have that we can't do certain things well, say, which I think is a pretty good one for this topic. So like in Ellen's case, she doesn't think she can do frisbee very well.

You haven't watched the tape yet.

And in my case, you know, I'm not very – I'm not very good at a lot of – like anything artistic, particularly - So – so, but that doesn't generalize to everything that I do. And a lot of what happens with the people that we are working – trying to collaborate with is that it does generalize. And that's what defeatist belief is. It's like too much. And so when I don't try things that I'm not so good at, I probably don't feel so bad because I don't suck at that unless I really love them.

But what happens with what we see in our research is that people really pull back from everything, and then that's really the poverty of the life that they have. And so – but – and our way through that is really to help them have the experiences that they – that are – that show them really they can do stuff. You know, so like one guy said, I'm a helpin' person, not a hurtin' person. That kind of thing.

Um hmm.

Or a good person rather than a bad person. That kind of thing.

So those are the kinds of things that we really see sit on top of some of the inactivity people have. Or in some cases the same beliefs can lead to sort of the folks who are really agitated, really trying to push to get what they want because they are so afraid they are not going to get it because they have such low expectations of themselves and other people.

Yeah. And it's interesting, but as you were speaking, and you said you were not good at art, it reminded me of the fact that the language that we use is really important because I used to say I wasn't good at art because my partner is an artist. And then she said, you know, but you are good at art, just a different form of art because I sing. And – and so we put a connotation on words. I think art means a visual thing.

Sure. Sure.

And then she had a much broader definition.

Sure.

And so that was a reminder.

Another question that a number of people asked was about the recovery map being used as a reflection tool for the clinician. And the question is, but can it be used with the person, and is there, in fact, a version that is specific to use with the person given that this work is at its very beginning a recovery approach?

I think that – like I said, we tend to not do this with the individual, and the reason being that a lot of the folks that we are using this approach with are people who really – like the idea of kind of self-reflection, thinking about thinking and so on is not generally an effective place to – certainly to start. It takes a lot of not just energy, but it takes a lot to be able to think about your patterns and all. And I think that is something that is done a little bit more traditionally. But it hasn't always – it just sometimes strikes out and often can be disengaging for folks to really break it down in that way, especially when we get to the later parts of the map where it is about more of the challenges.

I will say that one of the things that we have done is people have really started to pursue their aspirations and maybe run into challenges, is we might float some of the things that we have noticed in from the map. For example, an incredible young woman that we have worked with, she was getting really stressed out as it was time to move to, you know, her – her own place, the thing that she wanted for a long time, and started to have some challenges. And we were able to – I was able to say, you know, I think, you know, let me know if I got it right or not, but I think when sometimes we get really stressed out, you just kind of focus on some of these things that are going on and it just doesn't – things don't make a lot of sense sometimes. What do you think? And I was able to use the understanding from that to kind of float a cure. But we didn't really sit down and do it together.

That's not to say that for some they can't. I think that it's possible, oftentimes, though, the – the groups that we are working with, it just provides less of the learning than doing the action and actually kind of drawing conclusions about yourself in the moment.

Yeah. What we're not saying is it's not that we are doing it to the person. It's not that we're imposing something on them. And so if that's the way it's sounding, that's not the – the original reason we developed the map was to try to help teams coordinate their work and then figure out what they needed to be doing with the person, talking with the person about. And so – and we needed something that was relative – a single page to really help – help that out.

One of the things we – I mean I think there is a need for something in between here, and so I think you have raised an interesting point. There are the wrap (sp) form, the things of that sort, which we think sometimes are too extensive for a lot of the people that we are working with. And you really can get started on some really amazing work with just a couple of simple ideas. And so finding out – finding out what the person is interested in, that comes from them. Finding out and pulling out – finding out what they really want to be doing, I mean, you know, sort of what is most motivating to them. Kind of like some people might even call these kinds of things bucket list kinds of things, things are really the most motivating. That's inside of them. And so we have – we have to work with them to find that out.

The obstacles are often things that people – all that they talk about. So one of the reasons that we put them down – down the list is just because we want to put those in the context of the person, and the person – what the person wants. And then look at how those play out. So whether it be low energy, whether it be focusing on hallucinations, whether it being focusing on being worried that people are going to hurt you, or things of that sort. Or, you know, shall we say, getting angry at people a lot and doing something about it.

Um hmm.

So – so that's kind of – that's kind of the way we would think about it. And we are really focused on that – that – that –connection piece, that really doing things together. So we think that's –

Right. So –

Our thing.

I'm sorry. So one of the things that you have made clear in your research is that CTR is initially focused on and for people who are thought to be fairly shut down or disconnected as a result of their experience with their symptoms. So for people who have been diagnosed with schizophrenia and have been really hard to reach or really difficult to connect with others. One of the people in the audience, well actually a number of people in the audience, have asked if CTR can also be done with people with other diagnoses or who are not diagnosed with schizophrenia or may have primarily an addiction diagnosis.

Yes, definitely. We have actually had pretty considerable success with individuals with addiction, with very serious self-injury and different types of aggressive behavior, other things. And a lot of that has to do with the emphasis on the future and really the meaningful aspirations. I think that's a really key piece to that. Of course there are several other presentations, but yes, absolutely.

Yeah, I would – I would say –

Okay.

We've seen particular success with this with people who have severe forms of self-injury. And frequently these aren't people who have a diagnosis of schizophrenia, they don't really experience what a psychiatrist would call psychosis, but they do have a real problem with self-injury and they often find themselves in institutions and they scare a lot of people because they could easily die with their behavior that they are caught up in.

Um hmm.

But we find that this particular framework works pretty well for them because of the way kind of organizing what's going on and give them – because really what they are usually needing is control, and a sense of consistency and control and connection. And when they don't have these things, that's often when they – when the self-injury happens. So, but anyway, we've some actual amazing results there.

And I think in terms of substance use, again, it's sort of putting substance use in the context of what do you really want in life, what is it doing for you, and are there other things that might do that that might have more benefits or not. It's not so – it's not so much trying to drive the person to do what – what you as a family member or provider want them to do, but really kind of sort of cracking – cracking open their life a little bit. And, again, we have seen that that really has – and we have had to address all these kinds of issues because a lot of times people don't present with just one sort of thing that's getting in their way. It's a lot of things.

Um hmm.

We've worked a lot with the assertive community treatment team and so it's very – very, very sort of challenging kind of sets of things. And so – but we think that the recovery framework that we have, that we have started with here, really helps sort of set out what you need to do, and then we have a way with the cognitive model for understanding some of how the psychology is working. And then doing the sort of interventions that are related to what you are doing and experiencing success that really seems to do the trick.

Yeah. We could go on and on and on today, but we don't have that flexibility. What we do have is an opportunity to thank you all and to let the audience know that Paul and Ellen are going to be our presenters on the – on – on the whole series. Although for the last webinar, the fourth one, we will also have another voice to be heard from. I want to thank Paul and Ellen for their commitment to this series and sharing this information with us.

The context is recovery. And we want to see people succeed, and we know that the path of recovery for each person is individual. That any intervention only works if it works for the person themselves. And so we embrace the SAMHSA definition of recovery and know that these principles and dimensions are critically important.

Recovery to Practice is the initiative that brings this type of series to the people who are working in the behavioral health community across disciplines. And so we are always happy when we see a broad representation, be it nurses or peer specialists or psychiatrists or occupation therapists or people just entering the field. Also family members and students. We're glad that you are here and hope that you will join us. We want to contribute to your continued learning.

And so separate and apart from the information that the presenters are providing, we always bring to you some additional resources so that you can look more broadly at the themes that might be somewhat related to this discussion. And we also back this up with a companion newsletter that is soon to be released and available for you for reading online or for downloading. We do invite you to pass it on and to invite other people.

Our next webinar is going to be in two weeks. And this is number two of four so mark it on your calendar now. This is an unusual schedule for us. But on January 17 at 1:00 Eastern Time, be sure and change – make the adaptions you need to for your calendar. But January 17. Then again on February 7 and February 21. If you go to our website you will be able to see what the next topics are and how we progress through this work together.

If you want to get a Continuing Education hour, or if you want a Participation Certificate, follow the link on this page. It will also be available to you in just one moment on your screen. And fill out a short survey, or – and/or complete the quiz so that you can get the credit and make this hour be even more valuable to you.

We are happy that you are here. We hope you will join us for the rest of the series. It's a great way to kick off the year. I'm excited that we had so many people with us today. You all have a fantastic afternoon. For those of you who are about to be slammed by a storm, stay safe and warm. For those of you who are warm, enjoy it. Thanks for all you do. This concludes our webinar. Thank you.