Title: Social Recovery Therapy: A treatment manual.

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Abstract

Social Recovery Therapy is an individual psychosocial therapy developed for people with psychosis. The therapy aims to improve social recovery through increasing the amount of time individuals spend in meaningful structured activity. Social Recovery Therapy draws on our model of social disability arising as functional patterns of withdrawal in response to early socio-emotional difficulties and compounded by low hopefulness, self-agency and motivation. The core components of Social Recovery Therapy include using an assertive outreach approach to promote a positive therapeutic relationship, with the focus of the intervention on using active behavioural work conducted outside the clinical room and promoting hope, values, meaning, and positive schema. The therapy draws on traditional Cognitive Behavioural Therapy techniques but differs with respect to the increased use of behavioural and multi-systemic work, the focus on the development of hopefulness and positive self, and the inclusion of elements of case management and supported employment. Our treatment trials provide evidence for the therapy leading to clinically meaningful increases in structured activity for individuals experiencing first episode and longer-term psychosis. In this paper we present the core intervention components with examples in order to facilitate evaluation and implementation of the approach.

Keywords: psychosis, Cognitive Behaviour Therapy, social recovery, social functioning.

Disclosure statement: The authors report no conflict of interest.

Data availability statement: There are no datasets associated with this paper.

Word counts: Abstract 193, Manuscript 6500

Introduction

Social disability is a central issue for people with psychosis. Less than half of people with psychosis will achieve social recovery, with only 20% of people with schizophrenia obtaining competitive employment (Fusar-Poli, Byrne, Badger, Valmaggia, & McGuire, 2013; Harvey et al., 2009; Marwaha et al., 2007; Tandon, Nasrallah, & Keshavan, 2009). The onset of psychosis is often preceded by observable premorbid social decline, which can become entrenched over time (Hafner, Löffler, Maurer, & Hambrecht, 1999; Häfner, Maurer, Trendler, an der Heiden, & Schmidt, 2005). Social disability in populations defined as being at risk of psychosis increases the likelihood of transition to first episode, other adverse mental health outcomes (e.g. anxiety, depression), and poorer long-term functioning (Fowler et al., 2010). The economic cost of social disability in psychosis is high (Mangalore & Knapp, 2007). Thus. there is a major need to offer evidence-based interventions targeting social disability across the psychosis continuum.

Existing interventions for social functioning in psychosis, such as Individual Placement and Support (IPS), can effectively increase employment for people who are work-seeking; yet intervention effects are unclear for people with the greatest social disability and symptoms (van Rijn, Carlier, Schuring, & Burdorf, 2016). Psychological interventions, such as Cognitive Behavioural Therapy (CBT) and Cognitive Remediation Therapy (CRT), also appear to have only small and perhaps temporary effects on functioning (Devoe, Farris, Townes, & Addington, 2018; Laws, Darlington, Kondel, McKenna, & Jauhar, 2018). An intervention is thus indicated which combines the facilitation of engagement in constructive economic activities such as employment, alongside the broader identification and facilitation of meaningful structured and social activities, and with simultaneous support for managing residual symptom, cognitive, and systemic barriers to social recovery.

Our group have developed an individual psychosocial therapy to facilitate social recovery in psychosis. Social Recovery Therapy (SRT) is based on cognitive-behavioural models of social disability and social recovery (Fowler et al., 2012). Our model of social disability posits that social and occupational withdrawal develop as functional behavioural patterns of avoidance in response to early socio-emotional difficulties which are maintained by a lack of hopefulness, self-agency and motivation, and multi-systemic barriers to social recovery (Fowler et al., 2012). Social recovery represents increased engagement in structured and social activities which are personally meaningful and aligned with individual goals and values—structured activities can include employment, education, caring, leisure, sports and housework. SRT uses *in-vivo* assertive outreach working alongside traditional CBT techniques in order to promote personally meaningful structured activity, whilst addressing multi-systemic barriers. SRT emphasises building a positive therapeutic alliance and community working in order to engage people who struggle to access, participate in, or benefit from traditional services. Data from the ISREP (Fowler et al., 2009; Fowler, Hodgekins, & French,

2017) and SUPEREDEN3 trials (Fowler et al., 2018) suggest SRT can effect clinically meaningful increases in structured activity for people with social disability and psychosis. SRT also appears to be cost-effective compared to standard community mental health care for psychosis (Barton et al., 2009). The effectiveness of SRT for young people with complex emerging mental health problems, including at risk mental states for psychosis, is being tested in the PRODIGY trial (Fowler et al., 2017). Qualitative work suggests that SRT is highly acceptable, with clients valuing the emphasis on social recovery-focused goals (Gee et al., 2016), the tailored and individualised nature of the intervention, and the extent to which SRT is conducted outside of the traditional clinic setting in the individual's local area (Gee et al., in preparation).

This paper will outline the SRT treatment protocol as employed in the ISREP, SUPEREDEN3, and PRODIGY trials. Our aim is to facilitate dissemination, evaluation and implementation of SRT into clinical practice. We intend for clinicians to use the contents flexibly, with freedom to adapt as relevant to their psychological formulations of individuals' difficulties. More information and resources are available on our website (www.socialrecoverytherapy.co.uk).

General considerations in SRT

The core principles of SRT are assertive engagement, collaboration, and a behavioural and multi-systemic focus. This means emphasis on developing a positive therapeutic relationship and flexibly adapting the therapy to individuals' interests, goals, difficulties, preferences and needs. SRT therapists may need to spend multiple sessions on engagement whilst assessing and formulating the individual's difficulties, allowing for missed appointments, periods of disengagement, and wider case management-type work. The latter may help to address multi-systemic barriers to activity, whilst also building trust between the individual and therapist. SRT therapists may find that they need to be more directive than in other therapies, especially in the initial phases. In the context of individuals' fear, avoidance, anticipatory anxiety and/or ambivalence, an assertive therapist stance is essential. Therapists should engage in clear and transparent discussion from outset regarding the nature of SRT, how therapeutic tasks are linked to the formulation, and how therapists may—with permission—provide assertive encouragement to engage in feared situations throughout the intervention. These techniques ensure that the work can be directive whilst still collaborative.

There are three phases. Stage 1 involves assessment and developing a social recovery formulation whilst promoting hope for social recovery. Stage 2 involves identifying and working towards medium to long-term goals through the consolidation of hope and positive identity and the re/discovery of specific pathways toward activities guided by the individual's values. Stage 3 involves the active promotion of structured, meaningful activities using active behavioural work and supporting engagement with other organisations and institutions. The timing of the phases is

individually tailored, iterative and non-linear—with the introduction and use of cognitive and behavioural techniques being idiosyncratic and formulation-driven. Therapists should remain receptive, adaptable and person-centred throughout SRT, identifying and working collaboratively towards activity-related goals that are meaningful to the individual, whilst using their knowledge of cognitive-behavioural processes to target social disability mechanisms and maintenance factors. Therapists should track progress collaboratively with the individual, through review of the formulation and progress towards social recovery goals, and within their own supervision to guard against therapist drift.

Assessment

Assessment begins with the identification of social recovery goals, the development of a problem and goal list, and an in-depth assessment of a person's interests and values (a sense of where they want to go and what they want to be in life). Goals should be related to personally meaningful activity-based changes , such as finding employment or increasing social contacts. Values work is informed by Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and Personal Construct theory (Kelly, 1955), and can be completed informally or as part of a structured SRT values mapping exercise. Values assessment can help to identify long-term ambitions and priorities, as well as fears for the future; motivating the individual to take immediate steps towards long-term behaviour change. Interests can be identified using an SRT interest checklist and also through serendipitous engagement in novel activities during behavioural work. The SRT therapist should reflect on and revisit the individual's goals, values and interests throughout therapy.

An essential part of the assessment process is gaining a shared understanding of barriers to social recovery. Whilst discussing symptoms such as anxiety, depression, and psychotic experiences are a key part of assessment, these are discussed in terms of impact on social recovery. For example, it may be necessary to target suspicious thoughts using cognitive- behavioural techniques if it allows the individual to access desired places or activities. Assessment of the wider environment and system can help to identify practical barriers, such as poor access to finance or transport, or lack of awareness of local resources.

Assessment information can be gained from the individual, the system around them, and real-world observation. The latter is particularly helpful when the individual struggles to access or provide information in more formal clinical settings. Leaving the clinic room provides a more complete and real-time assessment of cognitions, emotions and behaviours as they naturally occur. It can also help support engagement and the development of a positive therapeutic relationship; emphasising that the SRT therapist 'walks alongside' the individual. There may be key learning points in SRT—potentially

following key behavioural interventions—at which point it is useful to review what new information or skills the individual has developed, reassess the barriers to social recovery and re-formulate goals for the next phase of therapy. Use of a timeline can also be helpful during the assessment phase, especially for understanding the timing and impact of the first and subsequent psychotic episodes. For example, someone who experienced an episode of psychosis whilst in the workplace or in a social situation may experience shame and anxiety in relation to returning to those environments.

Social recovery formulation

Formulation begins at outset and continues throughout SRT. The focus is on understanding the barriers preventing the individual from undertaking activity and achieving their desired goals and values. Key aspects of the formulation will now be considered in more detail.

Longitudinal formulation of social disability

Social difficulties may be quite longstanding and date back to early adolescence or even childhood. Understanding the individual's experience of school and early relationships is important as there may have been a key event which triggered the onset of the difficulties. Memories or images from these events may be activated by certain situations which the individual later avoids. Early social withdrawal may have undermined individuals' development of the necessary social skills to engage with their peers and transition into the workplace or higher education environments. Importantly, the individual may prefer to initially discuss current maintenance cycles and thus it may be best to return to historical issues later during the course of therapy.

Social disability maintenance cycles

It is likely that a number of maintenance cycles will need consideration in order to understand an individual's social disability. Avoidance can serve many functions; perhaps arising from self-regulation of unusual experiences or 'information-overload', manifesting as a safety behaviour in anxiety-provoking situations, or functioning as a protective strategy to manage fears of failure. Understanding what the individual is attempting to avoid is key. Avoidance clearly limits opportunities for testing out fears and negative self-beliefs—whilst providing temporary and short-term relief from associated anxiety—thus serving to maintain difficulties in the long-term. Other maintenance factors can arise from feelings of hopelessness, and negative beliefs about the self, world and others. Formulating social difficulties can identify a need for social skills training. Additionally, attitudes towards symptoms such as anxiety or psychosis should be carefully considered, particularly when individuals have adopted an attitude of 'waiting until I feel better' before engaging in activity.

Maintenance cycles may be usefully informed by published cognitive models, for example of depression (Beck, Rush, Shaw, & Emery, 1979) and social anxiety (Clark & Wells, 1995).

Multi-systemic factors

Multi-systemic factors often play an important role in maintaining social disability and should be considered within the longitudinal formulation and maintenance cycles. This includes reflection on the role of relatives, friends, educators, employers and wider society. Families or others in the system may unintentionally maintain individuals' problems by trying to protect them from further difficulties yet inadvertently dissuading or preventing them from engaging in new activities. This may maintain a sense of vulnerability and fear of failure. Similarly, educational institutions may promote avoidance to try and reduce an individual's distress—for example, by allowing individuals to leave a classroom or sending them home. Mental health stigma may also form a barrier to school or work engagement. Individuals also often face practical barriers. For example, if an individual's difficulties impacted on school attendance, this may have prevented their attainment of qualifications and skills needed to engage with further education or work. Similarly, there may be financial barriers which complicate engagement in social or community activities.

Social recovery formulation revisited

Following initial consideration of the social recovery formulation, behavioural work can be used to test out underlying beliefs identified in the assessment and formulation phase and to try different 'ways of being' (e.g. dropping safety behaviours). It is not necessary—or perhaps not possible—to have a full longitudinal formulation before behavioural or cognitive work can begin. Indeed, findings from behavioural assessments and experiments should be incorporated into the formulation to further refine the shared understanding of the individual's difficulties. Initial progress may be followed by a re-emergence of symptoms or fears about the long-term future and, understandably, individuals may revert to using safety-seeking strategies or avoidance in order to cope. Returning to the social recovery formulation to understand this process is key to maintaining progress.

Intervention

Behavioural work

Behavioural work provides the foundation for change within SRT and we strongly encourage starting this work early in the therapy. Behavioural activation and behavioural experiments are conducted in line with the individual's goals and values, to ensure that new or returned-to activities are personally meaningful; thus increasing the likelihood of maintaining structured activity gains

Behavioural activation (BA)

BA is especially important when depression is a barrier to social recovery. Emphasis is placed on the meaning of activity, including achievement, intimacy, and enjoyment. The therapist and individual work collaboratively to identify activities that seem both meaningful and potentially possible, and then start to incorporate these into daily life. The therapist will 'walk alongside' individuals to aid motivation and engagement in identified activities. These can be extremely varied from washing up at home, attending a club, or experiencing a new activity together.

Behavioural experiments (BE)

BEs help to challenge thoughts and beliefs and support learning and reflection on alternative ways of acting in and interpreting situations. SRT involves leaving the clinic or home environment as early in treatment as possible. If necessary, the therapist should model the experiment first and then use motivational interviewing and cognitive work to help encourage the individual to try to complete it themselves. BEs need to be carefully planned and flexibly enacted in close collaboration with the individual, with the proviso that therapists may need to be more directive in the early phase. Great care is taken to debrief and reflect following all BEs; reflecting on whether predictions occurred, whether safety behaviours were helpful or maintained the problem, and using outcomes for re-formulating the presenting difficulties and identifying future goals and therapeutic tasks. Behavioural work can be anxiety-provoking and may result in the enactment of safety-seeking and avoidant behaviours, —including cancelling sessions. It is, therefore, important for SRT therapists to anticipate this and discuss openly and honestly with individuals in advance. Key discussions points include validating the individuals' experience of anxiety and reflecting on how the behavioural work aligns with the goals, values and the SRT formulation. Emotion regulation, mindfulness and relaxation strategies, may also usefully support ongoing engagement in BEs.

BEs in SRT are sophisticated and multi-layered. In addition to providing the opportunity to test, for example, the impact of dropping safety behaviours or addressing beliefs relating to voices or paranoia, SRT BEs promote social recovery more broadly. This can include supporting a positive therapeutic relationship, facilitating leaving the clinic room or home, engaging in new and enjoyable experiences, identifying potential goals and interests, offering opportunities for the therapist to provide *in-vivo* social skills training through modelling, using the individual's engagement in BEs to promote hopefulness and positive self-beliefs, and facilitating observation by or BE involvement from others in the system to help generate multi-systemic support for SRT and social recovery. Furthermore, SRT therapists will flexibly and creatively capitalise on gains in the moment—for example, following a successful BE with a collaboratively designed extended or additional BE to be conducted in the moment. Table 1 provides example SRT BEs.

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Cognitive work

Cognitive work is always informed by the social recovery formulation and augments the other intervention components. The primary goal of cognitive work is to modify unhelpful cognitions which serve to maintain inactivity and generate more realistic or helpful cognitions which can facilitate meaningful structured activity. A variety of commonly cited CBT cognitive strategies can be used; thought records, positive data logs, positive self-statements and appraising advantages and disadvantages of alternative cognitions. SRT differs, however, from traditional CBT cognitive strategies in foregrounding the promotion of hopefulness and positive sense of self (Hodgekins et al., in press). Due to the often long-term social difficulties, generating positive self-beliefs and hope for social recovery can be something requiring gradual nurturing throughout SRT; scaffolded by a positive therapeutic alliance and updated cognitions arising from exposure to positive experiences. Initially, the therapist often 'holds' hope for the individual and acts as a 'cheerleader' in the individual's quest to engage in meaningful activities by modelling positive self-talk, and providing support, encouragement and recognition of successes. Following cumulative therapeutic gains, a shift is often noticed where hope is progressively owned by individuals themselves.

The outcome of behavioural work is purposefully used to challenge previously held negative cognitions and generate alternative cognitions which can be further tested—with an ongoing promotion of hope and positive self-beliefs. Evidence-gathering can support re-appraisal of previously held beliefs about themselves, the world and other people (e.g. I am not capable; The world is dangerous; Other people are untrustworthy), For example, asking individuals to re-rate beliefs and monitor change throughout SRT can lead to modified beliefs, which, in turn, are highlighted during sessions (e.g. using positive self-statements). This can help promote greater hope and positive self-beliefs, and motivate individuals to further engage in activities that are consistent with new belief systems (e.g. I am capable; The world is less dangerous; Others are okay).

Multi-systemic work

There may be complex multi-systemic barriers to social recovery which require consideration. Members of the individual's system, including mental health or other professionals, may discourage the person from engaging in new or previous activities due to concerns about stress and triggering relapse. Addressing attitudes of members of the social network and professionals may thus be important in developing a social recovery-focused system in which SRT gains are maintained. Sessions with families may be facilitated in which the SRT formulation may be shared to help families better understand the problems, generate support for the SRT intervention, potentially

participate in BA and BE, and reduce behaviours such as over-protective parenting or language and attitudes that undermine social recovery.

Multi-systemic work additionally includes 'plugging-in' individuals to institutions and organisations relevant employment, education, training, and leisure opportunities—and potentially advocating on behalf of the individual and family to support access to mental health or other services. In many cases, this might involve incorporating the role of what would typically be expected in more traditional care co-ordination or case management. Developing good links and relationships with local vocational, education and voluntary agencies is recommended. Opportunities are explored collaboratively with the individual and enrolment is informed by their values, goals and readiness to change. Introducing individuals to other organisations also creates excellent opportunities for BA and BE. Furthermore, the SRT therapist will work with these other institutions and organisations in order to facilitate a social recovery-focused system around the individual, i.e. through working to address factors in the wider system such as lack of funding and inadequate housing, advocating with employers and educational providers regarding providing reasonable adjustments to support re-entry, and discussing risk and care plans with mental health teams to ensure that such plans promote engagement in structured activity.

Implementation

Regular and effective supervision is essential as often the factors causing social disability are complex and bring challenges to the therapeutic process. Reviewing cases in supervision can help to formulate the social disability and identity necessarily innovative interventions. It is helpful if supervisors have knowledge of local resources and services to aid in community and multi-systemic working. The restorative function of supervision is very important within SRT as socially isolated individuals often feel hopeless and despondent, which can vicariously affect therapists' own hopefulness (Moorey, 2014). This could impact also on intervention effectiveness as professionals' optimism regarding patients' capacity for social recovery is linked to therapeutic relationship development and social outcomes (Berry & Greenwood, 2015, 2016; O'Connell & Stein, 2011). Access to both formal and informal supervision are essential in supporting therapists, including the provision of rapid *ad hoc* debriefing opportunities within a supportive team environment

As much of SRT takes place in community settings, therapists may encounter novel practical and logistical challenges which necessitate collaborative problem-solving to accommodate ongoing behavioural work. It is often useful for the therapist to drive individuals to new locations or accompany them on public transport. Even in the absence of face-to-face sessions, therapists should

attempt to maintain regular contact via phone, text, email and letter in order to support continued engagement. Regular discussion with other agencies can also help to re-engage individuals after missed sessions.

It should be emphasised that although evidence supports the effectiveness of SRT in psychosis (Fowler et al., 2017, 2018, 2009), and young people with emerging mental health problems have expressed that they found the approach useful (Gee et al., 2016; Notley et al., 2015), SRT can be challenging as it involves changing potentially long-term cognitive-behavioural patterns of avoidance. Future investigations should further explore when and for whom SRT is most effective. In the meantime, therapists should attempt to make SRT acceptable, useful and individually tailored to individuals, introducing elements of humour and fun wherever possible ―e.g. using characters from beloved comics or films to personify cognitions and behaviours.

Conclusions

SRT is a specialised psychosocial therapy for increasing social recovery with an emerging evidence base for individuals with complex mental health problems and social disability. It utilises assertive outreach, multi-systemic principles, and cognitive-behavioural techniques to formulate and address barriers to social recovery―ultimately promoting engagement in meaningful, structured activity. SRT is distinct from CBT and other psychological interventions through its core philosophy of focusing assessment, formulation and intervention on social recovery―with an emphasis on symptoms only insofar as they present social recovery barriers. Furthermore, SRT's core task is active behavioural work guided by the individual's values and goals, including sophisticated, multi-layered behavioural experiments conducted with the SRT therapist in the community. Finally, SRT involves the therapist working outside of the traditional bounds of psychological therapies in order to 'walk alongside' individuals as they enter into new structured activities, whilst additionally using multi-systemic techniques to support families and activity providers in providing a facilitative environment for maintaining social recovery.

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Table 1. Examples of SRT behavioural experiments.

	#	Experiment	Belief tested	Outcome	Learning
0	Layer 1—Simple behavioural experiment (BE)	Simple BE designed in previous session	Simple belief tested, determined in previous session	Outcome of simple BE	Learning in relation to simple belief tested
	Layer 2—Additional promotion of social recovery	-	Additional or core belief/s, problems, values, goals etc. not explicitly discussed prior to simple BE but identified within social recovery formulation	Outcome of BE in relation to additional promotion of social recovery	Learning in relation to additional promotion of social recovery
	Layer 3—Capitalising in the moment	Additional miniature in-the-moment BE or other behavioural work added to or conducted shortly after the initial experiment	Consolidation of test of simple original belief and/or test of additional or core belief/s identified within social recovery formulation	Outcomes of additional behavioural work and/or BE	Learning in relation to simple, additional and/or core beliefs
1	Layer 1—Simple BE	To walk around the centre of town	If I go outside, people will negatively judge me	People didn't pay me much attention.	People aren't really focusing on me
	Layer 2—Additional promotion of social recovery	-	It's safer and more enjoyable to stay at home	Enjoyed being in the sun and saw an interesting new computer games shop	I can enjoy being outside of my house; I can be outside without anything bad happening

	Layer 3—Capitalising in the moment	To go into the computer games shop and ask whether they purchase old games	If I talk to other people, I will get so nervous that they won't be able to understand what I'm saying	Had a fun conversation about old computer games with the shop owner and arranged to bring in some old games the following week	I am more capable of speaking with other people than I thought; Other people share my interests
2	Layer 1—Simple BE	To play badminton with SRT therapist	I won't enjoy it at all	Got into it and felt more motivated afterwards	I need to do things to improve my motivation; there are some things that I do enjoy
	Layer 2—Additional promotion of social recovery	-	I am not good at anything	Won badminton game against SRT therapist	Maybe if I stop worrying about failure, I can achieve more than I thought I could
	Layer 3—Capitalising in the moment	SRT therapist showed me a flyer at the gym advertising for volunteer tennis coaches	I can't have a job because I am not good at anything; there is no job I would enjoy doing	SRT therapist and I telephoned the number on the flyer together, and the lady who answered said that I should meet with her so she can help me find a volunteering opportunity	Maybe I could find a job I enjoy and could be good at; I am more capable than I thought I was
3	Layer 1—Simple BE	To go to a supermarket	I won't be able to stay in the supermarket because I will have a panic attack	Felt really anxious for the first ten minutes but didn't have a panic attack	I can go to supermarkets without having a panic attack; feeling really anxious doesn't necessarily mean I will have a panic attack

	Layer 2—Additional promotion of social recovery	-	I am boring	Looked at the film magazines with the SRT therapist and talked about films we both like	I have interests that are shared with other people and can talk about them
	Layer 3—Capitalising in the moment	SRT therapist models dropping shopping and money all over the floor	People will be horrible to me if I am too slow or makes mistakes	People helped the SRT therapist pick up all her belongings	People can be kind and helpful when someone is slow or makes mistakes
4	Layer 1—Simple BE	To drive the SRT therapist around whilst we look at other drivers	If I look at other drivers, they will swear and act aggressively towards me	No other drivers swore at us or acted aggressively	Other people are not always aggressive
	Layer 2—Additional promotion of social recovery	-	I can be trusted to drive the SRT therapist back in time for her next appointment	I drove the SRT therapist safely back to my house in time to leave for her next appointment	I am trustworthy and responsible
	Layer 3—Capitalising in the moment	To carry on driving to a park in the next town	I can't drive somewhere I haven't been before because I will get lost	We did get a little lost but made it to the park in time to have a look around	I can find my way to somewhere new; it's normal to get a little lost sometimes; getting lost might not always be my fault but could be because something is poorly signposted

Table 2: An SRT case example.

History	Jason was a 25-year old male who lives with his parents and sister. Jason described "overwhelming" social anxiety since about the age of 12 years, bullying at home and at school, and poor school attendance. At age 23 years, Jason experienced a month in which he could hear bullies from school making fun of him inside his head. Jason's GP referred him to mental health services who identified a first episode of psychosis.
Presentation	Jason was doing 2.79 hours of structured activity per week; 2.33 preparing food and 0.46 helping his Grandad with his cleaning. Other than helping his Grandad, Jason did not leave the house and spent his time playing computer games. Jason took antipsychotic medication and saw his support worker at home fortnightly.
Engagement	Jason felt ambivalent about SRT and worried about meeting the therapist. Jason and the therapist agreed to meet for short sessions at home with his Mum present to begin with. The SRT therapist and Jason played computer games at the start of the initial sessions.
Assessment and formulation	*Problems and goals* Jason's goals included; do something productive, feel better about himself, work toward having a job, help his Grandad more, and make some friends. Jason's problems included; feeling worried about talking to other people, others thinking he is boring and weird, feeling too anxious to try and go to college or get a job, and feeling belittled by his family. *Values* Jason identified that he valued helping other people and that he was living in accordance with this in helping his Grandad; although would like to provide more help, e.g. in the garden. *Behavioural* Initially the therapist and Jason used diaries to explore Jason's activities, thoughts and feelings. Jason realised that staying at home made him feel safer but also bored and unhappy.

	The therapist supported Jason to go to the local shop to further explore what Jason found difficult about going out. Jason was able to tell the therapist how he felt walking to and around the shop; noticing what he did to feel safe, like avoid eye contact with everyone. *Longitudinal formulation* Jason's early experiences of feeling belittled at home and at school contributed to him feeling negative about himself, the world and other people. Experiencing psychosis had deepened the extent to which Jason felt different to others and had led to a sense of 'shattered self'; believing all stressful experiences must be avoided to prevent relapse. *Maintenance cycles* Jason noticed that his worries about being judged and mocked by others contributed to him staying inside; yet this maintained his worries. Jason learnt form the behavioural assessment that avoiding eye contact actually made him feel more anxious and more isolated from others.
Behavioural work	*Behavioural Activation* Jason and the therapist practiced being active outside the home; first going for a walk, then to a local café, then meeting in the town centre. Jason found doing these activities improved his mood. The therapist also encouraged Jason to visit his Grandad more regularly and Jason felt that this made him to feel purposeful and positive. *Behavioural experiments (BE)* The therapist and Jason designed a BE (Table 1, experiment 3) to help Jason work towards his goal of helping his Grandad go shopping. Through the BE, Jason learnt that although he felt uncomfortable in the busy shop, he did not have a panic attack and was able to extend the experiment by staying in the shop with the therapist and conducting another experiment. Furthermore, the therapist and Jason also spent some time looking at film magazines and found they liked a lot of the same films. The therapist invited Jason to think about his perception of himself as being boring- noticing that he could talk with others about shared interests. Other BEs focused on Jason's worries about others thinking he was 'weird'. The

	therapist and Jason practiced focusing his attention externally when outside the home and considered how this reduced anxious thoughts.
Cognitive work	The therapist helped Jason to identify examples of his survival and resilience ('self as hero') and consider examples of more specific strengths, e.g. Jason's ability to live with humour and Jason's kindness and compassion in helping his Grandad. Jason and the therapist created in-session a survey based on Jason's beliefs about being mocked should he make a mistake in public. The therapist collected responses after the session and Jason found that people expressed mainly compassionate or disinterested (rather than cruel or punitive) views towards others.
Multi-systemic work	The therapist and Jason met with Jason's Mum to share the SRT formulation. They discussed how Jason tended to avoid going out and talking with others due to his worries. Jason's Mum remembered that in his childhood, she had tended to talk to people on Jason's behalf. Jason's Mum identified that she felt frustrated with Jason always being at home and noticed that she sometimes criticised Jason in front of his sister. Jason and his Mum agreed to try and go to a café so Jason could practice trying to interact with other people. Jason reported realising that his Mum did care about him but sometimes felt frustrated and did not know how to help. Towards the end of SRT, the therapist helped Jason to arrange to meet an advisor at a local college. The therapist and Jason arranged for Jason's Mum to accompany him but wait outside so Jason could try and attend the meeting alone. The therapist and Jason also had a session with Jason's support worker to plan how to best support Jason to continue increasing his activity beyond SRT.