TRAINING GUIDE

Windows of Opportunity in Early Psychosis Care: A Companion Guide for Navigating Cultural Dilemmas

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Technical Assistance Material Developed for SAMHSA/CMHS under Contract Reference: HHSS283201200002I/
Task Order No. HHSS28342002T

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This guide has been designed to accompany and expand on the training video series *Windows of Opportunity in Early Psychosis Care: Navigating Cultural Dilemmas*. These videos and guide address dilemmas around three common cultural themes:

- **Religion and Spirituality**
- **Family Relationships**
- **Masculinity and Gender Constructs**

The training videos are based on true stories of individuals with a first-episode psychosis (FEP) experience. They were created to offer specific examples of how providers can navigate common cultural dilemmas in early psychosis care, as well as how to embrace these dilemmas as opportunities to engage participants and their families more effectively. The dilemmas and best practices illustrated in these videos build on those described in the guide *Delivering Culturally Competent Care in FEP*. For more information, go to [www.ontrackny.org](http://www.ontrackny.org).

**WINDOWS OF OPPORTUNITY IN EARLY PSYCHOSIS CARE: NAVIGATING CULTURAL DILEMMAS VIDEO SERIES**

You can view the videos by following the links below:

- **Religion and Spirituality**
- **Family Relationships**
- **Masculinity and Gender Constructs (with a specific focus on masculinity)**

**WHAT WILL I FIND IN THIS GUIDE AND HOW CAN I USE IT?**

This guide provides information about the *dilemmas*, *best practices*, and *interventions* illustrated in each of the videos. In addition, this guide describes *important concepts and themes* that expand on the messages highlighted in the videos. Finally, for each video, the guide offers *discussion questions* to further explore these dilemmas, best practices, and interventions and to provoke reflections about how these may apply to dilemmas providers may encounter in their work with young people with FEP. These questions can be used by individual viewers to reflect on their own practice and by trainers or team leaders to facilitate group discussions.

**WHY USE TRAINING VIDEOS ON CULTURAL DILEMMAS IN EARLY PSYCHOSIS?**

Culture can be defined as what matters most to people—that is, how they make sense of their lives interacting with and negotiating multiple traditions of meaning from their families, communities, and society at large. Providers in early psychosis programs are faced every day with dilemmas about how to support individuals while bearing in mind their religious preferences, spirituality, family relationships, gender identity, and other aspects of culture. For instance, how do we support individuals to pursue what matters most to them when their families and communities value other things? How do we honor the cultural views of young people and their families while offering our expertise as providers? How do we help young people achieve their culturally defined recovery goals? How can we navigate the dilemmas that occur when these goals seem to risk a person’s safety or wellness?
Cultural dilemmas offer windows of opportunity to engage young people and their families.
These dilemmas provide unique and meaningful chances to strengthen trust within the provider-participant relationship. To seize these engagement opportunities, providers must develop the ability to navigate cultural dilemmas effectively.

WHAT ARE THE CULTURAL COMPETENCE SKILLS ADDRESSED IN THE VIDEO SERIES?
This training video series introduces best practices for teams to navigate cultural dilemmas commonly faced by providers of early psychosis programs. These best practices build on six core cultural competence skills essential for early psychosis providers to engage young people and their families effectively:

- Recognizing cultural dilemmas as engagement opportunities
- Developing self-awareness about one’s cultural views
- Respectfully exploring the cultural formulations of participants and families
- Empowering participants and families to express their cultural formulations
- Balancing culturally meaningful self-determination and providers’ duty to care
- Applying principles of good clinical practice to navigate cultural dilemmas

Recognizing cultural dilemmas as engagement opportunities:
Culture shapes how young people and their families see the psychosis experience, what concerns them most about it, what matters most to them in recovery, and what supports they would find helpful. Just as fish cannot see the water they swim in, it is often difficult for us to see “culture” and how culture informs clinical and service delivery dilemmas. This is particularly true when we assume that individuals and families we engage with come from our own cultural backgrounds. As a general practice, we must ask ourselves not if culture is related to a treatment or service delivery dilemma but how, since culture almost always is. Because of this, identifying the cultural nature of dilemmas in care may be a challenging task, but it is also essential. Recognizing the cultural dilemma—and not necessarily “solving” it—is what allows us to identify and seize a window of opportunity for engagement.

Developing self-awareness about one’s cultural views:
It is part of human nature to give meaning to events and phenomena in our world with the lenses we have been handed by the communities of which we are a part. As providers in early psychosis services, we are not exempt. These lenses include our race and ethnicity, gender, age, sexual orientation, and religious preferences. They also include our clinical or professional training, which provides a set of assumptions and interpretations about what is “normal” and what is not, psychosis signs and symptoms, and best treatment alternatives. To offer culturally competent care in early psychosis, it is essential for providers to become aware of and challenge the cultural lenses with which we interpret individuals’ experiences.
Respectfully exploring the cultural formulations of participants and families:
Providers in early psychosis care must explore how young people and their families see or “formulate” what is happening to them and what solutions they feel will help. Even if an individual does not express their views, they almost certainly have them. Eliciting individuals’ cultural formulations with cultural humility is a challenge and responsibility that falls to the provider. It is not a mere anthropological exercise, but an essential aspect of providers’ duty to care that can change the course of engagement, treatment, and outcomes for an individual.

Empowering participants and families to express their cultural formulation:
Conversations about the cultural formulations of participants and families require empowered individuals. Revealing personal views about the psychosis experience that may conflict with clinical interpretations, intimate aspects of one’s identities, and hopes for one’s life and recovery requires vulnerability on the part of young people and their families and can create feelings of shame and fear of judgment and criticism. It is crucial that providers create an empathic space for this dialogue where individuals can be reassured that their views will be heard and respected.

Balancing culturally meaningful self-determination and providers’ duty to care:
Exploring cultural views of young people can enrich their process of identifying recovery goals. However, dilemmas may arise when an individuals’ views or goals lead to concerns about their safety or wellness. Examples of these dilemmas may become apparent when individuals reveal that they: (a) want to stop taking medications because this conflicts with their religious views; (b) intend to pursue a career goal that conflicts with family traditions, which may threaten the emotional or financial support provided by loved ones; or (c) want to keep hearing voices that alleviate insecurities about one’s own gender identity. It is essential for providers to recognize tensions between culturally meaningful, self-determined goals and our duty to care, and to apply principles of culturally competent practice to use these opportunities to support recovery.

Applying principles of good clinical practice to navigate cultural dilemmas:
It is not possible—and in fact would be counterproductive—to provide prescriptive solutions for each cultural dilemma that providers will encounter in early psychosis care. After recognizing a cultural dilemma and gathering as much relevant information as possible, providers should apply principles of good clinical practice in early psychosis care to address them effectively. These include:

- Facilitating person-centered planning that includes individuals’ culturally defined goals.
- Relying on interdisciplinary and team approaches to process new cultural information and develop strategies to address cultural dilemmas.
- Ensuring that shared decision-making considers young peoples’ cultural formulations and the voices of individuals and communities that matter most to them.
NAVIGATING CULTURAL DILEMMAS ABOUT RELIGION AND SPIRITUALITY

The Cultural Competence Dilemma:
In this video, Ronke, a young woman who recently joined a Coordinated Specialty Care program, has told her psychiatrist that she is unhappy about her medications, that she feels “disconnected … lost,” and that she is thinking about stopping them. Her providers learn that Ronke believes she is having a positive spiritual experience, not a psychotic episode. Ronke dislikes the medications she started taking during her prior hospitalization because she feels they are making her lose her connection with God and getting in the way of finding a purpose in life. Ronke’s providers are faced with an important cultural competence dilemma in her care: How can providers honor a participant’s religious and spiritual views that may conflict with clinical recommendations, while still offering their expertise and fulfilling their duty to care?

CULTURAL DILEMMAS AND BEST PRACTICES

| Dilemmas                                                                 | Best practices                                                                 | Provider Interventions                                                                 | Timecodes  
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------
| Ronke feels her medications make her feel “disconnected … lost” and is thinking about stopping them. How do we honor Ronke’s concerns about medications and yet address her clinical needs? | Determine if participant has a religious interpretation about their experience of psychosis.  
Empower participant to express own cultural formulation. | Primary Clinician (PC) explores Ronke’s cultural formulation to discover the role of religion in her life, and how religion influences her perspective of what she is experiencing. | 00:31–01:08, 01:37–01:42 |
| Explore motivations for treatment. | Psychiatrist (MD) explores what Ronke means by feeling “disconnected … lost” and what matters most to her. |  | 01:25–01:36, 02:15–02:44 |
| Ronke asks PC if she believes in God. Will self-disclosing religious/spiritual views help to build trust with Ronke? | Practice self-awareness about religious/spiritual views.  
Recognize and seize “sliding door moments” to build trust. | PC discloses her spirituality to Ronke. | 01:08–01:25, 01:42–01:53, 02:45–02:53 |
Important Concepts and Themes to Consider:

- Finding meaning in events and experiences is integral to the human experience. For many young people experiencing first episode psychosis and their families, religion and spirituality are important sources of identity and key frameworks for how they understand and experience psychosis.

- For clinicians, a participant’s religious or spiritual views may seem to be contrary to the participant’s best interests at times, such as when these views lead them to reject medication or other forms of treatment. Even then, religion and spirituality can provide hope and strength for individuals in the midst of crisis and heartbreak, such as during a psychotic episode. Faith communities are often a crucial social support for individuals and their families.

- Because of the intimate nature of religious and spiritual views, it is often difficult for individuals to share them with others. This is particularly true when participants and providers may have—or are assumed to have—different religious backgrounds. Fear of shame, judgment, and criticism often create vulnerabilities that must be honored and respected.
• Building trust can be a long process of seemingly small moments of empathy and connection. Instances of vulnerability when a participant shares his or her religious views are like “sliding door moments”: unique opportunities to establish trust. When a provider seizes these moments and meets a participant with empathy and without judgment or criticism, a precious connection can form that allows individuals the safety and courage to express their religious and spiritual views.

Discussion Questions:
The following questions may help facilitate discussions about the dilemmas and best practices portrayed in this video and other dilemmas providers may encounter in their programs:

• A clinician who treated Ronke in the past tells Ronke that she is not having a spiritual experience but rather experiencing religious delusions. Have you reflected about your own religious or spiritual views and how these could consciously or unconsciously bias your clinical opinion?

• Ronke’s current primary clinician tells Ronke about her own spirituality. This seems to create a “sliding door moment” for Ronke to trust and share her spiritual experience. How would you decide whether and, if so, when self-disclosure would be helpful? By contrast, how would you handle a situation in which self-disclosure seems to backfire and create a rift in trust between provider and participant?

• What “sliding door moments” (trust-building opportunities) have you had with participants around religion and spirituality? Around other difficult or sensitive topics?

• Ronke and her providers found common ground in her desire to feel better and find purpose in life. This motivates Ronke to remain engaged in treatment. However, at times, finding common ground may not seem easy or possible.

  — How would you help a participant remain engaged in treatment when the participant does not agree with the diagnosis of psychosis, and instead sees the experience as a religious/spiritual event?

  — How would you support a participant who, because of their religious views, refuses treatment or supports that the team feels are essential, such as housing or psychiatric or non-psychiatric medication?

  — How would you support a participant who refuses treatment or supports that the team feels are essential but is open to other forms (e.g., wants help getting a job)?

  — How would you include other team members to foster engagement (e.g., peer support)?

  — How does your team determine when providers must intervene for the sake of the participant’s safety, despite their desire to respect a person’s religious views?
NAVIGATING CULTURAL DILEMMAS IN FAMILY RELATIONSHIPS

The Cultural Competence Dilemma:
In this video, we meet Mike, a young man who left college following his first psychiatric crisis. A year into recovery, he realizes he wants to return to school and pursue his dream of becoming a chef. To him, pursuing his personal career goal—following his own “dream” in a self-determined way—is essential to his recovery. His father, on the other hand, feels that Mike would be better served by not striking out on his own to pursue an ambitious career, but rather settling down within the family business where he might feel more secure and reduce his risk of recurrence. Key to the discrepancy are different cultural views on the value of autonomy and personal goal-setting, especially in a young person with a mental health condition, as well as different views on the value of continuing a family work tradition. Mike and his father have a painful argument because of what seem to be radically different perspectives, and Mike’s providers find themselves in a crucial dilemma about how to support them in a culturally competent way: How do we help Mike and his father understand each other’s perspectives and find common ground to make a decision in Mike’s best interest?

CULTURAL DILEMMAS AND BEST PRACTICES

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<td>Mike has said before he is unhappy with his current job, but this is the first time he says that he wants to go back to school. Why is this important to him now? How can we support Mike in feeling capable of achieving his dreams, while offering the supports to help him to take the steps to do so?</td>
<td>Identify what matters most to participants in their recovery and why.</td>
<td>Supported Employment and Education Specialist (SEES) explores what becoming a chef means to Mike, and why it is important for his recovery to pursue this now.</td>
<td>02:41–03:01</td>
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<td>His father wants Mike to take over the family business and not go away for college again. Why is this important to Mike’s father? What are his hopes and concerns? How can we create a safe space for Mike’s father to express his views and concerns for Mike’s recovery?</td>
<td>Explore family members’ views about the FEP experience and recovery.</td>
<td>At Mike’s request, Primary Clinician (PC) engages his father to participate in Mike’s treatment more actively. PC explores Mike’s father’s views of Mike’s situation and what he thinks will help.</td>
<td>03:34–04:17</td>
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You can view the video Navigating Cultural Dilemmas in Family Relationships by following the link below: Family Relationships.
Important Concepts and Themes to Consider:

- Families often provide emotional and practical support for recovery, help interpret how a young person experiences a first episode of psychosis, and guide which care decisions are made and how.

- Definitions of family can differ substantially across cultures, including who is considered a member (e.g., nuclear, extended, or non-blood relatives such as godparents and close friends and/or other natural supports like a coach, pastor, or spiritual healer).

- Culture also affects family dynamics (e.g., who makes decisions about care), at what age a young person becomes autonomous (especially when seen as “ill”), to what extent family goals take precedence over individual ones, and what values are held dear by family members. Culture also affects how each family member views the psychosis experience and their expectations about recovery, including diverse cultural views among family members of different generations.

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<td>Mike wants providers to talk to his father. How do we support and empower Mike in expressing his truth to his father?</td>
<td>Empower participants to express their views and hopes for recovery.</td>
<td>SEES supports Mike to record a video in which he tells his father why going back to school is so important to him.</td>
<td>01:58–02:07</td>
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<td>Mike’s father feels that it is best for Mike to stay in town. He is concerned that if Mike goes elsewhere he will end up hospitalized for life. How can we work together in alleviating Mike’s father’s fears, instill hope about Mike’s recovery, as well as enlist his support? How can we support Mike and his father to find common ground regarding Mike’s recovery goals?</td>
<td>Provide information and hope about recovery.</td>
<td>PC and SEES will share videos of other young people pursuing their career goals with Mike and his father and connect them to other participants and families for peer support.</td>
<td>04:56–05:32</td>
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<td>Foster empathy and create a safe space to discuss differing perspectives.</td>
<td>PC tries to foster empathy by suggesting to Mike’s father that Mike feels his purpose is to cook … what if becoming a chef could help him get better?</td>
<td>04:18–04:33</td>
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<td>Support participants and their families to find common ground.</td>
<td>PC suggests a meeting between Mike and his father to help them listen to and understand each other’s points of view, and find common ground in the fact they both want Mike to find his own way and a fulfilling purpose.</td>
<td>04:33–04:55</td>
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• It is often harder to identify cultural dilemmas among individuals and families from one’s own cultural background. For example, white families in the United States are often considered “culture-free” by many Americans. Culture is connected to race and ethnicity, but also to other sources of diversity, such as urban/rural setting, being working/middle class, gender, and being a youth/adult. These social characteristics shape views and values about the importance of individuals’ independence, work ethic, career, mental health, and many other important aspects of life.

Discussion Questions:
The following questions may help facilitate discussions about the dilemmas and best practices portrayed in this video and other dilemmas providers may encounter in their programs:

• What definitions of family do you encounter among participants in your program? Are they nuclear? Extended? Do they include non-blood relatives?

• Following a broad definition of culture (that includes aspects of identity besides race and ethnicity):
  — How does culture shape family dynamics and decisions in first episode psychosis care?
  — What is “cultural” about the dilemmas presented in this video?

• How do participants and families in your program make decisions about one member’s care? When they reflect about it, how and by whom do they think these decisions should be made? By the individual member? By the head of the family? By the family unit as a whole?

• How do your own views about first episode psychosis differ from those of the families you work with? For instance, what are your views about the role of the family in decision-making or about the importance of individuation and independence?

• How do cultural views and values interact with other considerations, such as economic concerns, in the decision-making process of families regarding early psychosis care?

• Sometimes a family’s views may seem detrimental to a participant’s recovery, such as when they hold stigmatizing views about the participant’s mental health condition, gender/sexual identity, or use of medications. Yet, the participant may want the family to remain involved in his/her care. In these situations, how can providers foster self-determination and person-centered care and ensure the participant’s safety?

• Considering that families are often there for the long haul in ways paid providers cannot be, how can you provide person-centered care and promote self-determination when participants and families seem to have drastically different views and hopes about treatment and recovery?
NAVIGATING CULTURAL DILEMMAS ABOUT MASCULINITY AND GENDER CONSTRUCTS

The Cultural Competence Dilemma:
David is a young man receiving services at a Coordinated Specialty Care program. He recently told his Peer Specialist that he is frustrated about his inability to ask a young woman he likes out on a date. If he cannot ask Malika out, “will he ever be a man”? David told his peer provider that the voices he hears really “attacked” him and his sense of masculinity (e.g., “sissy boy,” “you’re never going to be a man like your brothers”) just as he was trying to muster the courage to talk to her. Yet, David does not want to “get rid” of the voices. This is puzzling to his providers. As they support him, David’s providers learn that he hears “good voices” too, and that they “build him up,” bolstering his confidence to become the man he wants to be. David’s providers find themselves facing an important dilemma in his care: How do we support David in his desire to not get rid of the “good” (encouraging) voices, but also to overcome the tormenting voices that attack his sense of gender identity and hope for recovery?

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<td>David feels that if he can’t ask out Malika, he can never be the kind of man he wants to be. How do we help David pursue what is important to him, while building his sense of hope that he can achieve his goals?</td>
<td>Explore participants’ gender constructs. Foster self-awareness among participants about their personal definitions of gender.</td>
<td>Peer Specialist (PS) explores with David his views of what it means “to be a man.”</td>
<td>01:08–01:15</td>
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<td>01:59–02:19</td>
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<td>Provide empathy toward participants’ gender-informed concerns, and foster hope of achieving their goals.</td>
<td>PS shares his own experience with dating, pressures of developing a sense of gender identity, family expectations, and how he dealt with them.</td>
<td>01:35–01:41</td>
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<td>David felt “attacked” recently by the voices he hears, but he doesn’t want them to stop. He doesn’t want to explain why. How can we create a safe space for David to express his views about keeping the voices he hears?</td>
<td>Empower participants to express their own cultural formulation of the FEP experience.</td>
<td>Primary Clinician (PC) encourages David to express his own perspective about the voices he hears.</td>
<td>01:43–01:49 02:59–04:10</td>
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<td>Understand how cultural gender/sexual norms impact the psychosis experience and vice-versa.</td>
<td>PC explores whether and how the voices David hears are a source of stress or support for his gender identity.</td>
<td>04:33–04:56</td>
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<td>To David’s mother, a man deals with his problems alone, while for David asking for help is part of his construct of masculinity. How do we support David to express to his mother his personal definition of being a man and foster her understanding and support?</td>
<td>Support individuals to express their personal definitions of gender, while preserving and strengthening family and community support.</td>
<td>At David’s request, PC and PS will meet with his mom to support him as he expresses his views of masculinity and asks for her help in this new chapter of David’s recovery.</td>
<td>05:21–06:01</td>
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| David wants the good voices he hears to be louder than the bad voices, and to make the good voices his own. How do we help David internalize the positive messages of the “good” voices, while addressing our clinical concern about him still hearing distressing voices? | Strive for balance between self-determination and duty to care.                | PC and PS support David as he creates affirmations by building on the “good” voices he hears. PS suggests to David that he connect with peer support groups for men who hear voices. | 04:13–04:32
|                                                                           |                                                                                | 04:57–05:20                                                                 |                |

### Important Concepts and Themes to Consider:

- Cultural ideas of what it is “to be a man”—constructs of masculinity—often shape young people’s:
  - Care expectations and recovery goals, such as a desire to fulfill meaningful roles (e.g., provider, father, husband, boyfriend) and how to maintain or gain a sense of belonging within valued communities.
  - Sense of honor and dignity; feelings of shame, embarrassment, and humiliation following very stressful events that frequently accompany a FEP (e.g., hospitalization, interrupted schooling, loss of employment or career).
  - Formulation of their difficulties; what troubles them most about the FEP experience or treatment (e.g., loss of important relationships, changes in social status, concerns about sexual side effects of medications).

- Traditional, binary constructs of masculinity can function as a source of stress and vulnerability for young people with a psychosis experience (e.g., by challenging their ability to express emotions or seek help). Nevertheless, they can also be sources of strength, coping, and motivation to pursue recovery (e.g., concepts of determination, not giving up, being a good provider).
• Constructs of masculinity translate into expectations and messages by family members and peers (of all gender identities), media, and institutions. However, these constructs are complex, dynamic, and not homogenous. Often, young people find themselves having to negotiate discrepancies between their personal definitions and dominant views in their social networks and community.

• This video focuses on issues related to masculinity in FEP. However, masculinity is part of a wide spectrum of gender and sexuality constructs that impact young people of diverse gender identities and sexual orientations. Belonging to sexual and gender minorities (e.g., being gay, lesbian, bisexual, asexual, pansexual, transgender) can expose individuals in early psychosis to experiences of harassment, exclusion, and discrimination that can become sources of stress and barriers to care.

Discussion Questions:
In this story, David reveals to his peer specialist that he doesn’t want to “get rid” of the voices he hears, but he doesn’t want to explain why. The peer specialist wonders if this is connected to David’s fears about not realizing his goals that are related to cultural notions of masculinity but decides not to press for more information. While developing a trusting relationship between providers and participants can take time, unique windows of opportunity to engage individuals may come unexpectedly.

Considering this, the following questions may help facilitate discussions about the dilemmas and best practices portrayed in this video and other dilemmas providers may encounter in their programs:

• What examples can you think of when you or your team took a risk to engage with gender identity and it paid off? What factors would you attribute to its success?

• In what situations have you or your team found yourself in which pursuing an engagement opportunity about gender identity seemed to backfire? What factors contributed to things going wrong?

• How would you decide whether to pursue an engagement opportunity regarding gender identity when it first appears, or to wait until more trust is developed?

At the end of the video, David’s providers discuss several intervention strategies to support David’s goals of getting rid of the “bad voices” and making the “good voices” his own (i.e., creating affirmations, CBT, connecting to peer support, and meeting with his psychiatrist to discuss his medications).

• What other clinical interventions would you recommend to support David’s goal of making the “good” voices his own? These could include:
  — Pharmacotherapy
  — Supported education and employment
  — Peer support
  — Other services or supports
In the video, the providers learn that David’s mother feels that a man should deal with his problems alone, implying that David’s mental health struggles are a result of laziness. She tells David she doesn’t “want to hear any excuses.” The providers and David plan to meet with his mother to express his ideas and recovery goals to her, in the hope of helping her understand and ultimately support him.

• What other interventions could help David’s mom to be able to hear, and to see things from her son’s perspective?

• What can David’s providers do to help David to identify other sources of support, both within and outside his family?

David’s peer specialist shares his own experience with struggles regarding gender identity and the impact of constructs of masculinity.

• In what other ways can peer support help participants address issues regarding gender identity and sexual orientation?

• What are the advantages and disadvantages of engagement interventions that involve providers of similar gender identities as the participants?

In the United States, younger generations are increasingly embracing concepts of gender and sexual diversity.

• What examples of discrepancies do you observe between participants in your program and their family members over gender and sexuality constructs?

• Do you see this becoming a source of stress to young people with FEP experience? A cause for strained relationships within families? A source of resilience for individuals? A catalyst for stronger and more supportive families and communities?

• How would you support participants and families to find common ground around diverging perspectives about gender and sexuality?
CONTRIBUTORS

The STAR Center provided support in the development of the videos and this guide. In addition to the authors, the following individuals contributed to the development of the videos and provided comments on early drafts of this guide. The videos and guide reflect the authors’ final decisions regarding the material included and does not necessarily reflect their views.

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RECOMMENDED CITATION

ACKNOWLEDGMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS283201200002I/Task Order No. HHSS28342002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Jeanette Miller served as the Contracting Officer Representative. Monique Browning served as the Task Lead.

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