Coaching Intervention for Psychosis

A Lifestyle Redesigning Approach

Kwok-fai Leung
Iris Hiu Hung Chan
Nicole Ka Man Lau
Eric Yu-hai Chen

HKU PRESS
香港大學出版社

Hong Kong University Press
The University of Hong Kong
Pokfulam Road
Hong Kong
www.hkupress.hku.hk

ISBN 978-988-8390-92-2 (*Hardback*)
ISBN 978-988-8390-91-5 (*Paperback*)

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library.

10 9 8 7 6 5 4 3 2 1

Printed and bound by China Translation & Printing Services Ltd., Hong Kong, China

Contents

Illustrations

Tables

1
An Introduction to Early Psychosis

Psychotic disorders affect the brain systems that handle and interpret information from the environment, allowing us to construct a representation of the reality around us (Frith, 2005). When these systems fail, the brain misinterprets information from the environment, resulting in the subjects perceiving nonexistent objects or misinterpreting other information. Patients with psychotic illnesses often suffer hallucinations (perceiving nonexistent objects) and delusions (misinterpreting social reality) (Frith, 2005).

Psychotic disorders often start in late adolescence or early adulthood. Studies around the world indicate that the incidence rate of schizophrenia (one of the most important psychotic disorders) ranges from 17 to 30 people from a population of 100,000 each year (Saha, Chant, Welham, & McGrath, 2005). As much as 2 to 3% of the general population suffers from psychotic disorders (Altindag, 2007).

Psychosis is one of the top ten WHO global burden diseases (Rossler, Salize, van Os, & Riecher-Rossler, 2005). After the first acute psychotic episode, patients often continue to have problems with cognitive function and motivation (Keefe & Harvey, 2012). Much of the long-term burden of psychotic disorders comes from social isolation, lack of vocational and social capacities, and the risk of violence and self-harm. Due to challenges in detection and management, these burdens fall not only on the individual, but also on the family, social network, and the community. Persons in a psychotic state are usually unaware that they are unwell (Baier, 2010). Therefore, help seeking may be substantially compromised and delayed (Penttilä, Jääskeläinen, Hirvonen, Isohanni, & Miettunen, 2014).

Many patients present for assessment and help only after a long delay, during which a substantial deterioration has already occurred in both their social network and occupational opportunities. Many longitudinal studies have observed that long durations of untreated psychosis (DUP) are related to poor long-term outcomes (Penttila et al., 2014). Such findings urge experts in the field to find a way to detect the illness earlier and provide services in its early stages (McGorry, Killackey, & Yung, 2008). As the long-term outcome

of psychosis is relatively modest (Jobe & Harrow, 2005), clinicians and investigators have continued to explore ways to improve long-term outcomes.

Besides early detection, another focus is to provide intervention during the critical period. "Critical period" refers to the first three to five years after the onset of the illness, during which it displays more fluctuations than in subsequent years (Zaytseva, 2011). Longitudinal studies have showed that poor outcomes during the critical period are associated with poor long-term outcomes (Harrison, Croudace, Mason, Glazebrook, & Medley, 1996). Hence, one possible strategy for improving long-term outcomes is to focus resources on the critical period—a strategy that has been taken up by some services in recent years (McGorry et al., 2008). In addition to optimal treatment with medication, casework constitutes an important intervention strategy (International Early Psychosis Association Writing Group, 2005). Early psychosis case managers have specialized knowledge and skills to tackle problems that arise during the early stages of the illness, such as developing an understanding of the illness for the first time after psychotic symptoms have subsided, confronting the uncertainties of future relapses, and aiming to return to pre-morbid levels of functioning.

There are several components to casework for early psychosis. The first is basic case management, in which the case manager serves as the key person providing the patient and family with long-term follow-up. Through such contact, case managers are able to understand the needs of both patient and family, and thereby help the patient to make appropriate decisions for a smoother journey of recovery. Besides basic case management, casework also involves two types of special intervention skills. These skills are metaphorically mapped onto a football match, in which both "defending" and "attacking" moves are required. "Defending" is equivalent to protecting patients' mental states from adverse deterioration, such as depression, relapse, resistance to treatment, and poor functional outcomes. With well-trained case managers, treatment guidelines, and protocols, risks to a patient's mental state can be detected at an early stage to allow for timely management.

Casework also requires work on the "attacking" side, or striving for positive improvements. Recovery is not only about symptom remission, but also about viewing patients in a holistic way and striving to optimize their functioning and the quality of their lives. Coaching is one of the recently explored interventional approaches to address this "attacking" side. As patients often experience complex problems and disabilities in many social and vocational areas, a more focused and intensive intervention can help them to overcome these obstacles and therefore facilitate better overall outcomes. Lack of motivation is a common consequence of brain dysfunction after the remission of acute psychotic symptoms (Brown & Pluck, 2000). Patients' daily functioning can be severely hampered by low levels

of motivation. Apart from dysfunctions in the brain's motivational system, one of the reasons for this avolition may lie in the poor representation of goals for patients (Gold, Waltz, Prentice, Morris, & Heerey, 2008). Patients may also have difficulties in making plans; executive cognitive impairments may prevent them from constructing the series of steps used to plan and act toward positive outcomes in the future (Cools, Brouwer, de Jong, & Slooff, 1999). This ability to conceptualize about the future in a series of actionable steps is essential for reorienting patients' motivational systems. Patients may find it hard to break down their future prospects into relatively manageable steps; coaching may facilitate this process.

Beyond behavioral presentations, self-stigma is another common difficulty encountered by people with psychotic disorders. Self-stigma is an internalized, negative social representation associated with mental illness (Brohan, Elgie, Sartorius, & Thornicroft, 2010). For instance, patients might unnecessarily believe that they are incapable of certain tasks due to their illness: this belief then becomes an invisible psychological barrier affecting the journey of recovery. Coaching helps patients develop positive experiences to enhance their self-efficacy for achieving their goals, thus overcoming the possible effects of self-stigma. In the following chapters, the principles and applications of the coaching approach to psychotic disorders are systematically explored through practical examples and clinical guides.

Part I

History, Theories, and Basic Philosophy

2
Early Interventions for First Episode Psychosis

The Life Coaching Approach in the JCEP Project

A six-month, twelve-session group coaching program, named "Occupational Lifestyle Redesign" (OLSR) program, has been developed in the outpatient occupational therapy services in local public hospitals for people with a range of chronic illnesses. The program is delivered by occupational therapists with formal training in life coaching. There are two core elements in the OLSR program: (1) the practice of weekly goal setting and implementation in various life domains within the functional capacity of the participants; and (2) the learning, personalizing, and contextualizing of adaptive strategies and skills in important life domains through the implementation of weekly action plans.

Life coaching has been adopted by the Jockey Club Early Psychosis Project as an integral part of its services, aiming at facilitating the recovery of people with first episode psychosis. This is one of the non-pharmacological interventions adopted during the critical intervention period as both an approach and a structured intervention program. Case managers deliver life coaching in two forms: individual coaching and group coaching.

A "Lifestyle Redesign" Program (LSR) was developed for JCEP clients based on the same principles and format of OLSR program in local public hospitals. It is a short but intensive group coaching program that aims to create significant improvement in clients' life functioning. Once clients are recruited into the JCEP project, the case manager screens them and invites those with a certain degree of motivation to improve their current life to join the LSR program. There is no simple direct assessment of readiness for LSR. Case managers explain the nature, purpose, and process of LSR program to the client, stressing that LSR is a ten-session program and that participants are required to complete the program and commit to actively working to improve themselves. Those clients who demonstrate willingness to try are admitted to one of the LSR groups. If a client is not ready for the program, individual coaching is provided until they are ready, after which they are again invited to join.

Resuming one's pre-morbid lifestyle or assuming a normal lifestyle is the key theme of the LSR program. Clients are invited to consider and adopt this as their aim for attending the program. During the program, life, wellness, leisure, positivity, solution-focused, and (sometimes) career coaching are provided. Setting goals, planning actions, and learning adaptive strategies are the key activities of each LSR session. Clients are guided to plan an activity and implement the plan during the week between two consecutive LSR sessions. In the subsequent session, the clients share with the group their experiences of implementing their plans. The coach then guides the clients to consolidate what they have learned to maximize the benefits of their experiences.

Lifestyle and Lifestyle Redesign

Functional recovery from psychosis may not be a linear process. Recovery might be characterized by "ups and downs," or spiraling upward. The Lifestyle Redesign program is one of the many methods that are designed to reduce setbacks and promote faster recovery.

The term "lifestyle" has different meanings in different contexts. In the context of the Lifestyle Redesign program, it refers to what, when, where, how, why, and with whom one does activities in the areas of home, family, social, work, leisure and spiritual life, and how these activities are arranged, prioritized, and balanced in regards to time. Local occupational therapists have coined the term "occupational lifestyle" to express this meaning of "lifestyle." In most healthy people, the occupational lifestyle supports, to various extents, their physical and mental health, fosters personal growth and development, and leads to a generally happy and purposeful life.

Most clients who are recovering from their first episode of psychosis may experience a period of functional decline leading to disruptions in their occupational lifestyle. The term "lifestyle dysfunction" is used to refer to the failure to maintain one's customized lifestyle for various reasons (e.g., illness, disabilities, aging, etc.), or the failure to establish a new occupational lifestyle that is compatible to one's physical and mental health, available resources, personal goals, and environmental or social demands. Lifestyle dysfunction is manifested as a lack of activity content (happiness-, flow-, and meaning-inducing activities) and/or an imbalance of activities in everyday life. For example, in clients recovering from psychosis, daily life may only center around treatment-related activities, or include minimal amount of activities for prolonged periods of time. The consequences of lifestyle dysfunction include a dissatisfaction with life, lack of interest in everyday activities, lack of psychological strength to meet the challenges of everyday

life, and deterioration in overall physical and mental health—resulting in a vicious cycle of imbalance and dissatisfaction with life.

The Lifestyle Redesign process requires an active and conscious effort to explore, experiment, habituate, and internalize past and/or new daily activities, including self-care, home maintenance, work, leisure, and social and spiritual activities. Furthermore, Lifestyle Redesign prioritizes and organizes these activities into a new lifestyle in which one's physical and mental health can be maintained. The redesigned lifestyle is meant to nurture the spirit, facilitate personal growth, and foster meaning and happiness in one's life.

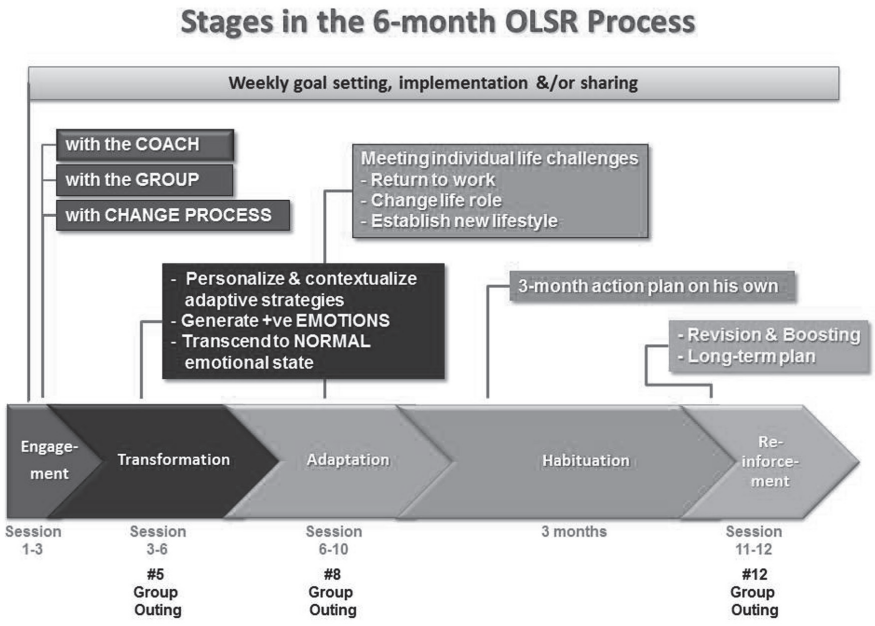
The Lifestyle Redesign Program

Lifestyle Redesign is one of many programs that can facilitate a functional recovery for people with psychosis. LSR facilitates the learning, practicing, and internalizing of adaptive strategies and techniques to foster lifestyle changes through individual and group coaching. Individuals exhibiting lifestyle dysfunction as a result of psychosis benefit from this program. Lifestyle Redesign is more concerned with capacity building rather than with the treatment of illness or management of symptoms. For this reason, we have adopted a functionality-oriented, rather than a psycho-pathological, conceptual frame to guide Lifestyle Redesign programs.

LSR programs are delivered in a mix of individual or group coaching sessions. The group sessions are packaged as training courses, thereby emphasizing active learning on the part of participants rather than the passive reception of a treatment. The training course is divided into five phases. The first three phases, i.e., the engagement, transformation, and adaptation phases, last for ten weeks. During these phases, group coaching sessions are held once a week. The fourth, or habituation, phase lasts for three months. The fifth phase, reinforcement, consists of two consecutive group sessions, held one week apart.

Unlike other skill training or psycho-educational programs, the LSR program does not have a structured "syllabus," i.e., pre-programmed themes, content, and activities for each session. Instead, it is organized into phases, each of which has a different aim and emphasis. In the first two phases—engagement and transformation—participants are coached to pursue happiness-inducing activities to boost their mood and self-efficacy. In these phases, it is essential to facilitate participants' active engagement with the learning and changing process. Engagement with the coach and fellow group members is also stressed. Successful engagement in happiness-inducing activities is meant to improve the participants' mood and self-efficacy, providing them with energy for the planning and implementation of further more complicated or important action plans.

Figure 2.1
The five phases of the Lifestyle Redesign program and their associated objectives



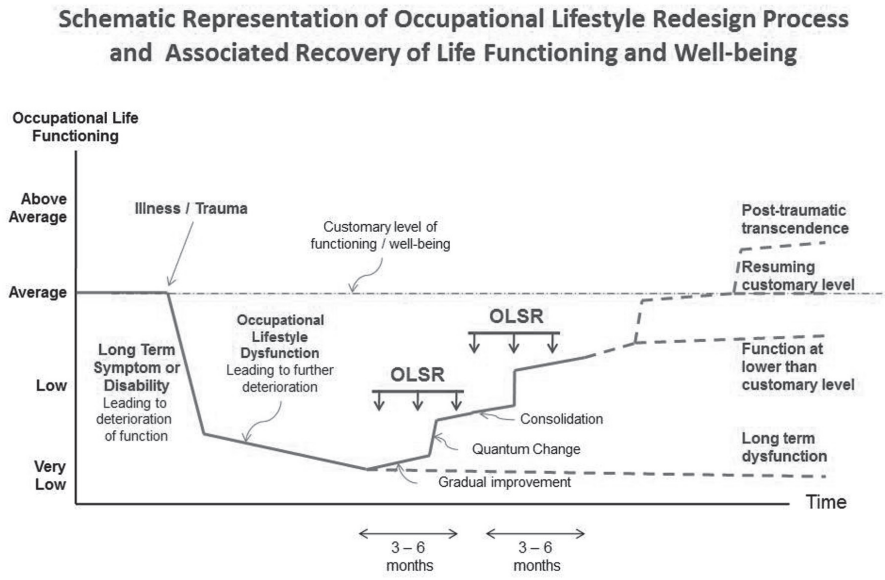
The engagement and transformation phases may last from four to six weeks; the LSR program allows participants to progress at different paces. Participants who engage with the group and process changes at a faster pace are guided into the adaptation phase earlier than the others.

In the adaptation phase, participants are coached to learn and practice adaptive strategies and skills to meet the demands of everyday activities. They are encouraged to plan and implement more complex tasks and to achieve bigger goals. New knowledge and adaptive strategies are introduced to the participants, who learn and apply them to ensure the successful implementation of their plans. In the adaptation phase, participants are coached to make an intensive effort to personalize, contextualize, and incorporate adaptive strategies into their living environment. Before the end of this phase, they are coached to make a three-month action plan that may involve the adoption of a new lifestyle and/or new life roles.

Habituation is the fourth phase of the LSR program, in which participants are asked to implement their three-month action plan on their own. According to the needs of the participants, some individual coaching sessions may also be arranged during this time.

The LSR program ends with two weekly sessions of reinforcement. During these sessions, the participants gather to share their success in

Figure 2.2
Lifestyle Redesign's trajectory and recovery outcomes



implementing their three-month action plans. Participants are also coached on how to plan longer-term actions on their own.

Upon completion of the program, improvements in mood, thinking, self-efficacy, and hope are found in most participants. Repeated, successful participation in a range of activities that induce happiness or meaning, that are challenging but achievable, and that allow the personalization of adaptive strategies, can generate a huge amount of energy and help the participant reach a higher level of awareness and self-efficacy. Many participants have what we call a "miracle occupational experience" that strengthens their willpower to accept and adapt to their condition, and also to reestablish a lifestyle that is compatible with their functional limitations. At the beginning of the process, these changes may seem gradual, but at some point the participant seems to ascend to another level suddenly and exhibits huge changes in both qualitative and quantitative terms. The term "quantum change" has been borrowed from physics to describe this phenomenon.

Life Coaching in the Lifestyle Redesign Process

Coaching—both its philosophy and technique—is extensively used in the LSR program. The program starts with positivity coaching, followed by solution-focused coaching, and ending with wellness and life coaching.

Positivity coaching guides participants to pursue flow- and happiness-inducing activities in order to generate positive feelings and emotions. Positive emotion is believed to be a major source of the energy that fuels the changing and learning process in the subsequent phases of the LSR process. Positivity coaching is usually adopted during the first two phases of the LRS program.

Solution-focused coaching refers to the more structured process of guiding participants to turn problems into achievable goals, to explore and plan ways to achieve those goals, to evaluate and adjust the course of action, and to learn from and appraise successful experiences. Solution-focused coaching is predominantly provided in the adaptation phase of LSR. Participants gradually learn the steps of solution-focused coaching so that they can independently plan and execute their plans in the future when the coach is no longer around.

Wellness coaching refers to the aspect of coaching that is centered on the management of symptoms and the promotion of health. Clients who are affected by either positive or negative symptoms are suitable candidates for wellness coaching.

Life coaching is an essential part of LSR. Participants are guided to explore and then prioritize their new life goals. This is particularly important in the later phases of the LSR program, i.e., the adaptation, habituation, and reinforcement phases.

Conclusion

In this chapter, the use of life coaching and the Lifestyle Redesign program were briefly presented. The following chapters introduce the rationale and theories behind the LSR programs. Readers are encouraged to equip themselves with this fundamental knowledge before applying the Lifestyle Redesign program to their clients.

Part II

Practical Guide

7
The JCEP Lifestyle Redesign Program

Content and Delivery

The present intervention, namely the "Lifestyle Redesign Program" (LSR Program), consists of ten intensive weekly group coaching sessions, each session lasting two hours. The ten sessions can be complemented with a three-month post-group follow-up. This intervention is based on the application of life coaching principles to develop human strength, with a focus on the functional recovery of early psychosis participants.

Table 7.1
Details of the JCEP Lifestyle Redesign program

Number of sessions:	• One individual session for a pre-group interview • Eight to ten group sessions • Graduation ceremony • One session for a post-group follow-up (3 months after the graduation ceremony)
Number of participants:	6–8 people
Duration:	2 hours (maximum 2.5 hours)
Number of coach(es):	1–2
Goals:	• Resume pre-morbid life • Assume pre-morbid highest level of life functioning • Redesign new and optimal lifestyle, where appropriate
Approach:	Making changes in participants' attitude, skills, and habits through daily life activities

Objectives

The JCEP life coaching intervention aims to motivate participants through generating successful experiences and positive feelings by accomplishing carefully selected, challenging but achievable, life goals. This group

intervention enables participants with first episode psychosis to build on their existing strengths, uncover their potential, and build both confidence and life skills with which they can meet challenges in their lives.

Stages

This intervention can be roughly divided into five stages (see Figure 2.1):

Stage 1 (Session 1–3): Engagement
Stage 2 (Session 4–6): Transformation
Stage 3 (Session 6–10): Adaptation
Stage 4 (Three months): Habituation
Stage 5 (Session 11): Reinforcement

Structure of the group sessions

Each session follows a similar structure, which includes:

1. Recapping what was learned in the previous session (5 minutes).
2. Reporting and evaluating the homework to support success and learning (60 minutes).
3. Tea break (15 minutes).
4. Setting goal(s) and making an action plan (60 minutes).
5. Sharing what each participant has learned from the session (10 minutes).

The LSR program is a structured, group-based coaching program that incorporates cognitive-behavioral and solution-focused therapeutic components. The program facilitates an active process of change via the identification of achievable personal goals, the formulation of action plans, the provision of constructive feedback, and progressive monitoring of goal attainment. During group sessions, the coach helps participants find out the discrepancy for potential change by asking open-ended coaching questions, with the aim of assisting participants to become aware of their own status or functioning in comparison to their pre-morbid functioning. With an increased understanding of their own status, participants are more able to identify and set their own goals in relation to the four life domains (leisure, domestic, social, and work). The coach then assists the participants with planning to achieve their goals via collaborative exploration. To ensure that participants have successful experiences and are able to build their self-efficacy, the coach has to guide the participants to find ways to overcome any foreseeable obstacles. By repeating this exercise in subsequent group sessions, participants learn

to incorporate and apply these steps to goal setting and implementation in their everyday lives.

The Core Components of Group Coaching at JCEP

- Provide a demand for recovery or self-improvement.
- Coach for weekly action planning, implementation, and sharing.
- Facilitate miracle occupational experiences.
- Facilitate social learning.
- Encourage and celebrate success.
- Provide unconditional care and love.

Reminder:
The stages we describe in the following section are general conditions; coaches can follow the steps flexibly. Be ready to listen, observe your participants, and choose the best strategies according to their situations and/or stage of illness. Different participants may progress differently. It is advisable to evaluate the progress of each individual before entering into the next session.

Recruitment

Eligibility criteria for this program include: (1) DSM-IV diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, or brief psychotic disorder; (2) positive symptoms of mild or lower severity (rating < 4 in all items of the Positive Symptom Subscale of PANSS); (3) impaired functioning with a SOFAS score less than or equal to 60; and (4) Cantonese speaking. Exclusion criteria include substance abuse, organic psychotic disorders, and mental retardation.

Pre-group session: Assessment (individual meeting)

Stage objectives

- To guide exploration of the participant's pre-morbid and current levels of functioning.
- To find out participants' concerns and make sense of their issues.
- To engage participants with the coach.
- To engage participants in the change process.

- Increase their self-efficacy by:
  - Predicting the potential benefits of a specific goal and inviting the participants to anticipate success. The greater their intention to anticipate success, the more likely it is that they will initiate their plan.
  - Exploring potential barriers and designing possible strategies for overcoming the hurdles. Better strategies and more options can increase the participants' persistence when they encounter difficulties.
  - Controlling the risk of failure through defining the smaller, adjustable steps by which they can achieve their goals. Help the participants find ways to control damage and restore hope. Help to regain control after a setback or failure.

Part 5: Preparation for the graduation ceremony

- Organize a formal ceremony to recognize the progress made after the completion of all sessions. In the ceremony, the progress of each participant is made known to others and repeated to the participant. This ceremony celebrates their progress and praises their efforts.
- Encourage participants to invite their significant others, e.g., their family members, friends, etc., to join the ceremony, especially people who have given them support or witnessed their changes during this period of time.
- Help each participant prepare a public speech or script to be presented during the ceremony. In the presentations, each participant should answer each of these questions:
  - What changes do you think you have made?
  - How did you find yourself making those changes?
  - What is your future three-month plan?
- Participants are encouraged to take up tasks (e.g., preparing food, acting as the MC, taking pictures, etc.) for the graduation ceremony so that they "own" the ceremony.

Tenth group session: Graduation ceremony

Stage objectives

- To consolidate learning and growing experiences
- To celebrate their achievements during this period of intensive change
- To set longer-term goals and build higher self-efficacy for achieving them

Group process

Part 1: Preparation

- Rehearse each participant's script with him or her.
- Make sure the food and refreshments are ready.

Part 2: Opening speech

- Introduce the group objectives to the participants and their guests.

Part 3: Consolidation and appreciation

- Invite the participants one by one to share what they learned during the program.
- Display the participants' achievements and important group experiences in the form of a slideshow, pictures, videos, etc.
- Invite the guests to share their appreciation for the participants' processes of change.
- Invite participants to share the goal they plan to achieve in the next three months.
- Videotape the whole sharing session and give a copy to the participants for future reference.

Part 4: Presentation of certificates

- Present the participants with certificates recognizing their progress.
- The coach(es) should give a final speech encouraging the participants to use the knowledge gained during the course of the program to strive to achieve their goals.

Part 5: Refreshments

- Celebration and interactions

After-program three-month habituation stage

Stage objectives

- To maintain the momentum of change

Change process

Step 1: Regular follow-up about the participants' progress and life situations

- Carefully review the steps to success. Set different milestones to achieve.

- Follow up either in a group or individually, i.e., through monthly group meetings or frequent phone contact, depending on the need for further coaching.
- Facilitate participants to develop self-awareness and acceptance of their existing strengths and weaknesses.
- Maintain a close rapport and sense of trust between the coach(es) and participants.
- Be attentive to potential situations that may tempt the participants to regress to an earlier stage—especially stressful situations or taking too big of a step forward. Give support and encouragement whenever needed.

Step 2: Review participants' progress and provide motivation

- Prompt the participants to review their own action plans and share their experiences after the end of the group sessions. Explore every detail and focus on new insights, appreciating participants' "moves" toward their goals, e.g., "What does doing something in this period mean to you?", "Have you experienced any changes?"
- Celebrate any progress made in this period.
- Identify the participants' difficulties (e.g., "Did you ever think about not doing your task?", "Was there any hesitation in finishing your task?", "Any obstacles?"). Suggest options and strategies by which they can tackle potential obstacles. Check the participant's confidence and motivation while they are using different strategies.
- Invite participants to describe their own feelings in order to better understand themselves, e.g., "Do you enjoy doing . . . ?", "How does this assignment benefit you?", "Do you think that you have dedicated enough effort to finishing this assignment?"
- Encourage participants to decide on a plan of action using the GROW model.

Step 3: Reviewing and maintaining momentum

- Invite participants to set a time for regular review and celebration of their achievements.

9
Conclusion

This book presents both the foundational principles for, and our pragmatic experiences of, using coaching intervention to improve the functional outcome of psychotic disorders. Coaching intervention offers an approach that can fill the current gaps in psychosocial intervention for early psychosis. Specifically, coaching intervention provides an intense, focused effort to mobilize motivational resources within the patients, in order to achieve a quantum improvement in their functioning within a defined period of time. This method is implemented using a group-based approach that not only increases cost-effectiveness, but also enables peer interaction, support, and mutual stimulation to play a significant role in mobilizing individual motivations.

Practicing the planning and execution of the sessions are indispensable. Details of the required skills and strategies have been discussed in the preceding chapters. However, in order to be effective, a clinician using the coaching approach must not only consider this step-by-step guide, but also holistically embrace the implicit philosophy of this approach.

Coaching is not only a set of skills but also a value system; in particular, it believes that human *beings* have an innate behavioral tendency to pursue competency, wellness, and personal growth. In adopting the coaching approach in psychosis intervention, we articulate the conviction that, despite the presence of "avolitional" states, there are still many ways to mobilize patients' drives to meet their intrinsic needs for the pursuit of success, happiness, and meaning—ultimately leading them to achieve an optimal lifestyle that supports both physical and mental health.

About the Authors

Kwok-fai LEUNG is manager of the Occupational Therapy Department in the Queen Elizabeth Hospital, Hong Kong. He was also the cluster manager of the Occupational Therapy Services and the clinical stream coordinator for Allied Health Services in the Kowloon Central Cluster of the Hospital Authority. Mr. Leung is experienced in both physical and psychiatric rehabilitation. He specializes in rehabilitation of the hand, vocational rehabilitation, social rehabilitation, and wellness and life coaching, especially in the area of self-management programs for chronic diseases. He is one of the key advocates for applying life coaching to occupational therapy in public hospital services in Hong Kong and has established a series of Occupational Lifestyle Redesign programs to enhance the life functioning of people with limitations caused by a range of illnesses, including mental illnesses. He has been an active member of the Jockey Club Early Psychosis Project and has introduced life coaching programs to the project for the promotion of successful, happy, and meaningful lifestyles to their clients.

Iris Hiu Hung CHAN was one of the case intervention officers for the Jockey Club Early Psychosis Project. She has received postgraduate training in social work and psychology at the Chinese University of Hong Kong. During her tenure as a case intervention officer for the Jockey Club Early Psychosis Project, Ms. Chan was mainly responsible for providing phase-specific case management services for clients with first episode psychosis and their families. She is also experienced in leading group-based life coaching intervention and psychoeducation programs for clients with first episode psychosis.

Nicole Ka Man LAU is a professionally trained life coach under the International Coach Federation (ICF) Accredited Coach Training Program and has extensive clinical experience in working with psychosis patients. She completed the master of psychological medicine (psychosis studies) program at the University of Hong Kong, and worked in the field of mental

health as a case intervention officer for the Jockey Club Early Psychosis Project and as the senior manager of the Early Psychosis Foundation, which provides case management services, intervention work, carers' education, psychoeducation, and public awareness programs. She is experienced in individual and group-based life coaching intervention as well as active in research related to mental health and evidence-based interventions.

Eric Yu-hai CHEN is Chi-Li Pao Foundation Professor of Psychiatry and head of the Department of Psychiatry at the University of Hong Kong. He is also president of the Hong Kong College of Psychiatrists. He was educated at Oxford University and Edinburgh University and has been leading the development of early intervention for psychosis projects in Hong Kong since 2001 (the EASY program is one of the first comprehensive early psychosis programs in Asia). He also led the successful large-scale Jockey Club Early Psychosis Project for adult-onset psychosis in Hong Kong from 2009 to 2015. Under his leadership, the HKU Psychosis Research Unit (PSI) has made important contributions to the field through long-term clinical studies. Professor Chen has also been studying the brain mechanisms of schizophrenia, particularly those related to language processes and cognitive functions. Results of these studies have been published in over 250 academic papers and book chapters. In 2014, he was awarded the prestigious Richard Wyatt Award by the International Early Psychosis Association (IEPA) for his contributions to early interventions for psychosis. Professor Chen has served as the vice-president of the International Early Psychosis Association (with more than 2,000 members worldwide) and on the board of directors of the Schizophrenia International Research Society (SIRS), the most prestigious academic society in the field. He also founded the Asian Network for Early Psychosis (ANEP). Previously, he was a visiting professor at the Medical School and the Institute of Mental Health, Singapore.