

MODULE 4

Understanding Resilience and Recovery From the Consumer Perspective

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“...the initiative [Pennsylvania’s] to reduce the use of seclusion and restraint is part of a broader effort to reorient the State mental health system toward a consumer-focused philosophy that emphasizes recovery and independence.”

—Charles G. Curie, Administrator, SAMHSA

Learning Objectives

Upon completion of this module the participant will be able to:

- Define resilience.
- List characteristics of resilient people.
- Define recovery and list the eight assumptions of recovery.
- Effectively implement recovery and resilience strategies that lead to the elimination of seclusion and restraint.

MODULE 4: UNDERSTANDING RESILIENCE AND RECOVERY FROM THE CONSUMER PERSPECTIVE

Background for the Facilitators	4
Presentation (2 hours, 45 minutes)	6
Overview	6
Resilience	7
<i>Exercise: Someone Who Believed in Them (20 minutes)</i>	9
Recovery	11
<i>Exercise: "Recovery as a Journey of the Heart" (35 minutes)</i>	13
<i>Exercise: "What Are We Recovering From?" (15 minutes)</i>	16
<i>Journal/Take Action Challenge (20 minutes)</i>	18
Handouts for Participants	19
Journal and Take Action Challenges for Modules 3 & 4	19
Someone Who Believed in Them Helped Them to Recover	20
Recovery as a Journey of the Heart	23
Recovery From Mental Illness—Guiding Vision	30
Resources: Self-Help Guides	43
References	44

BACKGROUND FOR THE FACILITATORS: RESILIENCE AND RECOVERY FROM THE CONSUMER PERSPECTIVE

Overview

This module will explain the concepts of resilience and recovery and how they relate to the elimination of seclusion and restraint.

Resilience and recovery inspire hope. Both are empowering. Direct care staff and consumers working together can “beat the odds,” and develop healthy lifestyles that do not include the use of seclusion and restraint. A shift from deficit to strength-based assets of consumers can also lend itself to the reduction and elimination of seclusion and restraint. Perhaps Dr. Pat Deegan (2001) says it best: “Professionals who learn to collaborate with the active, resilient, adaptive self of the client will find themselves collaborating in new and rewarding ways with people who may have been viewed as hopeless by others.”

Resilience

In the 1980s, researchers examined risk factors underlying issues such as substance abuse, mental illness, teenage pregnancy, suicide, and problem behaviors. However, identifying risk factors does not provide enough information nor does it account for success stories.

The term “resilience” was originally borrowed from the engineering field and adapted for use in social services. The engineering term refers to how much volume and weight (risk) a bridge can sustain before incurring damage. In the mental health field, no agreement on a single definition of resilience has been reached. However, it generally means the ability to bounce back after adversity (Resnick, 2000).

The stories are countless of people who, in spite of all expectations and overwhelming odds against them, are healthy and are contributing positively to society. The common variable in increasing resilience is a positive connection with another human being. Oftentimes, people who have overcome enormous adversity in their lives can pinpoint a single person who made the difference for them. It is a person who took the time to listen, who believed in them and offered them hope. The person may not have even been trying to increase the other person’s resilience—it just happened.

Other science-based factors which contribute to resilience include caring relationships, high expectations, adequate support, and opportunities to contribute. These factors might seem quite obvious and based on common sense. Indeed, they are. As humans, we all want opportunities to belong, to be supported, and to contribute.

We all have the capacity to increase resilience for people diagnosed with mental illnesses, their families, and caregivers. This section on resilience is meant to inspire and encourage all of us to internalize hope and pass it on to others. Included in this section are definitions of resilience, a personal story of resilience, and characteristics of resilient people.

Recovery

Since the 1980s much has been written about recovery from the consumer's, family member's, and mental health worker's perspectives. Recovery is based on the assumption that people diagnosed with mental illnesses can and do become healthy and live meaningful lives. The emergence of recovery as a philosophy in mental health came from the writings and practices of the consumer movement. People diagnosed with mental illnesses challenged the myth that the most they could hope for was stability. Mental health workers initially dismissed the idea of recovery until Yale researchers did a study of "chronic schizophrenics" who were deinstitutionalized from Vermont State hospitals. The hospital staff had deemed these "patients" hopeless and helpless—they could not even dress themselves. The researchers asked the "patients" what they would need to get out of the hospital and they told them—jobs, friends, and a decent place to live. Almost 25 years later, one-half to two-thirds of the "patients" showed no signs of schizophrenia (DeSisto et al., 1995).

Many have adopted recovery as a viable model. Empirical evidence has supported the positive outcomes of an individualized recovery process that includes hope, personal responsibility, education, advocacy, empowerment, and respect (Anthony, 1993; Deegan, 1988; Leete, 1989; Unzicker, 1989). "All services for those with a mental disorder should be consumer oriented and focused on promoting recovery" (*Mental Health: A Report of the Surgeon General*, 1999, p. 455).

It is important for mental health workers to communicate that recovery is possible and to verbalize hope. "Hearing from a mental health professional that recovery is an achievable goal can make a tremendous difference in a person's approach to treatment and success" (Courtenay Harding, Ph.D., Director of the Institute for the Study of Human Resilience, Boston University, 2001).

We all have our own processes of recovery, whether we are people diagnosed with a mental illness, a family member, or a mental health worker. Recovery may include the use of the following tools: building and sustaining a strong support system; developing an individualized plan to monitor and respond to symptoms; accessing good medical care and treatment which may or may not include medication; and developing and maintaining positive coping mechanisms to support everyday life that enhance wellness. Recovery is a self-empowering concept and critical to the successful collaboration between people diagnosed with mental illnesses and mental health workers.

This section includes a personal story of recovery, definitions of recovery, assumptions of recovery, identification of what people are recovering from, and principles on which psychosocial rehabilitation is based. We encourage you to add your own stories of recovery when applicable.

PRESENTATION



Welcome participants, review names, and make sure everyone has a nametag or name tent. It may be helpful to provide a quick review of Module 3: Creating Cultural Change. Allot time to complete Journal/Take Action Challenges covering Modules 3 and 4.

Learning Objectives

Upon completion of this module the participant will be able to:

- Define resilience
- List characteristics of resilient people
- Define recovery and list the eight assumptions of recovery
- Effectively implement recovery and resilience strategies that lead to the elimination of seclusion and restraint.

Overview

- This module will explain the concepts of resilience and recovery and how they are related to the elimination of seclusion and restraint.
- Words are so powerful. They can hurt or they can help. Choosing words that help—like recovery, resilience, and hope—are useful.
- Recovery and resilience inspire hope.
- Resilience and recovery empower people diagnosed with a mental illness.

- Using resilience and recovery means a paradigm shift from deficit to strength-based approaches.
- Assets of consumers assist in reducing and eliminating seclusion and restraint.
- There is no agreement on the definition of resilience in the mental health field. Generally, it means the ability to bounce back after adversity.
- There are countless stories of people diagnosed with mental illnesses who, in spite of all expectations and overwhelming odds, are healthy and contributing positively to society.
- One common variable in increasing resilience is a positive connection with another human being. Very often a person who has overcome adversity can pinpoint a single person who made a difference for them.

Resilience

- There is no one definition of resilience in the literature.
- It is a difficult concept to describe.
- Following are some examples of resilience definitions.

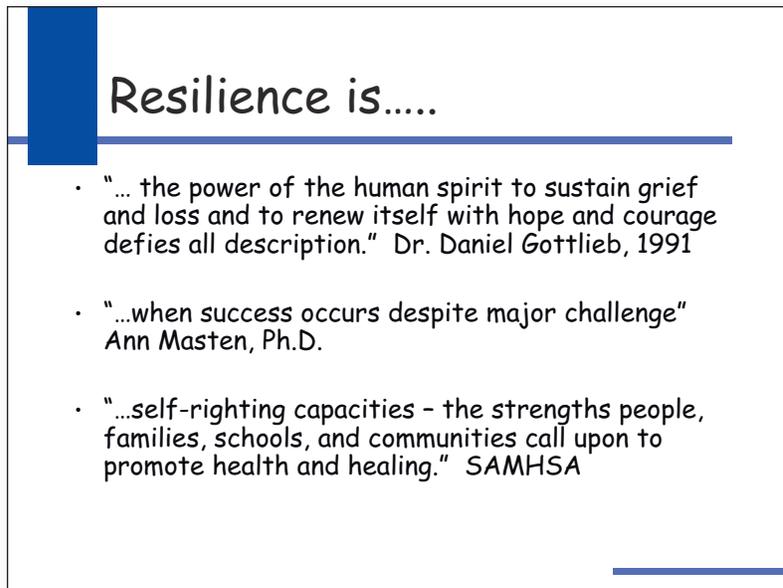
Resilient People Beat the Odds

"Resilient people are those who 'beat the odds.' They have good healthy outcomes, even in the presence of enormous adversities in their lives."

Michael Resnick, Ph.D., 2000

- Dr. Resnick is a well-known researcher in the area of adolescent health. His work has been influential in looking at what individuals, schools, and communities can do to promote resilience.
- Researchers used to study what risk factors made it more likely for someone to have health-related problems. Now our focus has changed to what keeps people, particularly young people, from ever developing health-related problems, including mental illness. These characteristics have also been called assets.
- One of the key outcomes of resiliency research has been shifting from a deficit frame of mind to a resilient frame of mind.

- Here are a few definitions of resilience.



Resilience is.....

- "... the power of the human spirit to sustain grief and loss and to renew itself with hope and courage defies all description." Dr. Daniel Gottlieb, 1991
- "...when success occurs despite major challenge" Ann Masten, Ph.D.
- "...self-righting capacities - the strengths people, families, schools, and communities call upon to promote health and healing." SAMHSA

- As you can see, there are many definitions of resilience. What is important to know is that you, as direct care staff, can foster resiliency in consumers diagnosed with mental illnesses.

Exercise/Discussion—Module 4

Someone Who Believed in Them

OBJECTIVE: Participants will identify key concepts of human connection and its role in fostering resilience.

PROCESS: Distribute the handout *Someone Who Believed in Them Helped Them to Recover* and give the participants time to read the article in class.

Ask each participant to think of someone who believed in him or her and inspired him or her with hope during a difficult time. Have them write down three things that the person said or did that were helpful. Ask for volunteers to share their experiences. Facilitate a discussion.

DISCUSSION QUESTIONS: What kinds of relationships help foster resilience?
What characteristics of direct care staff could help consumers to be more resilient?

MATERIALS REQUIRED: *Someone Who Believed in Them Helped Them to Recover* handout

APPROXIMATE TIME REQUIRED: 20 minutes

- Resilience is an interaction of changing the external environment as well as inspiring hope in individuals.
- Research shows the following foster resilience:
 - Caring relationships
 - High expectations
 - Adequate support
 - Opportunities to contribute
- People who are resilient have some common characteristics.



End this section on some kind of positive, inspirational note. You may use the Starfish poem or some of your own materials.

- The following poem is an example of resiliency and how one person can make a difference.

As the old man walked along the beach at dawn,
he noticed a young woman ahead of him picking up
starfish and flinging them back into the sea.
Finally, catching up with her,
he asked why she was doing this.
The answer was that the starfish would die
if left until the morning sun.
"But the beach goes on for miles and there must be
millions of starfish," said the old man.
"How can your effort possibly make a difference?"
The young woman looked at the starfish in her hand,
Threw it to safety in the waves and said,
"It makes a difference to this one!"

Recovery

- Recovery is based on the assumption that people diagnosed with mental illnesses can and do improve, become healthy, and live meaningful lives.
- Recovery initially emerged from the consumer movement in the 1980s.
- Science-based evidence supports a philosophy of recovery.
- The Surgeon General said in 1999, “All services for those with a mental disorder should be consumer oriented and focused on promoting recovery” (US DHHS, 1999).
- The Resources handout has information on how to access *Self-Help Guides for Recovering Your Mental Health*.
- Just as there are many definitions of resilience, there are many definitions of recovery. Here are a few examples:

Recovery is...

...a common human experience and a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills or roles toward our understanding of mental illness (Anthony, 1993).

Recovery is...

..."a process, an outcome, and a vision. We all experience recovery at some point in our lives from injury, from illness, from loss, or from trauma. Recovery involves creating a new personal vision for one's self. (Spaniol, Gagne, & Koehler, 1997).

- Pat Deegan, Ph.D., has written and spoken extensively about recovery.
- Dr. Deegan is associated with Boston University's Institute for the Study of Resilience.
- For those of you who are interested, you may want to visit her Web site at www.patdeegan.com. Many of her articles and speeches are available online and serve as an excellent resource for consumers as well as staff.
- We recommend using the video *Recovery as a Journey of the Heart* by Pat Deegan. To obtain a copy of the video, contact Dr. Deegan at pat@patdeegan.com or at Pat Deegan, Ph.D., & Associates, LLC, P.O. Box 208, Bayfield, MA, 01922.

Exercise/Discussion—Module 4

“Recovery as a Journey of the Heart”

OBJECTIVE: Participants will identify key concepts of recovery from a personal recovery story.

Participants will uncover their own biases about the recovery process for people diagnosed with mental illnesses.

PROCESS: Distribute the handout *Recovery as a Journey of the Heart*.

Play the 13-minute excerpt from *Recovery as a Journey of the Heart* video.

Ask each participant to write down three things that promote and three things that hinder recovery.

Divide the group into four or five smaller groups and have each person share their findings. Tell each group to pick a recorder to keep track of the responses and a reporter who will report the major themes back to the larger group.

Have each group report to the larger group. If time allows, facilitate a large group discussion.

DISCUSSION QUESTIONS:

- What were the similarities among all the groups?
- We are all recovering from something. What have your own experiences of recovery been like?

MATERIALS REQUIRED:

- Video—*Recovery as a Journey of the Heart*
- A copy of the *Recovery as a Journey of the Heart* article for each participant.

APPROXIMATE

TIME REQUIRED: 35 minutes

- We are all recovering from something.
- Bill Anthony, Ph.D., has also written extensively about recovery. Dr. Anthony is associated with Boston University's Center for Psychiatric Rehabilitation.
- For those of you who may be unfamiliar with his work, you may want to visit his Web site at www.bu.edu/cpr. Several of his articles and speeches are available online and are great resources for both consumers and staff.
- In 1993, he wrote a seminal article outlining the assumptions of recovery.



Distribute the article by Bill Anthony, Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. (Please read the article so you as the facilitator can discuss each of these assumptions. Instruct participants to read it on their own time.)

Recovery Assumptions

1. Recovery can occur without professional intervention.
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
3. A recovery vision is not a function of one's theory about the causes of mental illness.
4. Recovery can occur even though symptoms reoccur.

- #1 – Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery. The task of consumers is to recover. What prompts recovery is not just an array of mental health services. It is essential to have adult education, sports, clubs, churches, self-help groups, families, and friends.
- #2 – Individuals need people who believe in them and can be there in time of need.
- #3 – The cause of the mental illness does not matter.
- #4 – Mental illness is episodic in nature. Just because an individual has an episode does not mean he or she is not in recovery.

Recovery Assumptions

5. Recovery changes the frequency and direction of symptoms.
6. Recovery does not feel like a linear process.
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.
8. Recovery from a mental illness does not mean that one was not “really mentally ill”.

- #5 – Even though symptoms may reoccur, they are most often less severe and last for a shorter amount of time.
- #6 – Recovery does not feel systematic and planned. Often there are steps forward, then back, and then forward again.
- #7 – The barriers faced when one is categorized as “mentally ill” can be overwhelming. The discrimination in employment and housing and lack of opportunities is disempowering.
- #8 – At times, people who have successfully recovered have been discounted as not having “really” been mentally ill. Individuals in recovery are often not seen as a model, but rather as an aberration or even a fraud.
- All have their own recovery process, whether they are consumers, direct care staff, or family members.
- Even if you have never personally experienced mental illness, you still have a recovery process.
- Because we all have a recovery process, it is important to look at what exactly we are recovering from.

Exercise/Discussion—Module 4

“What Are We Recovering From?”

OBJECTIVE: To increase participants’ awareness that consumers, caregivers, and families each have a recovery process.

PROCESS: On either a chalk board or flip chart, write the question, “What are people diagnosed with a mental illness recovering from?” Have the group brainstorm as many responses as possible.

What Are Consumers Recovering From?

- *Major losses of people and opportunities*
- *The catastrophe of mental illness*
- *Trauma from mistreatment*
- *Negative professional attitudes*
- *Lack of recovery skills of professionals*
- *Devaluing and disempowering programs, practices, and environments*
- *Lack of enriching opportunities*
- *Stigma and discrimination from society*
- *Lack of opportunities for self-determination*
- *Crushed dreams*
- *Lack of a sense of self, valued roles, and hope*

On either a chalk board or flip chart, write the question, “What are direct care staff and/or families recovering from?” Have the group brainstorm as many responses as possible.

Exercise/Discussion—Module 4

“What Are We Recovering From?” (continued)

What Do Direct Care Staff and/or Families Recover From?

- *Worn out beliefs*
- *Hopelessness and helplessness*
- *Need to be in control*
- *An unbalanced relationship*
- *Disbelief in consumer's ability*
- *Fear of mental illness*
- *Discrimination*
- *Hopes and expectations*

DISCUSSION QUESTIONS:

- What are the similarities between the two lists?
- What helps/hinders people in recovery?
- How can you as a professional best assist recovery?
- What advice would you give to a person in the first stages of recovery?
- How do you think professionals view the process of recovery?
- What do you think about individuals speaking out about their mental illness?
- Have you had personal experience(s) with stigma concerning mental illness? How does stigma affect recovery?

**APPROXIMATE
TIME REQUIRED:** 15 minutes

SOURCE: Recovery material from Spaniol, Gagne, & Koehler (1997)

Page 2 of 2

JOURNAL/TAKE ACTION CHALLENGE



Give participants time to respond to one to two questions from the Journal section and at least one question from each of the Personal Take Action Challenges and the Workplace Take Action Challenges. They will use these Take Action Challenges extensively on the last day of the training.

JOURNAL TOPICS AND TAKE ACTION CHALLENGES FOR MODULES 3 & 4

Journal Topics

Pick one or two questions and write your responses. Your responses are confidential.

- What do you like/dislike about cultural change theory?
- When you have been in a stressful situation in the past, what has been helpful for you to hear? What has not been helpful?
- What are words or phrases that you use that might be helpful/hurtful to consumers?
- How do the concepts of recovery relate to you personally?
- What scares and inspires you most about people diagnosed with a mental illness working in the mental health field?
- How could you implement programs based on models of resiliency and recovery?
- How would your daily work change if the mental health system wholeheartedly adopted the underpinnings of resilience and recovery?
- Where do you feel empowered to make changes? Where do you feel disempowered to make changes? What can you do about it?
- What are the unwritten and/or unspoken rules or beliefs about seclusion or restraint in your work environment? Do you agree or disagree with these rules/beliefs? How do these rules/beliefs get perpetuated and what would it take to change them?

Personal Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

- Find one area in your life where you could work on fostering your own resilience or recovery. How would your life look different if you adopted these philosophies?
- Make a list of two things you can personally commit to in your daily life to move you forward in your own resilience and recovery.

Workplace Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

- What do you see as your professional responsibility in changing the culture at work as it pertains to eliminating seclusions and restraint?
- Find one area where you could expand on the philosophy of resilience and recovery philosophy in your daily work. How would it change how you currently interact with consumers? How would things stay the same?
- Make a list of two things that you personally can commit to every day to incorporate resilience and recovery into your work. Make a detailed plan of how you will implement these changes.

Someone Who Believed in Them Helped Them to Recover

by Dan B. Fisher, M.D., Ph.D., National Empowerment Center

People who have significantly recovered from mental illness frequently say they were greatly helped by someone who believed in them. One woman stated that there was a doctor who “Believed in me. She never gave up. She was the only one who didn’t give up as far as [my] being in the hospital.” Another woman stated that for her it was a caring therapist. She said, “He was the first person I encountered out of the ordeal that actually had some sort of feeling. He was sympathetic at least and was understanding. He was really helping me out and motivating. Motivating me to keep on fighting, don’t give up...Don’t let them get their way, just keep on fighting.”

A nurse working with me reflected that the most important elements to her recovery were “Having a mentor, a connection and a relationship...someone I made a strong connection to and they made one to me and they believed in me and I knew it...There was a knowing in their eyes that I saw that said I see you and I really believe in you. Someone that carried me. Somehow that encouraged me to not fall backwards.”

Another woman in describing the residential counselor as the most important person in her recovery stated, “She believed in me...She sent me a card that said, ‘keep up the good work.’ She saw a spark in me. She told me from the start I had a good deal going for me. She helped encourage me and put courage in me. She gave me incentive.”

The people who work in residential services are often the ones whose belief made a difference in someone’s recovery. Jim is an example of such a worker. For 8 years he has patiently and respectably offered his heart and hand to consumer/survivors. Recently he described a priceless moment with a consumer/survivor, Eric, whom everyone else had written off. During a walk with Eric, Jim commented on the beauty of the sky. Eric replied, “It is of no importance to me now; why are you telling me about it.”

Jim was delighted. It was one of the first times that Eric had expressed a strong emotion directly to another person. It was also one of the first times that he stated that his needs were different from those of others. Jim thinks that Eric now feels safe enough to express strong feeling within their relationship. Over several years, Jim has carefully won Eric’s trust through listening to his deepest requests. For instance, Eric has bitterly complained that he has not felt alive on his major tranquilizer. Jim has been able to help Eric to negotiate a much lower dose. Though in the past Eric suffered increased paranoia when his medication was lowered, he has not done so this time. I am sure this is because of his close relationship with Jim which has allowed him to feel safe with greater feelings. Eric has also started to listen to different music. For many years he

Page 1 of 3

Someone Who Believed in Them (continued)

would only listen to heavy metal which Jim felt he needed to listen to because it was needed to drown out his painful thoughts. Now Eric is able to listen to soft rock and folk.

When I asked other staff about Jim they said he reminds them of Yoda, the wise being from *Star Wars*. When he walks into a room everyone feels a sense of calm and peace, yet he can be firm. A consumer called and was abusive to him on the phone. He calmly said, “I won’t talk with you when you treat me that way. When you can have a civil conversation call me back.” In a few minutes she did and they had a productive conversation. He has a sense of humor. One day a consumer was getting very angry on the bus. Others felt threatened, but Jim suddenly burst out laughing and so did the consumer. When I asked Jim what he felt was most important in his relating with consumer-survivors, he said, “I just accept them, the real person. Then they will present more and more of themselves to you.” Such an elusively simple description of the beauty he weaves.

Jim’s manner reminds me deeply of the contact I yearned for and occasionally found in my own journey to recover my own lost self. After a year with an emotionally remote analyst, I sought a different kind of therapist, one that was more human and showed more of himself to me. I made one request at the start of our therapy. “Could you please be a real person with me?” He said he would try to and the combination of his acceptance of my request and his humility planted the roots of trust. There were many tests of our relationship, but he was consistent in his support of me at a deep level. When I told him I wanted to become a psychiatrist he said he would be there for my graduation and he was, even though I was no longer in therapy with him. When I would thank him for an insight he would insist that I had done the work and the healing. He said he had merely provided the setting. When I asked how he felt about my attending a group with another therapist. He said he trusted that I knew what I needed to heal.

Equally compelling is the centering and spiritual renewal coming for the person who does the believing in another. Whether it is for our children, lover, pet, or person in need of help, there is deep meaning for the person who can step outside their world to support another’s. A client I had seen through many hospitalizations recently had a long period free of such episodes. She clearly had a new light in her eye. When I asked what had changed she said now that she was working as a provider she had a sense of meaning and purpose in her life. Helping others gave her sufficient meaning that she felt her life was worth living.

These observations recall the research of Carl Rogers into the nature of the helping relationships. He stated that “the safety of being liked and prized as a person seems a highly important element in a helping relationship” (*On Becoming a Person*, 1961). Martin Buber

Someone Who Believed in Them (continued)

also describes the importance of having someone believe in you. He calls this characteristic “confirming the other...Confirming means accepting the whole potentiality of the other. I can recognize in him the person he has been created to become.” Rogers goes on to State that “if I accept the other person as something fixed, already diagnosed and classified...then I am doing my part to confirm this limited hypothesis. If I accept him as a process of becoming, then I am doing what I can to confirm or make real his potential.

These descriptions, however, were mostly for people with moderate emotional problems. When someone is labeled with mental illness, it is as if all that has been learned to be helpful in therapy is thrown out. Medical students are taught to medicate, not to converse with mental patients. They are told that people labeled with mental illness have a brain disease and you cannot talk to a disease. Our lived experiences speak otherwise. Our lives show that people labeled with mental illness need a therapist and other people who believe in them.

We, who have been labeled with mental illness, remain just as human if not more so than others who are temporarily not labeled. Our needs are human needs of which the most basic is to enter into trusting, loving, and caring relationships. These relationships need to be nurtured and cultivated for us to find the compass of our true self to guide our recovery. Any system of care which disturbs or interferes with these relationships is preventing, not promoting, recovery.

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Recovery as a Journey of the Heart

by Patricia E. Deegan Ph.D.

... We pass on knowledge about mental illness. Students emerge from school with knowledge about neurotransmitters and schizophrenics and bipolars and borderlines and multiples and OCDs. They become experts in recognizing illness and disease. But this is where we so often fail them. We fail them because we have not taught them to seek wisdom—to move beyond mere recognition in order to seek the essence of what is. We have failed to teach them to reverence the human being who exists prior to and in spite of the diagnosis we have placed upon them. Just as the generic, anatomical heart does not exist, neither does “the schizophrenic” or “the multiple” or the “bipolar” exist outside of a generic textbook. What exists, in the truly existential sense, is not an illness or disease. What exists is a human being, and wisdom demands that we see and reverence this human being before all else. Wisdom demands that we wholeheartedly enter into a relationship with human beings in order to understand them and their experience. Only then are we able to help in a way that is experienced as helpful.

Those of us who have been labeled with mental illness are first and foremost human beings. We are more than the sum of the electrochemical activity of our brains. Our hearts are not merely pumps. Our hearts are as real and as vulnerable and valuable as yours are. We are people. We are people who have experienced great distress and who face the challenge of recovery.

The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. Like a pebble tossed into the center of a still pool, this simple fact radiates in ever larger ripples until every corner of the academic and applied mental health science and clinical practice are affected. Those of us who have been diagnosed are not objects to be acted upon. We are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have become self-determining. We can take a stand toward what is distressing to us and need not be passive victims of an illness. We can become experts in our own journey of recovery.

The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes.

The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. The philosopher Martin Heidegger said that to be human means to be a question in search of an answer. Those of us who have been labeled with mental illness are not de facto

Page 1 of 7

Recovery as a Journey of the Heart (continued)

excused from this most fundamental task of becoming human. In fact, because many of us have experienced our lives and dreams shattering in the wake of mental illness, one of the most essential challenges that faces us is to ask, “Who can I become and why should I say ‘yes’ to life?”

To be human means to be a question in search of an answer. However, many of us who have been psychiatrically labeled have received powerful messages from professionals who in effect tell us that by virtue of our diagnosis the question of our being has already been answered and our futures are already sealed. For instance, I can remember such a time during my third hospitalization. I was 18 years old. I asked the psychiatrist I was working with, “What’s wrong with me?” He said, “You have a disease called chronic schizophrenia. It is a disease that is like diabetes. If you take medications for the rest of your life and avoid stress, then maybe you can cope.” And as he spoke these words I could feel the weight of them crushing my already fragile hopes and dreams and aspirations for my life. Even some 22 years later those words still echo like a haunting memory that does not fade.

Today I understand why this experience was so damaging to me. In essence the psychiatrist was telling me that my life, by virtue of being labeled with schizophrenia, was already a closed book. He was saying that my future had already been written. The goals and dreams that I aspired to were mere fantasies according to his prognosis of doom. When the future has been closed off in this way, then the present loses its orientation and becomes nothing but a succession of unrelated moments. Today I know that this psychiatrist had little wisdom at that time. He merely had some knowledge and recognized me as “the schizophrenic” who had been handed down through the generations by Kraepelin and Bleuler. He did not see me. He saw an illness. We must urge our students to seek wisdom, to move beyond mere recognition of illness and to wholeheartedly encounter the human being who comes for help. It is imperative that we teach students that relationship is the most powerful tool they have in working with people.

Beyond the goals of recovery, there is the question of the process of recovery. How does one enter into the journey of recovery? Today I would like to begin a conceptualization of recovery as a journey of the heart. We will begin in that place where many people find themselves—in that place of being hard of heart and not caring anymore.

Prior to becoming active participants in our own recovery process, many of us find ourselves in a time of great apathy and indifference. It is a time of having a hardened heart. Of not caring anymore. It is a time when we feel ourselves to be among the living dead: alone, abandoned, and adrift on a dead and silent sea without course or bearing. If I turn my gaze back

Recovery as a Journey of the Heart (continued)

I can see myself at 17 years old, diagnosed with chronic schizophrenia, drugged on Haldol and sitting in a chair. As I conjure the image, the first thing I can see are the girl's yellow, nicotine-stained fingers. I can see her shuffled, stiff, drugged walk. Her eyes do not dance. The dancer has collapsed and her eyes are dark and they stare endlessly into nowhere.

...During this time people would try to motivate me. I remember people trying to make me participate in food shopping on Wednesday or to help bake bread or to go on a boat ride. But nothing anyone did touched me or moved me or mattered to me. I had given up. Giving up was a solution for me. The fact that I was "unmotivated" was seen as a problem by the people who worked with me. But for me, giving up was not a problem, it was a solution. It was a solution because it protected me from wanting anything. If I didn't want anything, then it couldn't be taken away. If I didn't try, then I wouldn't have to undergo another failure. If I didn't care, then nothing could hurt me again. My heart became hardened. The springs came and went and I didn't care. Holidays came and went and I didn't care. My friends went off to college and started new lives and I didn't care. I remember sitting and smoking and saying almost nothing. And as soon as the clock struck 8, I remember interrupting my friend in mid-sentence and telling her to go home because I was going to bed. Without even saying good-bye, I headed for my bed. My heart was hard. I didn't care about anything.

I trust that the picture I am painting here is familiar to many of us. We recognize this picture of apathy, withdrawal, isolation, and lack of motivation. But if we go beyond mere recognition in search of wisdom we must dig deeper. What is this apathy, indifference, hardness of heart which keeps so many people in a mode of survival and prevents them from actively entering into their own journey of recovery? Is it merely the negative symptoms of schizophrenia? I think not. I believe that becoming hard of heart and not caring anymore is a strategy that desperate people, who are at the brink of losing hope, adopt in order to remain alive.

Hope is not just a nice sounding euphemism. Hope and biological life are inextricably intertwined. Martin Seligman's (1975) work in the field of learned helplessness offers us great insight into the chiasmic intertwining of hope and biological life.

...I would say that when those of us with psychiatric disabilities come to believe that all of our efforts are futile. When we experience that we have no control over our environment; when nothing we do seems to matter or to make the situation better; when we follow the treatment team's instructions and achieve their treatment goals for us and still no placement opens up in the community for us; when staff decide where we will live, with whom we will live, under what rules we will live, how we will spend our money, if we will be allowed to spend our money, when we will have to leave the group home, and at what time we will be

Recovery as a Journey of the Heart (continued)

allowed back into it, then a deep sense of hopelessness, of despair, begins to settle over the human heart. And in an effort to avoid the biologically disastrous effects of profound hopelessness, people with psychiatric disabilities do what other people do. We grow hard of heart and attempt to stop caring. It is safer to become helpless than to become hopeless.

Of course, the great danger is that staff will fail to recognize the intensity of the existential struggle that the person who is hard of heart is struggling with. The danger is that the staff will simply say, “Oh, this person just has a lot of negative signs and symptoms and that’s a poor prognosis and we mustn’t expect much from this person.” Or staff may become judgmental and dismiss us as simply being lazy and unmotivated. Or the staff may succumb to their own despair and simply write us off as being “low functioning.”

...However the staff must not fall into despair, feel like their efforts are futile, grow hard of heart, and stop caring themselves. If they do this, then they are doing exactly what the person with a psychiatric disability is doing. Staff must avoid this trap. They must do what the person cannot yet do. Staff must role model hope and continue to offer options and choices even if they are rejected over and over again.

Additionally, environments must include opportunities for people to have accurate information. Information is power and information sharing is power sharing. People who feel powerless can increase their sense of self-efficacy by having access to information. People who feel powerless also feel that what they say does not matter. Taking the time to listen to people and to help them find their own unique voice is important. Having a voice in developing rules as well as having a say in the hiring and evaluation of staff are important ways of exercising a voice that for too long has been silenced. Finally, it is important to have other people with psychiatric disabilities working as paid staff.

Role models provide hope that maybe I, too, can break out of this hardened heart and begin to care again. People who are defending themselves against the possibly lethal effects of profound hopelessness must see that there is a way out and that actions they take can inch them ever closer to their desired goal. They need to see that the quality of life can get better for people who have been similarly diagnosed. They need to see that there are opportunities for improving their situation. That is why hiring people with psychiatric disabilities as mental health professionals and staff is so important. It is also why exposure to peer support, self help, and mutual support are so important.

Choice, options, information, role models, being heard, developing and exercising a voice, opportunities for bettering one’s life: these are the features of a human interactive environment which support the transition from not caring to caring, from surviving to becoming an

Recovery as a Journey of the Heart (continued)

active participant in one’s own recovery process. Creating such environments are the skills which tomorrow’s mental health professionals must master.

As for myself, I cannot remember a specific moment when I turned that corner from surviving to becoming an active participant in my own recovery process. My efforts to protect my breaking heart by becoming hard of heart and not caring about anything lasted for a long time. One thing I can recall is that the people around me did not give up on me. They kept inviting me to do things. I remember one day, for no particular reason, saying “yes” to helping with food shopping. All I would do was push the cart. But it was a beginning. And truly, it was through small steps like these that I slowly began to discover that I could take a stand toward what was distressing to me.

I know that anger, especially angry indignation, played a big role in that transition. When that psychiatrist told me the best I could hope for was to take my medications, avoid stress, and cope, I became enraged. (However, I was not smart enough to keep my angry indignation to myself because the #1 rule is never get enraged in a psychiatrist’s office if you’re being labeled with chronic schizophrenia!) I also remember that just after that visit I made up my mind to become “a doctor.” I was so outraged at the things that had been done to me against my will in the hospital as well as the things I saw happen to other people, that I decided that I wanted to get a powerful degree and have enough credentials to run a healing place myself. In effect I had a survivor mission that I felt passionately about.

I was also careful not to share my newfound aspiration with anyone. Imagine what my psychiatrist would have said to me if I had announced at age 18, having virtually flunked out of high school, with a combined GRE score of under 800, with a diagnosis of chronic schizophrenia, that I was planning on getting my Ph.D. in clinical psychology. “Delusions of grandeur!” But in essence that is precisely what I did. Starting with one course in English Composition at the local community college, I slowly made my way. Dragging my textbooks into the mental hospital with me or trying to read with double vision due to Prolixin, I inched my way forward. I had a strong spirituality that really helped. I had a strong therapeutic alliance with a psychotherapist. I lived with latter-day hippies who had tolerance for lots of weird behavior, including my psychotic episodes. After some experimenting in my early teens, I somehow intuited that drugs and alcohol were bad news for me and I did not use them even though the people around me did. In retrospect, I know this was a wise decision. I read books about healing and psychopathology and personality theory in an effort to understand myself and my situation. I was always trying new ways of coping with symptoms, including my relentless auditory hallucinations. And perhaps most importantly of all, when I got out of bed in the morning, I always knew the reason why—I had a purpose in life, I had been called, I had

Recovery as a Journey of the Heart (continued)

a vocation, and I kept saying yes to it. Even in the present I must make a daily affirmation of my vocation in order to keep going. The temptation to give up is still strong sometimes.

My journey of recovery is still ongoing. I still struggle with symptoms, grieve the losses that I have sustained, and have had to get involved in treatment for the sequel child abuse. I am also involved in self help and mutual support and I still use professional services including medications, psychotherapy, and hospitals. However, now I do not just take medication or go to the hospital. I have learned to use medications and to use the hospital. This is the active stance that is the hallmark of the recovery process.

There is more to the recovery process than simply recovering from mental illness. We must also recover from the effects of poverty and second class citizenship. We must learn to raise our consciousness and find our collective pride in order to overcome internalized stigma. Finally, many of us emerge from mental health treatment settings with traumatic stress disorders related to having sustained or witnessed physical, sexual, and/or emotional abuse at the hands of staff. “Sometimes I scream at night because I dream about the hospital I was raped in or some other hospital I’ve been in” (LaLime, 1990). Sometimes recovering from mental illness is the easy part. Recovering from these deep wounds to the human heart takes longer.

Recovery does not mean “cure.” It does not mean stabilization or maintenance. Rather recovery is an attitude, a stance, and a way of approaching the day’s challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting, and regrouping. Each person’s journey of recovery is unique. Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again. In order to support the recovery process, mental health professionals must not rob us of the opportunity to fail. Professionals must embrace the concept of the dignity of risk and the right to failure if they are to be supportive of us.

A new age is upon us. ...Understanding that people with psychiatric disabilities are first and foremost people who are in process, growing, and changing is the cornerstone of understanding the concept of recovery. We must not let our hearts grow hard and callused toward people with psychiatric disabilities. Our role is not to judge who will and will not recover. Our job is to create environments in which opportunities for recovery and empowerment exist. Our job is to establish strong, supportive relationships with those we work with. And perhaps most of all, our greatest challenge is to find a way to refuse to be dehumanized in the age of managed profit and to be bold and brave and daring enough to remain human hearted while working in the human services.

Recovery as a Journey of the Heart (continued)

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Recovery From Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s

by William A. Anthony

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Abstract: The implementation of deinstitutionalization in the 1960s and 1970s, and the increasing ascendance of the community support system concept and the practice of psychiatric rehabilitation in the 1980s, have laid the foundation for a new 1990s vision of service delivery for people who have mental illness. Recovery from mental illness is the vision that will guide the mental health system in this decade. This article outlines the fundamental services and assumptions of a recovery-oriented mental health system. As the recovery concept becomes better understood, it could have major implications for how future mental health systems are designed.

The seeds of the recovery vision were sown in the aftermath of the era of deinstitutionalization. The failures in the implementation of the policy of deinstitutionalization confronted us with the fact that a person with severe mental illness wants and needs more than just symptom relief. People with severe mental illnesses may have multiple residential, vocational, educational, and social needs and wants. Deinstitutionalization radically changed how the service system attempts to meet these wants and needs. No longer does the State hospital attempt to meet these multiple wants and needs; a great number of alternative community-based settings and alternative inpatient settings have sprung up since deinstitutionalization. This diversity has required new conceptualizations both of how services for people with severe mental illnesses should be organized and delivered, and of the wants and needs of people with severe mental illness. This new way of thinking about services and about the people served has laid the foundation for the gradual emergence of the recovery vision in the 1990s.

As a prelude to a discussion of the recovery vision, the present paper briefly describes the community support system (CSS) concept and the basic services integral to a comprehensive community support system. Next, the more thorough understanding of the total impact of severe mental illness, as conceptualized in the rehabilitation model, is succinctly overviewed. With the CSS service configuration and the rehabilitation model providing the historical and conceptual base, the recovery concept, as we currently understand it, is then presented.

Page 1 of 13

Recovery From Mental Illness—Guiding Vision (continued)

The Community Support System

In the mid-1970s, a series of meetings at the National Institute of Mental Health (NIMH) gave birth to the idea of a community support system (CSS), a concept of how services should be provided to help persons with long-term psychiatric disabilities (Turner & Ten-Hoor, 1978). Recognizing that post-deinstitutionalization services were unacceptable, the CSS described the array of services that the mental health system needed for persons with severe psychiatric disabilities (Stroul, 1989). The CSS filled the conceptual vacuum resulting from the aftermath of deinstitutionalization (Test, 1984). The CSS was defined (Turner & Schifren, 1979, p. 2) as “a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.” The CSS concept identifies the essential components needed by a community to provide adequate services and support to persons who are psychiatrically disabled.

The essential components of a CSS have been demonstrated and evaluated since its inception. Test (1984) concluded from her review that programs providing more CSS functions seem to be more effective (with fewer rehospitalizations and improved social adjustment in some cases) than programs that provide fewer CSS functions. More recently, Anthony and Blanch (1989) reviewed data relevant to CSS and concluded that research in the 1980s documented the need for the array of services and supports originally posited by the CSS concept. It appears that the need for the component services of CSS has a base in empiricism as well as in logic. Most comprehensive mental health system initiatives in the 1980s can be traced to the CSS conceptualization (National Institute of Mental Health, 1987).

Based on the CSS framework, the Center for Psychiatric Rehabilitation has refined and defined the services fundamental to meeting the wants and needs of persons with long-term mental illness. Table 1 presents these essential client services.

The Impact of Severe Mental Illness

This new understanding of the importance of a comprehensive, community-based service system is based on a more thorough and clear understanding of that system’s clients. The field of psychiatric rehabilitation, with its emphasis on treating the consequences of the illness rather than just the illness per se, has helped bring to this new service system configuration a more complete understanding of the total impact of severe mental illness. The psychiatric rehabilitation field relied on the World Health Organization’s 1980 classification of the consequences of disease to provide the conceptual framework for describing the impact of severe mental illness (Frey, 1984).

*Recovery From Mental Illness—Guiding Vision (continued)***Table 1**
Essential Client Services in a Caring System

Service Category	Description	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services client needs and wants	Services accessed
Rehabilitation	Developing clients' skills and support related to client's goals	Role functioning
Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things client needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment

Adapted from Cohen, A B., Nemec, P.B., Farkas, M.D., & Forbess, R, (1990). Psychiatric rehabilitation training technology. Case management (trainer package). Boston: Boston University, Center for Psychiatric Rehabilitation.

In the 1980s, proponents of psychiatric rehabilitation emphasized that mental illness not only causes mental impairments or symptoms but also causes the person significant functional limitations, disabilities, and handicaps (Anthony, 1982; Anthony & Liberman, 1986; Anthony, Cohen, & Farkas, 1990; Cohen & Anthony, 1984). The World Health Organization (Wood, 1980), unlike mental health policymakers, had already developed a model of illness which incorporated not only the illness or impairment but also the consequences of the illness (disability and handicap). As depicted in Table 2, these terms can be reconfigured as impairment, dysfunction, disability, and disadvantage. This conceptualization of the impact of severe mental illness has come to be known as the rehabilitation model (Anthony, Cohen, & Farkas, 1990).

Recovery From Mental Illness—Guiding Vision (continued)

The development of the concept of a comprehensive community support system, combined with the rehabilitation model's more comprehensive understanding of the impact of severe mental illness, has laid the conceptual groundwork for a new vision for the mental health service system of the 1990s. Based on the insights of the 1970s and 1980s, service delivery promoting recovery from programs and systems will be guided by a vision of promoting recovery from mental illness (Anthony, 1991).

Table 2
The Negative Impact of Severe Mental Illness

Stages	I. Impairment	II. Dysfunction	III. Disability	IV. Disadvantage
Definitions	Any loss or abnormality of psychological, physiological, or anatomical structure or function	Any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being	Any restriction or lack of ability to perform a role in the manner or within the range considered normal for a human being	A lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual
Examples	Hallucinations, delusions, depression	Lack of work adjustment skills, social skills, ADL skills	Unemployment, homelessness	Discrimination and poverty

Adapted from Anthony, W.A, Cohen, M.R., & Farkas, M.D. (1990). *Psychiatric rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Recovery: The Concept

The concept of recovery, while quite common in the field of physical illness and disability (Wright, 1983), has heretofore received little attention in both practice and research with people who have a severe and persistent mental illness (Spaniol, 1991). The concept of recovery from physical illness and disability does not mean that the suffering has disappeared, all the symptoms removed, and/or the functioning completely restored (Harrison, 1984). For example, a person with paraplegia can recover even though the spinal cord has not. Similarly, a person with mental illness can recover even though the illness is not “cured.”

Recovery From Mental Illness—Guiding Vision (continued)

In the mental health field, the emerging concept of recovery has been introduced and is most often discussed in the writings of consumers/survivors/clients (Anonymous, 1989; Deegan, 1988; Houghton, 1982; Leete, 1989; McDermott, 1990; Unzicker, 1989). Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being, from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.

Recovery is what people with disabilities do. Treatment, case management, and rehabilitation are what helpers do to facilitate recovery (Anthony, 1991). Interestingly, the recovery experience is not an experience that is foreign to services personnel. Recovery transcends illness and the disability field itself. Recovery is a truly unifying human experience. Because all people (helpers included) experience the catastrophes of life (death of a loved one, divorce, the threat of severe physical illness, and disability), the challenge of recovery must be faced. Successful recovery from a catastrophe does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever. Successful recovery does mean that the person has changed, and that the meaning of these facts to the person has therefore changed. They are no longer the primary focus of one's life. The person moves on to other interests and activities.

Recovery: The Outcome

Recovery may seem like an illusory concept. We still know very little about what this process is like for people with severe mental illness. Yet many recent intervention studies have in fact measured elements of recovery, even though the recovery process went unmentioned. Recovery is a multi-dimensional concept: there is no single measure of recovery, but many different measures that estimate various aspects of it. The recovery vision expands our concept of service outcome to include such dimensions as self-esteem, adjustment to disability, empowerment, and self-determination. However, it is the concept of recovery, and not the many ways to measure it, that ties the various components of the field into a single vision. For service providers, recovery from mental illness is a vision commensurate with researchers' vision of curing and preventing mental illness. Recovery is a simple yet powerful vision (Anthony, 1991).

*Recovery From Mental Illness—Guiding Vision (continued)***A Recovery-Oriented Mental Health System**

A mental health service system that is guided by the recovery vision incorporates the critical services of a community support system organized around the rehabilitation model’s description of the impact of severe mental illness—all under the umbrella of the recovery vision. In a recovery-oriented mental health system, each essential service is analyzed with respect to its capacity to ameliorate people’s impairment, dysfunction, disability, and disadvantage (see Table 3).

Table 3 provides an overview of the major consumer outcome focus of the essential community support system of services. The services mainly directed at the impairment are the traditional “clinical” services, which in a recovery-oriented system deal with only a part of the impact of severe mental illness (i.e., the symptoms). Major recovery may occur without complete symptom relief. That is, a person may still experience major episodes of symptom exacerbation, yet have significantly restored task and role performance and/or removed significant opportunity barriers. From a recovery perspective, those successful outcomes may have led to the growth of new meaning and purpose in the person’s life.

Recovery-oriented system planners see the mental health system as greater than the sum of its parts. There is the possibility that efforts to affect the impact of severe mental illness positively can do more than leave the person less impaired, less dysfunctional, less disabled, and less disadvantaged. These interventions can leave a person not only with “less,” but with “more”—more meaning, more purpose, more success, and more satisfaction with one’s life. The possibility exists that the outcomes can be more than the specific service outcomes of, for example, symptom management and relief, role functioning, services accessed, entitlements assured, etc. While these outcomes are the *raison d’être* of each service, each may also contribute in unknown ways to recovery from mental illness. A provider of specific services recognizes, for example, that symptoms are alleviated not only to reduce discomfort, but also because symptoms may inhibit recovery; that crises are controlled not only to assure personal safety, but also because crises may destroy opportunities for recovery; that rights protection not only assures legal entitlements, but also that entitlements can support recovery. As mentioned previously, recovery outcomes include more subjective outcomes such as self-esteem, empowerment, and self-determination.

Basic Assumptions of a Recovery-Focused Mental Health System

The process of recovery has not been researched. The vagaries of recovery make it a mysterious process, a mostly subjective process begging to be attended to and understood. People with severe disabilities (including psychiatric disabilities) have helped us glimpse the process through their words and actions (Weisburd, 1992). In addition, all of us have directly experienced the recovery process in reaction to life’s catastrophes. Based on information gained from the above, a series of assumptions about recovery can be identified.

Page 6 of 13

Recovery From Mental Illness—Guiding Vision (continued)

**Table 3
Focus of Mental Health Services**

Recovery development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.				
	Impact of Severe Mental Illness			
Mental Health Services (and Outcomes)	Impairment (Disorder in thought, feelings, and behavior)	Dysfunction (Task performance limited)	Disability (Role performance limited)	Disadvantage (Opportunity restrictions)
Treatment (Symptom relief)	X			
Crises Intervention (Safety)	X			
Case Management (Access)	X	X	X	X
Rehabilitation (Role functioning)		X	X	X
Enrichment (Self-development)		X	X	X
Rights Protection (Equal opportunity)				X
Basic Support (Survival)				X
Self-Help (Empowerment)			X	X

1. Recovery can occur without professional intervention. Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer’s natural support system. After all, if recovery is a common human condition experienced by us all, then

Recovery From Mental Illness—Guiding Vision (continued)

people who are in touch with their own recovery can help others through the process. Self-help groups, families, and friends are the best examples of this phenomenon.

It is important for mental health providers to recognize that what promotes recovery is not simply the array of mental health services. Also essential to recovery are non-mental health activities and organizations, e.g., sports, clubs, adult education, and churches. There are many paths to recovery, including choosing not to be involved in the mental health system.

2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery. Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need. People who are recovering talk about the people who believed in them when they did not even believe in themselves, who encouraged their recovery but did not force it, who tried to listen and understand when nothing seemed to be making sense. Recovery is a deeply human experience, facilitated by the deeply human responses of others. Recovery can be facilitated by any one person. Recovery can be everybody's business.
3. A recovery vision is not a function of one's theory about the causes of mental illness. Whether the causes of mental illness are viewed as biological and/or psychosocial generates considerable controversy among professionals, advocates, and consumers. Adopting a recovery vision does not commit one to either position on this debate, nor on the use or nonuse of medical interventions. Recovery may occur whether one views the illness as biological or not. People with adverse physical abnormalities (e.g., blindness, quadriplegia) can recover even though the physical nature of the illness is unchanged or even worsens.
4. Recovery can occur even though symptoms reoccur. The episodic nature of severe mental illness does not prevent recovery. People with other illnesses that might be episodic (e.g., rheumatoid arthritis, multiple sclerosis) can still recover. Individuals who experience intense psychiatric symptoms episodically can also recover.
5. Recovery changes the frequency and duration of symptoms. People who are recovering and experience symptom exacerbation may have a level of symptom intensity as bad as or even worse than previously experienced. As one recovers, the symptom frequency and duration appear to have been changed for the better. That is, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free. Symptom recurrence becomes less of a threat to one's recovery, and return to previous function occurs more quickly after exacerbation.
6. Recovery does not feel like a linear process. Recovery involves growth and setbacks,

Recovery From Mental Illness—Guiding Vision (continued)

periods of rapid change and little change. While the overall trend may be upward, the moment-to-moment experience does not feel so “directionful.” Intense feelings may overwhelm one unexpectedly. Periods of insight or growth happen unexpectedly. The recovery process feels anything but systematic and planned.

7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult than impairment issues. An inability to perform valued tasks and roles, and the resultant loss of self-esteem, are significant barriers to recovery. The barriers brought about by being placed in the category of “mentally ill” can be overwhelming. These disadvantages include loss of rights and equal opportunities, and discrimination in employment and housing, as well as barriers created by the system’s attempts at helping, e.g., lack of opportunities for self-determination, disempowering treatment practices. These disabilities and disadvantages can combine to limit a person’s recovery even though one has become predominantly asymptomatic.
8. Recovery from mental illness does not mean that one was not “really mentally ill.” At times people who have successfully recovered from severe mental illness have been discounted as not “really” mentally ill. Their successful recovery is not seen as a model, as a beacon of hope for those beginning the recovery process, but rather as an aberration, or worse yet as a fraud. It is as if we said that someone who has quadriplegia but recovered did not “really” have a damaged spinal cord! People who have or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering.

Implications for the Design of Mental Health Systems

Recovery as a concept is by no means fully understood. Much research, both qualitative and quantitative, still needs to be done. Paramount to the recovery concept are the attempts to understand the experience of recovery from mental illness from those who are experiencing it themselves. Qualitative research would seem particularly important in this regard.

However, it is not too early for system planners to begin to incorporate what we currently think we know about recovery. For example, most first-person accounts of recovery from catastrophe (including mental illness) recount the critical nature of personal support (recovery assumption #2). The questions of system planners are: Should personal support be provided by the mental health system? And if so, how can this personal support be provided? Should intensive care managers fill this role? What about self-help organizations? Should they be expanded and asked to perform even more of this function?

Recovery From Mental Illness—Guiding Vision (continued)

If personal support is characterized as support that is trusting and empathic, do human resource development staff members need to train helpers in the interpersonal skills necessary to facilitate this personal relationship? Quality assurance personnel would *need* to understand the time it takes to develop such a relationship and figure out ways to assess and document this process.

Recovery, as we currently understand it, involves the development of new meaning and purposes in one’s life as one grows beyond the catastrophic effects of mental illness. Does the mental health system help in the search for this new meaning? Does it actively seek to provide opportunities that might trigger the development of new life purposes? Is this the type of service professionals and survivors talk about when the value of “supportive psychotherapy” is mentioned? Is there the support of therapists trained to help persons with mental illness control their lives once again—even without fully controlling their mental illness?

There are a number of possible stimulants to recovery. These may include other consumers who are recovering effectively. Books, films, and groups may cause serendipitous insights to occur about possible life options. Visiting new places and talking to various people are other ways in which the recovery process might be triggered. Critical to recovery is regaining the belief that there are options from which one can choose—a belief perhaps even more important to recovery than the particular option one initially chooses.

Recovery-oriented mental health systems must structure their settings so that recovery “triggers” are present. Boring day treatment programs and inactive inpatient programs are characterized by a dearth of recovery stimulants. The mental health system must help sow and nurture the seeds of recovery through creative programming. There is an important caveat to this notion of recovery triggers. At times the information provided through people, places, things, and activities can be overwhelming. Different amounts of information are useful at different times in one’s recovery. At times denial is needed when a recovering person perceives the information as too overwhelming. At particular points in one’s recovery, denial of information prevents the person from becoming overwhelmed. Information can be perceived as a bomb or a blanket—harsh and hostile or warm and welcome. Helpers in the mental health system must allow for this variation in the time frame of information they are providing—and not routinely and simply characterize denial as nonfunctional.

Similarly, the range of emotions one experiences as one recovers cannot simply be diagnosed as abnormal or pathological. All recovering people, whether mentally ill or not, experience strong emotions and a wide range of emotions. Such emotions include depression, guilt, isolation, suspiciousness, and anger. For many persons who are recovering from catastrophes other than mental illness, these intense emotions are seen as a normal part of the recovery

Recovery From Mental Illness—Guiding Vision (continued)

process. For persons recovering from mental illness, these emotions are too quickly and routinely considered a part of the illness rather than a part of the recovery. The mental health system must allow these emotions to be experienced in a nonstigmatizing and understanding environment. Helpers must have a better understanding of the recovery concept in order for this recovery-facilitating environment to occur

Concluding Comments

Many new questions and new issues are stimulated for system planners by a recovery-oriented perspective. While we are nowhere near understanding the recovery concept nor routinely able to help people achieve it, a recovery vision for the 1990s is extremely valuable.

A vision pulls the field of services into the future. A vision is not reflective of what we are currently achieving, but of what we hope for and dream of achieving. Visionary thinking does not raise unrealistic expectations. A vision begets not false promises but a passion for what we are doing (Anthony, Cohen, & Farkas, 1990).

Previous “visions” that guided the mental health system were not consumer-based. They did not describe how the consumer would ultimately benefit. For example, the deinstitutionalization “vision” described how buildings would function and not how service recipients would function. Similarly, the CSS “vision” described how the service system would function and not the functioning of the service recipients. In contrast, a recovery vision speaks to how the recipients of services would function. Changes in buildings and services are seen in the context of how they might benefit the recovery vision. In contrast to the field of services, biomedical and neuroscience researchers have a vision. They speak regularly of curing and preventing severe mental illness. They have helped to declare the 1990s “the decade of the brain.” Recovery from mental illness is a similarly potent vision. It speaks to the heretofore unmentioned and perhaps heretical belief that any person with severe mental illness can grow beyond the limits imposed by his or her illness. Recovery is a concept that can open our eyes to new possibilities for those we serve and how we can go about serving them. The 1990s might also turn out to be the “decade of recovery.”

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Recovery From Mental Illness—Guiding Vision (continued)

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