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disorders, and one size does not—and will not—fit all. We can, however, leverage one guiding principle—the importance of meeting people where they are. The 4 articles in this Special Report provide valuable perspectives on some of the ways we can meet people where they are.

In his article on stage-specific treatment of psychotic disorders, Patrick D. McGorry, MD, PhD, highlights the differing needs of individuals across the various stages of illness. The philosophy is akin to treating patients with cancer; these patients are not uniformly treated with chemotherapy but rather are prescribed individually tailored treatment based on the specific stage of illness. In psychiatry, we need to consider psychotic disorders not as a single monolithic disorder, but rather a disorder that unfolds in stages. As such, we need to focus our efforts on preventing or delaying progression to subsequent stages, from which recovery may be more challenging. This stage-specific framework for understanding and treating psychotic disorders incorporates important public health principles, including aims for primary and secondary prevention.

In the article on prescribing hope for recovery by Patricia E. Deegan, PhD, we hear the voice of someone who is not only an academic expert and pioneer in the topic of recovery, but also someone with lived experience. Dr Deegan is uniquely positioned to help clinicians understand how to effectively engage and empower individuals with psychosis to find hope and meaning by incorporating goals and preferences that matter to them. Everyone has dreams, hopes, values, preferences, and interests. Dr Deegan reminds us that symptom reduction might be helpful, but only in the service of personally meaningful goals.

The article on phenomenology and disordered selfhood by Josef Parnas, MD, and Maja Zandersen, MSc, PhD, highlights the importance of going beyond symptom checklists to understand the subjective experience of individuals with schizophrenia. They remind us that we must listen to what our patients tell us to appreciate the phenomenological essence and experience of schizophrenia spectrum disorders. This kind of careful listening and exploration, which involves joint collaboration as well as putting oneself in the mindset of the patient, can lead not only to improved understanding and prediction of schizophrenia, but may also be therapeutic in itself.

Last but not least, Antonio Waldo Zuardi MD, PhD, and José Alexandre Crippa, MD, inform us about the therapeutic potential of cannabidiol in individuals with psychotic disorders. Many patients look to and experiment with complementary and alternative products, whether for recreational use or perceived health benefits. Given the abundant evidence of the detrimental effects of cannabis on psychosis and psychosis risk, clinicians may be wary of any ingredients in cannabis. The authors differentiate the potentially anxiolytic and antipsychotic effects of cannabidiol from the psychotomimetic effects of THC. While cannabidiol is not approved for clinical use, Dr Zuardi and Dr Crippa summarize the research, which may be controversial and confusing for clinicians.

> "These data serve as a call to action for psychiatry to shift from the traditionally reactive to a more proactive approach to patient care—one that does more to meet patients where they are."

I am thrilled that the knowledge and perspectives of these experts could be brought together for clinicians. The hope is that the insights and recommendations in this Special Report can help psychiatry to go beyond what the biomedical model has traditionally prescribed for schizophrenia and proactively meet people where they are. We cannot afford not to, as underscored by $155.7 billion in economic costs associated with schizophrenia. Above all, meeting people where they are is a matter of public health—the health and quality of people's lives depend on it.

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# Prescribing Hope for Recovery

» Patricia E. Deegan, PhD

When I was a teenager, I received a diagnosis of schizophrenia. My psychiatrist told me schizophrenia was a disease from which no one can get well. He told me to take high-dose antipsychotics for the rest of my life. At discharge, he told me to take my meds religiously and to avoid stress: no college, no romance, and no work.

After discharge I returned to my parents' house and for many months sat in a chair in the living room, staring blankly into a cloud of cigarette smoke. My despair was palpable, but it was misunderstood as negative signs of schizophrenia. As the months passed by in a meaningless succession of minutes and hours punctuated only by the next med check visit and the next, it seemed to me the treatment was worse than the disorder. And so I stopped taking the antipsychotic.

Abruptly rejecting antipsychotic medicine was a resilient act of self-affirmation. I am a person, not an illness. I am a person, not a schizophrenic. I do not lack insight into the fact that I am unwell. My psychiatrist lacks insight into ME. I want to live my life, not my diagnosis.

Like so many who abruptly discontinue antipsychotics, I was rehospitalized within a few months. Looking back, I know progress in my recovery did not begin until my psychiatrist and I learned a new way of working together. Distilled from my personal experience, as well as from 3 decades of work articulating the journey of recovery and building pragmatic tools to support it, I offer the following thoughts.

## Avoid prescriptions for noncompliance

A prescription for noncompliance arises when a message of hopeless chronicity is paired with a psychiatric medication. You have schizophrenia. You will be sick for the rest of your life. You must use medication for the rest of your life. This common message is a prognosis of doom. Many people will reject this hopeless forecast by rejecting the medicine. In rejecting the medication, they reject the prognosis of doom as well.

A prescription is more than what is written on a pad of paper. It is an interpersonal process. It includes the one who prescribes and the one who will try out and explore the prescription and its fit with the self. From day one, prescribe hope for recovery. Let people know that with effort and support it is possible to live a full and meaningful life beyond the diagnosis. Never mistake the person for the illness. Never tell people they will have to use medications for the rest of their life. Instead, take a pragmatic approach. Focus on how and if medication is helpful in supporting goal achievement in the present and the near future. Remember that using medication is not the goal. Medication is a means to get and to keep the life we want for ourselves.

## Engage your recovery partner

Those of us who have a diagnosis of a psychotic disorder are, above all, human beings. We are more than the disorder. We are not passive objects to be fixed or cured. Even when experiencing psychosis, we are actively problem solving and trying to do something about it (eg, listening to music to distract ourselves from distressing voices). This active subject, the person, is our recovery partner. This is the person with whom we must develop the therapeutic alliance. Engagement and activation strategies should be used even during initial encounters, such as admissions or emergency department visits.

## Personal Medicine

### What I do and how it helps me

| | |
|---|---|
| Reading my Quran before bed... | ...helps to quiet me down so I can sleep. |
| Looking at pictures of my friend on my phone... | ...reminds me I am loved and don't have to self-injure. |
| Walking in the park each morning... | ...gives me hope that all things renew, even me. |
| Saying what I am thankful for each day... | ...helps me avoid my negative "stinkin thinkin." |
| Playing the saxophone... | ...helps me measure my breathing and calm anxiety. |



A simple question can be used to discover our recovery partner: "What do you already know how to do that helps?" A person may not have all the answers, but everyone tries something in an effort to manage psychosis. For instance, during my early psychosis, I told myself I had taken LSD (even though I had not). This was not a delusion. It was a strategy that helped me manage acute episodes of psychosis because an LSD trip is time limited. Knowing the experience would end helped me endure it.

Another powerful engagement and activation strategy is introducing *Personal Medicine* as part of recovery. Do this very early on in treatment. Personal Medicine[1] is what we do to get well and stay well. It is self-initiated, nonpharmaceutical self-care activities that serve to decrease symptoms and improve thinking, mood behavior, and well-being, while also helping to avoid unwanted outcomes such as hospitalization. Examples include: reading Scripture at night helps me feel safe; working on car engines helps me ignore my voices; singing in my choir helps me forget my troubles; walking my dog gives me a reason to get up in the morning. All these strategies are Personal Medicine. "Smoking cigarettes helps me relax" is not, however. Tobacco is something we take, it is not what we do. Also, notice that Personal Medicine is different from generic coping strategies. Personal Medicine is personal.

Encouraging its use in psychiatric care underscores the importance of actively engaging in self-care during recovery. It elevates self-care to the status of medicine, which can be just as important as pharmaceutical medicine for recovery. Passively waiting for psychiatric medicine to make us well is usually futile. Personal Medicine does not compete with psychiatric medicine. The key is finding a synergy between the two. For many, the pathway into recovery involves finding the right balance between the things we do to be well and the pills we may take. Over time, Personal Medicine can grow into an entire toolkit of self-care strategies.[2] Psychiatric medicine then becomes one tool among the many we use to support our recovery.

Use a simple, 2-part template to help people discover their Personal Medicine: "What do you do that helps you feel better and how does it help?" In some settings, certified peer supporters, therapists, and rehabilitation specialists help people discover their Personal Medicine prior to med visits. At each clinic visit ask, "Have you been using your Personal Medicine?"

Be sure to adjust psychopharmacology if it is interfering with Personal Medicine and the things that give life its meaning, purpose, and joy. If medications are causing a woman's hands to tremble so much that she cannot do her job stitching flags (her Personal Medicine), then who would be surprised if she stopped taking those drugs? In a recovery-oriented approach, pharmacology must support—not disable—the things that matter, such as work. Finding the right balance between psychiatric medicine and personal medicine is the pathway to recovery for many patents.

### From "What's the matter?" to "What matters to you?"

It can be challenging to take an antipsychotic each day; over time, people need a sense of how the medication helps them. There is no sense in taking pills that do not seem to work. Clinical phrases are often obtuse and unhelpful (eg, "The meds will help organize your thinking"; "The meds will make you less paranoid"; "The meds will return you to baseline"). These abstractions may not speak to what matters to the person. Instead, I recommend 2 approaches.

The first approach is to directly ask, "How will we know this medicine is working for you?" Examples might be: I'll know the meds are working for me when I: "can concentrate on my biology homework"; "am more patient with my toddler"; "can follow a football game"; or "win at online gaming again."

When first asked, people may say, "I don't know. You're the doctor. You tell me how the meds are supposed to help." Redirect the person by prompting, "I am happy to share my ideas, but I need to understand what matters to you. If this medicine works for you, what will change for the better?" The answers will provide a wealth of information. For instance, it is not unusual to hear that a person has unrealistic expectations for medications: "I'll know the medicine is working for me if my marriage improves." Of course, medication cannot improve a marriage. Having such an expectation can be a set-up for rejecting medications that are not working. Helping people shape expectations is important. For instance, "The meds can't improve your marriage per se, but if they work, they can help you focus more on your partner and less on your fears. How does that sound?"

Even during acute episodes of psychosis, demonstrating concern and understanding for what matters to the person can be extremely reassuring and help build an alliance. We can use our intuition to infer what matters. For instance, a person who has been hearing distressing voices may be exhausted and would welcome some rest: "This medicine will help you rest and feel safe. How does that sound to you?"

A second approach to helping people establish their goals for medication treatment is the use of *Power Statements*.[3] Power Statements help people express how they want medicine to help. A 2-part stem can be used to help people create their power statement: "I want medicine to help ____, so that I can ____." Examples include: "I want medicine to help make the voices go away so that I can focus on my job at the pizza shop"; "I want medicine to help me relax, so I can get together with my boyfriend again"; and "I want medicine to help me concentrate again so I can graduate from high school."

Power Statements act like a compass, keeping treatment focused on outcomes that matter to the person. Typically, we assess treatment outcomes by more generic measures such as the Positive and Negative Syndrome Scale (PANSS) score, lower recidivism, and longer community tenure. But at the level of the individual, those metrics can disguise treatment failure. For instance, people may have fewer hospitalizations and be stabilized and maintained on high-dose antipsychotics in the community, but they may also be living an isolated life in smoke-filled, single room-occupancy lodgings, staring at a television, and sleeping their lives away. This is not recovery and, at the level of the individual, it is a treatment failure.

Power Statements provide psychiatric care providers with an understanding of what successful treatment outcomes are, as defined by the individual. They are a study of N=1, focusing psychiatric care providers on symptom reduction in the service of personally meaningful goals. Complete symptom suppression is not a prerequisite for recovery. Many of us learn how to manage symptoms while living the life we want for ourselves.

Power Statements are easy to scale and can be created as a pen-and-paper task. In some settings, certified peer supporters, therapists, and rehabilitation staff help people prepare their statements before the med check visit.[4] Psychiatric care providers begin the visit by reviewing the statement and asking, "Is this still your goal for our work together?" or "Are we making progress toward your goal?"

The journey to use medication optimally to support recovery involves many challenges.[5] It is more than learning to swallow pills on schedule. Psychiatric care providers can support us on that journey through recovery-oriented strategies that convey hope and engage us as partners in the creation of a life beyond the diagnosis.

**Dr Deegan** *is Principal and owns 50% of the company Pat Deegan, PhD & Associates, LLC in Byfield, Massachusetts. The company created the CommonGround Program, which includes software, training, and an online Recovery Library. Personal Medicine and Power Statements, mentioned in the article, are two elements of the CommonGround Program.*

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