# CHAPTER 1

# Introduction to Recovery-Oriented Cognitive Therapy



Michael, a resident of a state hospital for several decades, spent most of his time sitting and staring at the wall. When you did see him walking about, he was usually muttering to himself about having billions of dollars and thousands of wives. He was almost always alone.

Change started with an engaging conversation. A member of the treatment team approached Michael. Noting his football cap, she asked him whether he was a fan, and then where in town he was from. Michael soon shared a few of his interests: music, fishing, and motorcycles. They agreed to talk again.

Over the next few conversations Michael talked about dating and getting back on a motorcycle. The team member said that people often got together in a club to talk about the things they like, and what they wanted outside of the hospital. If he joined, he could teach others about motorcycles and good fishing spots in the city.

Michael did join the club. From the start, he demonstrated tremendous knowledge and love for music of the 1960s, plus a beautiful singing voice. He began to connect with people, dancing to the music and telling others about various singing groups. Those conversations led naturally to others about food and where the club members could eat and listen to music in the community outside of the hospital walls.

Eventually, Michael started to talk more about his desire to have a girlfriend. He sang songs in the club that he would sing to her. He began thinking about what it would mean to have a girlfriend. He wanted to take her out, be a loving and supportive boyfriend, and show her around the town. This would probably be easier if he were not in the hospital. For the first time in decades, Michael contemplated accepting a community housing offer. Ultimately, after a visit, he moved from the hospital into a transitional group home.

At the residence, Michael also discovered a talent for art, and began giving his drawings to other residents as gifts. He talked about his giving as a step toward making and keeping friends and a nice thing to do for a girlfriend. With his case team, Michael and other members visited neighborhood places where they shared food, listened to music, even went to church.

The church invited him to help in the food pantry. Soon Michael asked to join the cooking team in his residence. He recruited a friend from the house to join him in the pantry. Little by little, Michael

developed a social network beyond his team. Eventually, he went to a less restrictive residence and began going out more and more on his own in the community. Michael became a familiar face in certain coffee shops. He struck up conversations with other regulars and eventually began dating someone he met at the coffee shop. He also got a job at a nearby diner.

Michael's life transformed dramatically. Decades of relative inactivity and disconnection gave way to an expanding life that realized his desire for meaningful relationships and a daily experience of purpose. The dreams, actions, and success were—and are—his. The guide to this new life: recovery-oriented cognitive therapy (CT-R).

The CT-R approach emphasizes meeting people where they are as the starting point. The team member knew to look for Michael's adaptive personality, finding it in sports and motorcycles. Trust and connection through action help to build momentum. The team first discussed Michael's interests and later offered him the opportunity to join the club. In this way, an interpersonal role for him evolved. The team also knew to draw Michael's attention to his successes and begin to think about his future. Hope came, evidenced by his voicing his wish for a romantic partner, and then action—taking steps to get out of the hospital and participate more fully in the community. The community team met with Michael and the hospital team, picking up the program and continuing his success and emerging autonomy—creating art, giving it away, developing friendships, starting to date, and getting a job.

CT-R reliably produces the right kind of interactions between service partners like yourself and individuals. This book is a how-to guide for partnering with individuals like Michael that enables them to move from languishing to flourishing.

In this chapter, we present the fundamentals of CT-R that lay the foundation for our subsequent work. The basic CT-R model involves the concept of recovery, the cognitive model, and the idea of modes. We introduce recovery mapping and the parts of CT-R. At the end of the chapter, we consider the evidence base for the approach.



## RECOVERY—FROM POLITICAL MOVEMENT TO STANDARD OF TREATMENT

Mental health care has changed profoundly since the early 1960s in terms of the location—institution to community—and nature of care—from custodial to empowering (Broadway & Covington, 2018; Lutterman, Shaw, Fisher, & Manderscheid, 2017; Pinals & Fuller, 2017). The modern approach to recovery began as a political movement among individuals who were mostly in state hospitals advocating for themselves and others to receive better (or in some cases, any) treatment (Chamberlin, 1990). Their inspiration was the civil rights movement (Davidson, Rakfeldt, & Strauss, 2011).

A watershed year in turning recovery ideology into practice was 1999, with the publication of the Surgeon General's Report on Mental Health, and the U.S. Supreme Court's decision in *Olmstead v. L. C.* In that decision, mental health was equated with physical health. Effective treatments existed, and the court confirmed that people have the right to receive these treatments and pursue life in the community rather than within institutions: "The notion of recovery reflects a renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts, and the opportunities open to persons

with mental illness to participate to the full extent of their interests in the community of their choice" (Satcher, 2000, p. 94).

Further steps were advanced in the final report of President George W. Bush's New Freedom Commission on Mental Health (2003), which endorsed a need to completely embrace recovery in mental health care, focusing on full community participation for everyone. In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a federal action agenda to carry out the aims of the New Freedom Commission. This document called for a revolution in the organization and delivery of mental health services.

## RECOVERY—WHAT IT IS LIKE FROM THE INSIDE

The concept of recovery is admirable and broadly appealing. How to realize it in a person's life can be challenging. Two questions leap to mind: What is recovery-oriented care? and How do you do it?

Individuals who have received psychiatric treatment for serious mental health conditions offer a way forward. One such person created Figures 1.1 and 1.2 to distinguish bad from good approaches, respectively, that providers can take toward treatment. In Figure 1.1, psychiatric diagnosis and treatment is the largest circle, with all of the other factors in life being given lesser importance. In this approach, the provider prioritizes dealing with psychiatric issues, perhaps with the assumption that these must resolve prior to addressing the others.



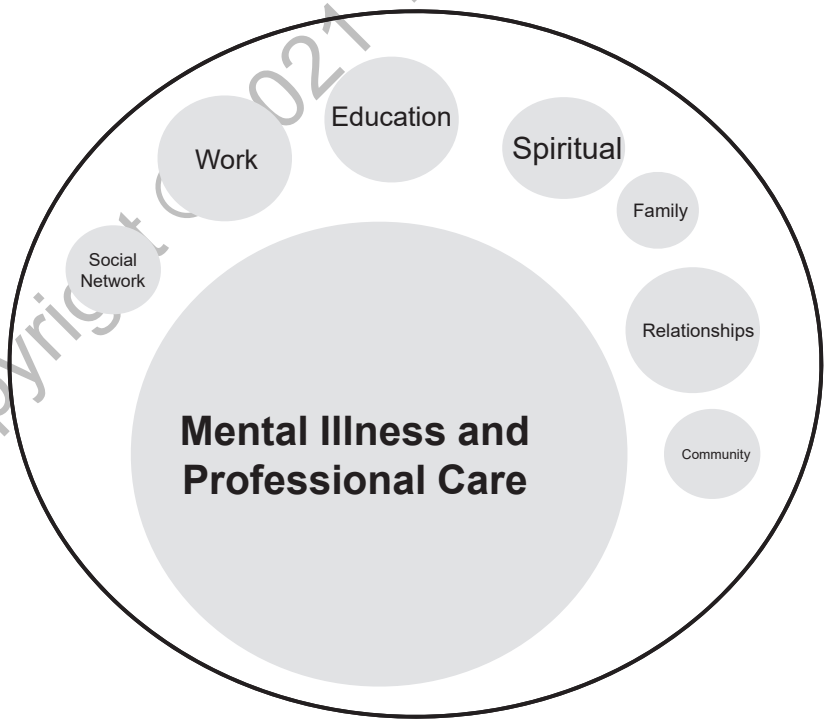


**FIGURE 1.1.** A less appealing focus of treatment.

As disengagement from treatment predicts a poor quality of life, institutionalization, homelessness, and greater disability for individuals given serious mental health diagnoses (Kreyenbuhl, Nossel, & Dixon, 2009), this first circle suggests why some might choose not to engage or to drop out.

Figure 1.2 contains the more appealing focus. Here aspects of life, such as going to school, dating, making friends, having a meaningful role, and working are much larger circles, with psychiatric treatment being a smaller circle. Providers delivering desirable treatment prioritize life and participation, and place psychiatric treatment within that context. Focusing treatment more squarely on recovery can broaden its appeal and potentially impact people who may not otherwise participate (Dixon, Holoshitz, & Nossel, 2016).

A recovery-oriented approach to treatment should emphasize the pursuit of an individualized sense of purpose (having a job, volunteering, helping your family) and meaningful relationships (friends, collegial, dating), as well as interests and hobbies. Individuals should have the opportunity to discover their inner power to help themselves or seek help when stress or problems arise. Everyone's life has challenges; treatment should promote resilience in regard to problems in the context of a person's fuller life.

**Recovery means recovery of the individual's:**

- ✓ Interests
- ✓ Capabilities
- ✓ Aspirations
- ✓ Ability to problem-solve
- ✓ Ability to communicate effectively
- ✓ Resilience in the face of stress

In CT-R, recovery is defined broadly, in terms of people connecting—or reconnecting—with other people and with values that drive the life they want to be living. There are certain basic human needs that seem to underlie individuals' hopes and aspiration and lead to wellness and expression of their best self—connection, trust, hope, purpose, and empowerment (Harding, 2019).

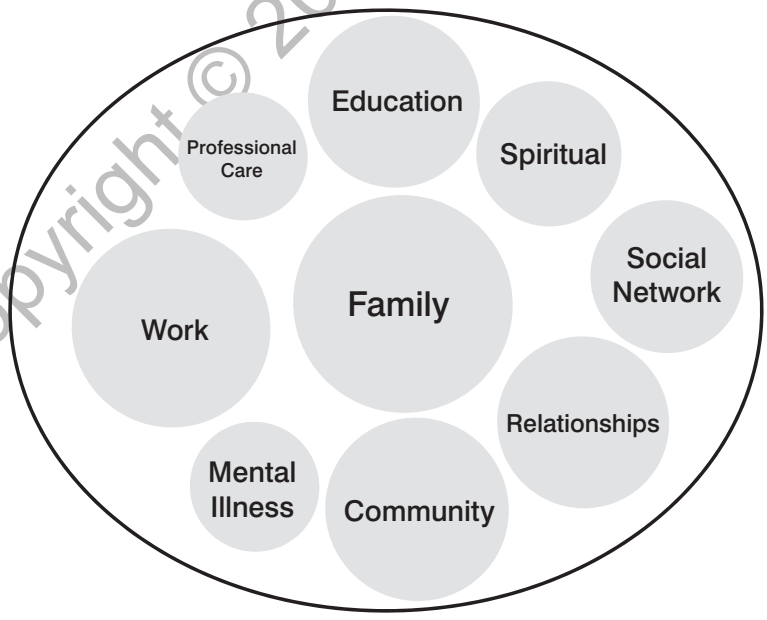


**FIGURE 1.2.** A more appealing focus of treatment.

## THE COGNITIVE MODEL

Now that we have a better sense of what care should look like, how do you realize recovery? The cognitive model is useful in this regard (Beck, 1963). This model helps us understand how people flourish, as well as how they get stuck, in terms of beliefs they hold—about themselves, about other people, and about their future.

We can think of the person's best self, the person they want to be and experience more often (Callard, 2018). This self gets expressed in positive beliefs: "I am a good person," "I am a helping person," "I can be successful," "Others value me," "I belong to the group," "I am loved," "I have a future full of possibility to make a difference." With CT-R we identify this self, help the person live it every day, and strengthen the underlying beliefs.

## ADAPTIVE MODE AND NOTICING AT-THEIR-BEST MOMENTS

We all speak of being in "work mode," "vacation mode," "survival mode." A *mode* is a manner of acting or doing that involves beliefs, attitudes, emotion, motivation, and behavior (Beck, 1996; Beck, Finkel, & Beck, 2020). We all have times when we are at our best, as do the individuals we work with. These *at-their-best* moments are an experience of one's best self and might occur during music group, at a birthday party, during a sporting event, or when describing a recipe. What do we see during these times? The person is warm, funny, connected, alert, knowledgeable. We refer to this way of being as the *adaptive mode*.

At-their-best moments occur when the individual connects with at least one other person and participates in a mutually beneficial activity. We can tell that these individuals are in the adaptive mode by their expression and behavior. They become animated, less pressured, and have a good time. Positive beliefs become more available, such as "I can have a good time," "I can be effective," and "I can be friends with other people." These positive beliefs are accompanied by energy, motivation, and good mood that free up latent capabilities and behaviors.

Treatment that focuses on the adaptive mode looks like that prescribed in Figure 1.2. It meaningfully involves other people, as well as a person's own strengths and talents, dreams and ambitions.

The adaptive mode is not exclusive to people given a diagnosis of a serious mental health condition; it is a general feature of being human. In CT-R, recovery means recovery of the adaptive mode: recovery of the individual's interests, values, capabilities, and aspirations, as well as their ability to problem-solve, think flexibly, communicate effectively, and be resilient in the face of stress. Recovery means flourishing in a desired life.

## CHALLENGES AND THE STUCK QUALITY OF THE "PATIENT" MODE

Individuals may not get to experience their best self or adaptive personality that often. This may be a large part of why they are in care. Days may be dominated by the experience of low motivation, lack of pleasure, hallucinations, delusions, aggressive behavior, disorganization, or self-injury. These experiences are frequently fluctuating and time limited, yet can pose a significant challenge to daily living (Mote, Grant, & Silverstein, 2018).

The cognitive model (Beck, 1963) is also useful for our understanding of challenges. When in this "patient" mode, individuals see themselves as weak, incompetent, incapable; they see others as threatening, rejecting; and they see their future as uncertain and forbidding (Beck, Himelstein, & Grant, 2019). These beliefs have gravity. They seem like facts. It becomes hard to access motivation, easy to be consumed by hallucinations and delusions—and above all to be held back from the life of one's choosing. The negative beliefs coalesce into a negative sense of self that can have a strong pull on a person—the essence of being stuck.

## PUTTING IT ALL TOGETHER

The whole focus of the CT-R approach is to locate the adaptive mode in the individual. Because the mode tends to be dormant, we need to energize it and then help the person develop, actualize, and strengthen it. Accessing the adaptive mode generally involves activities that do not look like traditional talk therapy.

What really works for people is the pursuit of some purpose that brings them a tremendous amount of meaning (Frankl, 1946). It's not about being busy or convincing yourself that things are okay; it's about making a difference. At the heart of CT-R is collaborating with individuals so they might develop and realize their mission in life.

CT-R helps individuals to locate their best self, develop it, and live their purpose every day. It focuses on what matters to individuals and places psychiatric problems in the context of the lives they want to live. It meets them where they are, even if they have low access to motivation and minimal interest in treatment or trust of service providers.

Figure 1.3 illustrates the essential components of CT-R. The adaptive mode is the focus of each part: accessing and energizing it, developing it, actualizing it, and strengthening it. The arrow itself is an image of progress. And the rectangles show how each of the components will

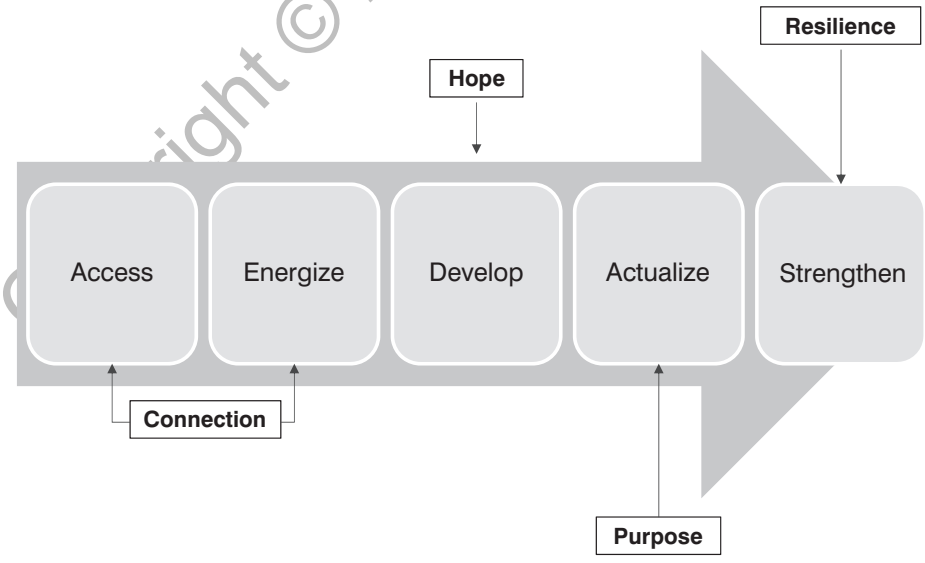


**FIGURE 1.3.** The CT-R arrow.

help you bring about the key aspects of recovery and wellness: connection, hope, purpose, and resilience. The CT-R arrow will be our guide throughout the first part of this book.

## Introducing Recovery Mapping and the Recovery Map

CT-R requires a focus that expands beyond challenges to include interests, aspirations, and positive beliefs. We use the term "recovery mapping" to refer to the process of collecting information about all of these, develop an understanding in terms of beliefs, and planning treatment. The Recovery Map (see Appendix B) is a one-page living document that you can use individually or with your team. It guides the development of your CT-R understanding. It helps you plan strategies and interventions—with concrete targets for change—that collaboratively promote a meaningful life. The Recovery Map keeps you focused on beliefs at each step of treatment and helps ensure that problems are kept in the context of the whole person, especially their interests, aspirations, and meanings. In Chapter 2, you develop your recovery mapping skills.

The following describes the parts of the CT-R approach, including how the Recovery Map comes into play at each step.

## Accessing and Energizing the Adaptive Mode through Connection

A significant number of people given a diagnosis do not say they want treatment, a diagnosis, or help. They may be discouraged, feeling that whatever they're doing is as good as it gets. They might not be trusting of mental health professionals.

Because of these concerns, you have to meet them where they are. This is a matter of finding and accessing their adaptive mode. We do this through human connection over shared interests and activities that excite the person. Accessing the adaptive mode requires an understanding of why a person might not initially want to engage with you. It also entails persistence to keep trying interests and activities until one of them generates a response. You can recognize when individuals are at-their-best and help to make these experiences happen more often.

But accessing the adaptive mode is not enough. We need to help the individual energize it. The aim is for the adaptive mode to occur more frequently and predictably. You can repeatedly develop the connection through shared interests that involve the individual helping you in some way. Energizing the adaptive mode requires repeated activity, based on the person's interests, that increases energy over time and lead to easier access of the adaptive mode. Ultimately, the individual can begin to project a future. The first row of the Recovery Map (see Appendix B) tracks accessing and energizing the adaptive mode.

As your relationship and doing activities together—either individually or as a team—is central to accessing and energizing efforts, this part of CT-R embodies human connection, which is an important feature of recovery and wellness. Chapter 3 enhances your skill at accessing and energizing the adaptive mode.

## Developing the Adaptive Mode by Eliciting and Enriching Aspirations

When individuals become more connected to other people, develop trust, get more energy, and gain more access to motivation, it is time to focus on the life the person really wants to have. Specific features of that life could include owning a home, getting a romantic partner, starting

a family, becoming a nurse, starting a business, or helping animals or the less fortunate. We use the term "aspirations" to refer to what people really want in their lives. Critical to CT-R is identifying aspirations that are big, meaningful, motivating desires.

It is particularly important to elicit meaning, which almost always involves helping other people, making a difference in the world socially, contributing in a significant way to family, or giving to others who are struggling. The meanings of aspirations are targets for everyday action. You can help enrich aspirations through the development of a recovery image that helps empower the person when stressful experiences occur. Individuals experience a palpable sense of hope when developing their adaptive mode. Hope is key to successful recovery and sustained wellness.

The second row of the Recovery Map (see Appendix B) is the place to record aspirations and the meanings driving them. Chapter 4 helps you develop skill in eliciting and enriching aspirations.

### Actualizing the Adaptive Mode with Positive Action

It is not enough to just dream—recovery and flourishing are about realizing dreams. Aspirations help us to know what matters most to the person. Once we know the meaning of a person's aspiration, we need to get that into their life to actualize it every day. Individuals create their own desired life through positive, daily action that realizes their valued meanings. Such actions can be taking a step toward reaching the aspired-to goal or engaging in an activity that has the same underlying meaning—for example, helping people. Each success in these kinds of daily activities can strengthen positive beliefs and weaken negative ones. You can introduce flexible schedules to help the person structure their desired life.

Skipping over the third row for now (which we come back to when discussing challenges), the fourth row of the Recovery Map captures your action steps in CT-R as well as targets for positive change. This is where you enter positive action that lets individuals have a daily sense of purpose through experiencing the meaning of their aspirations. Purpose is another critical aspect of recovery and wellness (Harding, 2019). Chapter 5 helps you develop skill with positive action.

### Strengthening the Adaptive Mode by Drawing Conclusions and Empowering Resilience

The fifth box in the CT-R arrow (see Figure 1.3) features strengthening the adaptive mode. CT-R is an experiential process, and each of the four boxes to the left require a process of drawing conclusions during the experiences. Succeeding interpersonally, making a difference with other people, getting a desired life—these are all opportunities to strengthen positive beliefs about self, others, and the future. Individuals are capable, lovable, can enjoy things, can connect, and are caring. Other people appreciate them, care, and want to know them. They can make a difference in the future.

The box appears at the right-hand side near the tip of the arrow in Figure 1.3 to illustrate the importance of drawing conclusions to progress with CT-R. This collaborative process helps the person get the most out of experiences that reveal their potential in action. You can

focus attention on these positive meanings and draw conclusions with straightforward, custom-tailored questions. The fourth row of the Recovery Map also captures these meanings. Individuals develop resilience and empowerment through this process. Chapters 3–5, and especially 6, show you how.

## Challenges, Resilience, and Empowerment

Everyone's life has stress in it. As you help the person begin to live the life they want, stressors and challenges will likely crop up. When life is more difficult, challenges can emerge, such as negative symptoms, hallucinations, delusions, aggression, and self-injury.

Resiliency is about discovering and developing a sense of empowerment with regard to these stressors. It involves the person knowing they can get beyond them. Stress may raise the desire to isolate, listen to voices, focus on delusions, increase aggressive urges—but one can learn how to refocus away from such desires and toward the activities that matter most. As specific challenges come up, CT-R emphasizes understanding them and promoting strategies for empowerment. The third row of the Recovery Map captures the challenges and the beliefs that underlie them.

Resilience enables a person to continue pursuing goals and aspirations despite challenges that arise. One of the greatest discoveries we can help an individual make is that when things don't work out, it's not a catastrophe; all hope is not lost. Developing resilient beliefs of this sort is another essential part of CT-R that propels and sustains individuals as they pursue the life they want to live. Chapters 7–11 show you how.



### BOX 1.1. CT-R Is Good Medicine

Epidemiologists have discovered that individuals who are given a diagnosis of schizophrenia and other serious mental health conditions live, on average, 20 fewer years than the average person, early death being most likely caused from a physical illness (e.g., digestive and endocrine diseases, infectious diseases, respiratory diseases, heart condition, metabolic imbalance) rather than directly from a mental health feature, such as suicide (Lee et al., 2018; Saha, Chant, & McGrath, 2007).

At the same time, a revolution in the field of public health over the past 30 years has identified social factors—disconnection, lack of purpose, lack of hope, disempowerment—linked to poorer physical health outcomes and lower life expectancy independent of the presence of a mental condition (Harding, 2019; Murthy, 2020).

This makes CT-R good medicine, as the focus is on social connections, meaningful aspirations, purpose-infused action, and sustaining empowerment. The cognitive model becomes a mediator of wellness—developing and living one's best self can lead to a richer and longer life.

Evidence that this formula for wellness works comes from a study of 50 high-achieving individuals who were given a diagnosis of schizophrenia. Common factors the group cited in their success were having valuable relationships, personally meaningful action every day, and a way to manage stress (Cohen et al., 2017).

## STRUCTURE OF A CT-R INTERACTION

Whether you are working with an individual in one-to-one therapy, in group therapy, on a milieu, or in the community, any interaction can be a CT-R interaction. The key components include (1) opening by tapping into the individual's adaptive mode, (2) establishing a collaborative target for your time together, (3) developing or reviewing an individual's aspirations and their meaning, (4) addressing challenges or taking steps in the context of aspirations, and (5) collaboratively developing an action plan that helps translate whatever you did together into the individual's daily life (see Figure 1.4).

Starting any interaction with access to the adaptive mode brings energy, focus, and connection. It communicates that you are invested in the individual as a whole person, not just in the challenges, and it provides enough momentum to progress through the rest of the steps.

Next, a meaningful bridge, similar to traditional cognitive therapy (Beck, 2020), gives you the opportunity to check in on any activities or aspiration steps the individual took since your last interaction. It also gives you the opportunity to reestablish the mission you and the individual are on together. In some circumstances, this will revolve around achieving aspirations and their meaning. In other circumstances, it will be about readiness to transition to a less restrictive level of care, while for others it could be about turning dreams into action. The mission should be developed together.

Aspirations provide the driving force for any CT-R interaction and should be regularly developed, enriched, and referenced. Aspirations are "why to try things out." Strategizing helps identify "what to try." Challenges are addressed when they impact progress toward the aspirations. Finally, an action plan puts aspirations into practice. It is what the person takes away from the interaction. Would it be worth it for the person to do more outside of time with you? What can they do the rest of the day or week to keep the momentum going?



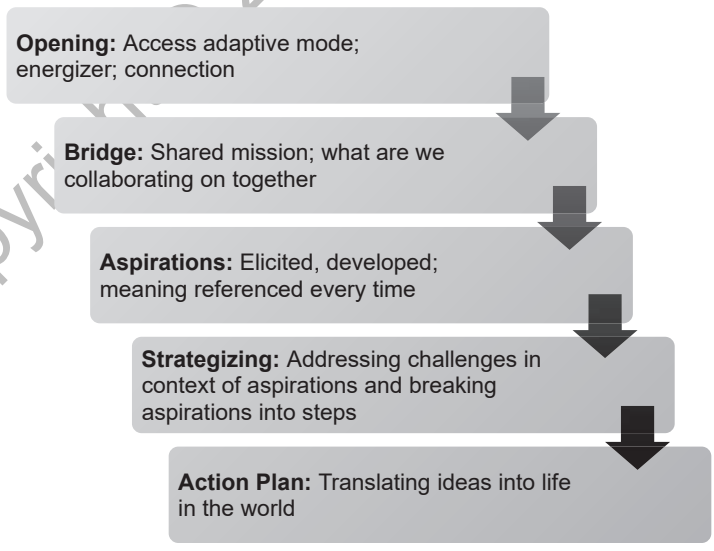


**FIGURE 1.4.** The structure of a CT-R interaction.

## HOW DO WE KNOW THAT CT-R WORKS?

CT-R is an evidence-based practice. Research studies support the cognitive model as a good guide for how people with serious mental health conditions thrive and how they get stuck (Beck, Himelstein, & Grant, 2019; Beck, Rector, Stolar, & Grant, 2009; Grant & Best, 2019). A randomized controlled trial supports the effectiveness of CT-R to promote living better lives of their choosing (Grant, Huh, Perivoliotis, Stolar, & Beck, 2012). Program evaluation outcomes show that CT-R makes an impact across levels of care where individuals find themselves, and across disciplines of care providers they might be working with (Grant, 2019a).

### Evidence Supporting Positive Beliefs in Helping People Do Better

The power of positive beliefs to promote recovery can be seen in a study where we simulated the therapeutic process of CT-R by collaborating with individuals to succeed at a task. Success was best predicted by the person's increase in positive beliefs about themselves and others, as well as an increase in their experience of positive emotion (Grant, Perivoliotis, Luther, Bredemeier, & Beck, 2018). In a related study, we found that people with serious mental health challenges who had higher levels of positive beliefs were participating more in the community 6 months later. They were also experiencing less disruption from negative symptoms, hallucinations, and delusions (Grant & Best, 2019).

### Evidence Supporting the Role of Negative Beliefs in People Getting Stuck

When we asked a person why they no longer did the things they used to enjoy (such as basketball or cooking), they said things like "Why try, I'm only going to fail." We labeled these kinds of statements "defeatist beliefs," because the person is protected from failure by being inactive.

We conducted a study (Grant & Beck, 2009a) showing that defeatist beliefs were related to negative symptoms and performance on tests of memory, attention, and problem solving—factors that predict living a less full life. Our original finding has now been reproduced many times, both in the United States and in other countries (Campellone, Sanchez, & Kring, 2016).

People who are given a diagnosis experience defeatist beliefs more in their daily life, and these beliefs are related to being less likely to leave their house, and less likely to physically move (Ruiz et al., 2019). If they feel rejected and not a part of any social group, they are much more likely to endorse defeatist beliefs (Reddy, Reavis, Polon, Morales, & Green, 2017). And, on the flip side, when defeatist beliefs become less strong, people given a diagnosis have more success at work, and also more success socially (Mervis et al., 2016).

Defeatist beliefs are a general factor impacting negative symptoms and impeding individuals' pursuit of the meaningful life they would otherwise want. The disruptive power of the beliefs emerges in adolescence (Clay et al., 2019; Perivoliotis, Morrison, Grant, French, & Beck, 2009), cutting the person off from being a part of something bigger with other people (Fuligni, 2019) and leading to isolation and disability.

Our interviews also uncovered asocial beliefs, preferences to be alone rather than with other people (Grant & Beck, 2010)—for example, "People sometimes think I am shy when I

**BOX 1.2. The Meaning of Difficulties with Attention, Memory, and Problem Solving**

Poor performance on tests of memory and attention have been taken to mean that there's something broken about the test-taker's brain (Andreasen, 1984). We don't think this is true. We published a review study that inspires hope for individuals given a diagnosis of schizophrenia and their families and care providers (Beck, Himelstein, Bredemeier, Silverstein, & Grant, 2018).

In the paper, we show that there are many factors that generally contribute to poor performance on tests and tasks independent of a mental health diagnosis: elevated stress, low mood, expectations of failure, low effort, and low access to motivation. These factors also contribute to poor performance for people given a diagnosis of schizophrenia. These factors can all be addressed with psychosocial treatments. The upshot is that individuals are not limited and can succeed; they hold the key to their own potential to contribute (Grant, Best, & Beck, 2019).

really just want to be left alone." These beliefs protect individuals from the pain of social rejection. In one study (Grant & Beck, 2010), we demonstrated that asocial beliefs predicted a future of not doing activities or spending much time with others. Another study looked at defeatist and asocial beliefs, finding both to be linked to less access to motivation and lower community participation (Thomas, Luther, Zullo, Beck, & Grant, 2017).

As we will see, the key to empowerment in CT-R is to start with participation, increase access to motivation, and then strengthen positive beliefs about capability and the value of other people.

## Randomized Trial

In our clinical trial, we recruited individuals with elevated negative symptoms and randomly assigned them to continue their standard treatment in the community or to receive weekly CT-R (Grant et al., 2012). Active treatment lasted up to 18 months. To get a feel for how people were doing at the start of the study, if each participant took snapshots of themselves and their surroundings each hour for an entire day, you would see cigarette smoke, the television, mealtimes, a case worker, a psychiatrist visit—not a lot of activity.

At the end of 18 months of treatment, the assessors—who were blind to condition—determined that individuals in standard treatment had not improved. By contrast, people in the CT-R condition showed improved functional outcomes. They had increased motivation, and their hallucinations, delusions, and communication disturbances were reduced. In real-world terms, the change experienced by the typical person in the CT-R condition was from spending all week smoking cigarettes and watching TV, to making a friend, volunteering, starting to go back to school, starting to date—well on the way to the life of their choosing.

After 6 months during which no treatment was delivered, the people in the CT-R condition still had greater functioning, greater motivation, and reduced hallucinations, delusions, and communication disturbances as compared to people in the standard condition (Grant, Bredemeier, & Beck, 2017). Importantly, improvement in positive beliefs over the 24 months of the

study best predicted improvement in community involvement and participation (Grant & Best, 2019). Positive beliefs are the royal road to recovery and living a desired life.

A source of hope is that people who received a diagnosis 20, 30, or 40 years before entering the study still showed improvement by 24 months. Recovery extends to all; everyone can start the life they want.

## Program Evaluation Outcomes

CT-R has been successfully implemented in large state and municipal systems of care in Pennsylvania, New York, Montana, Vermont, New Jersey, Massachusetts, and Georgia. This has involved diverse settings, such as long- and short-term hospitals, programmatic residences, and forensic settings, and community, specialty care, and integrated health teams. These implementations involved direct care staff, nurses, art therapists, recreational therapists, occupational therapists, social workers, peer specialists, psychologists, and psychiatrists. Successful CT-R has taken the form of individual therapy, group therapy, milieu, and team-based applications.

Outcomes show that CT-R improves care providers' ability to promote recovery and resiliency in individuals who had been stuck. In acute and long-term hospital settings, CT-R has produced a dramatic reduction in the use of instruments of control (Chang, Grant, Luther, & Beck, 2014)—restraints, seclusion, medications to calm—and eliminated mechanical restraints completely. Individuals came out of their rooms more often to participate. Fee-for-service teams report more quality contacts evidenced by an increase in units of service. Hospitalization rates have lessened, jail days have been reduced, and individuals have moved to less restricted levels of care. They report being less lonely, more hopeful, and starting to flourish. They find use for



WORDS OF WISDOM

### BOX 1.3. Recovery Is a Process of Flourishing

*Recovery* is not a destination; it is the evolution of a pathway of flourishing. It is successful participation and involvement in the community of one's choosing. In CT-R, recovery is the active fulfillment of one's highly valued aspirations. It involves a series of milestones as one's life space widens. Occasional setbacks provide the opportunity to build resilience and discover inner strength. Some individuals move rapidly along the recovery pathway, whereas others take longer. With CT-R and sufficient time, all individuals can achieve varying degrees of flourishing. Research shows us that *recovery extends to all.* Milestones include but are not limited to:

- Engagement and accessing the adaptive mode.
- Repeated activation of the adaptive mode.
- Preparation of the Recovery Map.
- Selection and enrichment of aspirations.
- Success achieving the meaning of aspirations.
- Resilience experiences and conclusions.
- Empowerment relative to personal challenges.

the skills of everyday living. In one large system, two-thirds of individuals improved on at least one of the four SAMHSA recovery dimensions within 6 months of supervised CT-R (Grant, 2019b).

The cognitive model guides a person-centered, individualized way of understanding how people thrive and how they get stuck. The theory is supported by a diverse set of research studies. The therapy has been validated in a randomized trial and shown to improve outcomes for diverse care providers in diverse settings. Recovery extends to all, and there are concrete and effective procedures for bringing it about. All individuals have an adaptive mode within them, and everyone who works with them can collaborate to promote flourishing. Subsequent chapters show you how to do it.

## SUMMARY

- CT-R is a procedure that reliably produces the right kind of interactions between you and individuals with lived experience to promote recovery, resiliency, and empowerment.
- A mode is a manner of acting or doing that involves beliefs and attitudes, emotion, motivation, and behavior. We use the term "adaptive mode" to describe what seems to drive adaptive behavior. We believe the adaptive mode is present, but inactive, when the individual is experiencing challenges. On the other hand, when individuals are drawn into a meaningful, pleasurable activity, the adaptive mode becomes activated.
- The core components of CT-R and the adaptive mode are accessing and energizing the adaptive mode, developing the adaptive mode, actualizing the adaptive mode, and strengthening the adaptive mode.
- The Recovery Map is a one-page, living document that can guide you in developing a CT-R understanding of an individual and in developing strategies and interventions for collaboratively promoting a meaningful life.
- There is a strong evidence base proving the efficacy of CT-R, including a randomized controlled trial, follow-up to that trial, and program evaluation outcomes.
- Positive beliefs are the royal road to sustained recovery and flourishing in the community of one's choosing.





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