

*The RECOVERY Model*  
(Compiled by Chris Summerville, D.Min., CPRP)

- 1. Why A Shift To Recovery?**
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## **1. Why A Shift to Recovery?**

From the old school (biomedical) to the new school (bio-psycho-social-spiritual)!

The Diagnostic and Statistical Manual-IV, the standard for diagnosis of schizophrenia and other mental illnesses, describes the illness with such dark and devastating language that you may feel any hopes you have for your ill family member are based in delusion.

Life was impossible. Dreams of independence were unattainable and that long-term institutionalization was inescapable.

“Kiss of death diagnosis”

Outcome of mental illness: poor prognoses with progressively downhill courses

According to renowned researcher Courtenay Harding, Ph.D., recovery from mental illness has been researched and proven for decades, and she will cite ten studies from all over the globe as evidence (Harding, 2004). The irony is, as Harding will point out, you won't find a section on recovery in the American Psychiatric Association's (APA).

“The psychology of adjustment attempts to adjust *you* to a baseline that is usually your lowest functioning level with a mental illness. Everything else you attempt to do is seen as delusional. A psychology of respect would be based on strengths and teaching skills, rather than trying to adjust you to your mental illness.”

**(RECOVERY IN MENTAL ILLNESS *Broadening Our Understanding of Wellness***

By Ruth O. Ralph & Patrick W. Corrigan. p. 33.)

“Settings that rely solely on the medical model as a way to understand mental illness tend to focus on pathology and disease (Mead, Hilton, & Curtis, 2001) and to define recovery as a set of predetermined outcomes that emphasizes symptoms elimination and a return to premorbid functioning. This model of illness and recovery can be detrimental to a person's experience of recovery, because it undermines hope (Chamberlin, 1978; Lovejoy, 1984), which has been described as one of the cornerstones of recovery (Deegan, 1988).”

**(RECOVERY IN MENTAL ILLNESS *Broadening Our Understanding of Wellness*** By Ruth O. Ralph & Patrick W. Corrigan. p. 176.)

## **The new school says:**

- Recovery is a naturally occurring phenomenon.
- As with other medical illnesses, people can recover from mental illness with proper treatment and supports.
- Recovery reintroduces the idea of hope in understanding serious mental illness.

The recovery movement has challenged the way we think about mental illness and even the concept of mental illness. It has helped many people begin to have hopes and dreams—something they had been discouraged from having in the past.

“At its core, recovery challenged the stories that we’ve been told about our experiences and what they mean. It opens up the possibility of discussion about how we can work together in ways that really share power, risk, and expertise. It must be a process in which everyone moves out of old, comfortable roles and begins to talk about mutuality, boundaries, risk, and who gets to define and decide on treatment. For this to happen, everyone involved must challenge his or herself to respond in new ways.”

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By Ruth O. Ralph & Patrick W. Corrigan. p. 15.)

At the heart of the recovery movement is the idea that instead of focusing on the disease or pathological aspect of schizophrenia—as does the medical model—emphasis is placed on the potential for growth in the individual. That potential is then developed by integrating medical, psychological and social interventions.

“I define recovery as the development of new meaning and purpose as one grows beyond the catastrophe of mental illness,” says William A. Anthony, Ph.D., executive director of Boston University’s Center for Psychiatric Rehabilitation. I think the literature on long-term studies...shows people do get past mental illness. My feeling is you can have episodic symptoms and still believe and feel you’re recovering.

(New Hope For People with Schizophrenia, February 200)

## **2. What Is Recovery?**

Exactly what is meant by recovery?

First of all, there is no consensus on how recovery should be defined (e.g., as a process or an end state) or how it should be measured.

Members of the Provincial Advisory Council on Mental Health in Manitoba offered their definitions at a workshop on December 8, 2005:

1. "Achieving a self satisfactory label of daily functioning in all areas of life." (Shelley Smith)
2. "Recovery initially is healing and returning to an acceptable and/or previous state of health. It then becomes TRANSFORMING..." (Randall Klaprat)
3. "Recovery is an ongoing process involving all senses; physical, emotional, mental, and spiritual and finding empowerment to reach and maintain a sense of worth in the community of life." (JoAnne Lowenberger)
4. "Recovery is a process whereby a person suffering from mental illness is able to regain self-confidence have as near social relationships as possible & have meaningful jobs. Taking medication either regularly or when needed (Just like some people take anti depressant/aspirin, cholesterol pill, etc.)." (Gerald Shewchuk)
5. "Recovery is discovering and working toward my fullest potential as a human being." (Ron Dyck)
6. "Recovery is being accepted- as the new person I have become, saying goodbye to the old, being (embracing) a new me!" (Dorothy Weldon)
7. "Recovery is a unique and very personal journey. Using the best practices for the individual is what works. Instilling hope for a meaningful life strengthened by experience is a main goal of recovery." (Warren Butcher)
8. "Finding what was once lost, me." (Arlene L. Mayes)

"Recovery is the awakening of hopes and dreams. The recovery process involves gaining the knowledge to reclaim one's desires by learning to make choices that bring strength rather than harm. Recovery involves living a meaningful life with a capacity to love and be loved." (Telecare Corporation)

Is it a process or outcomes?

### **Outcomes?**

Viewed as an outcome, recovery represents a change from a previously maladaptive state to a position of “normal” living.

“To return renewed with an enriched perspective of human condition is the major benefit of recovery. To return at peace, with yourself, your experience, your world, and your God, is the major joy of recovery.” (Granger, 1994)

“Family groups and most mental health providers frequently define recovery as an outcome. Important to them is the idea that their patient or family member ‘gets better’; that they somehow overcome the symptoms and disabilities that trouble them and society so much (Lefley, 1997). Consumer, survivor, and ex-patient groups are more likely to embrace recovery as a naturally occurring phenomenon or as process.” (Ralph, 2000)

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### **Process?**

“...this group proposes recovery as a process; namely, people who are concerned about their psychological well-being, struggling with their symptoms, and attempting their life goals are ‘in recovery’ regardless of where they fall in terms of any outcome criteria. As a result, the process approach to recovery focuses less on measuring whether any change has occurred or end state has been achieved and instead concerns itself with indicators that represent the person is in recovery.”

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By Ruth O. Ralph & Patrick W. Corrigan. p. 5.)

“Recovery can be defined as a process of learning to approach each day’s challenges, overcome our disabilities, learn skills, live independently and contribute to society. This process is supported by those who believe in us and give us hope.” (Unknown source)

“The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms” (Unknown source)

President’s New Freedom Commission on Mental Health’s *Achieving the Promise* report, The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms (2003).

“Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times, our course is erratic and we falter, slide back, regroup, and start again.... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.” (Deegan, 1988)

“Recovery from mental illness is the process of healing the effects of (a) one’s illness and its consequences, (b) the social stigma attached to the illness, and (c) the iatrogenic effects of treatment interventions (Spaniol, Gagne & Koehler, 2003). Recovery implies a process of retrieval (regaining what was lost because of one’s illness and its treatment) and a process of discovery (moving beyond the illness and its limitations).

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“Recovery is the experiential shift from despair to hope, alienation to purpose, isolation to relationship, withdrawal to involvement, and from passive adjustment to active coping.” (Ridgeway, 2001)

“Spaniol and Koehler (1998) offer a definition of recovery that encompasses recovery as a process, an outcome, and a vision. As a

process, recovery is a common human phenomenon that we all experience at some point after injury, illness, loss, or trauma. The process includes healing physically and emotionally; adjusting one's attitudes, feelings, perceptions, beliefs, roles, and goals in life; and engaging in a process of self-discovery, self-renewal, and transformation. Recovery as a process also involves creating a new personal vision for oneself. As an outcome, recovery is engaging in work, having friends, and living in a place of one's own choosing. This is the aspect of recovery most often embraced by researchers and professionals."

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By Ruth O. Ralph & Patrick W. Corrigan. p. 49.)

### 3. What Is It Not?

It is not necessarily an absence of the use of medication.

It does not mean being totally symptom free.

“Although recovery does not necessarily mean being symptom free or without disability, descriptions of recovery as an outcome typically include accomplishing life goals in important life domains such as work and housing, as well as reporting both psychological well-being and improved quality of life.”

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“An additional reason that recovery is not typically viewed as a return to a previous state is that advocates often view the experiences of disability, treatment, hospitalization, stigma, and discrimination associated with their mental illness as having changed their lives irrevocably. Like trauma survivors who can never simply return to their lives prior to the traumatic event, mental illness in its more severe forms may be experienced as a life-altering condition.

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“Recovery in this sense does not mean the illness has gone in to complete remission. It means that over time, through what for many is a long and difficult process, individuals come to terms with their illness, learn first to accept it and then move beyond it. They learn to believe in themselves as individuals, learn their strengths as well as their limitations and come to realize that they have the capacity to find purpose and enjoyment in their lives despite their illness. The recovery upon the potential for growth within the individual. That potential can then be developed by integrating medical, psychological and social interventions. The recovery model sees individuals with mental illness as active participants in the recovery process.”

(“Approaches to Recovery,” Rethink.)

#### **4. What Are Principles of Recovery?**

“People play an active role in their recovery process; recovery is a nonlinear, ongoing process-people do not move through the recovery process in a predetermined, orderly manner; hope is an essential ingredient; meaning and purpose in life are necessary; and relapse is part of the process and not a failure. In all of these models, recovery is defined in terms of continual growth, increased control over one’s life, and either a redefining or reestablishing of a sense of self in the recovery process. This new understanding of recovery in terms of a highly individualized process, rather than as a universally defined end state, requires methods of research that can capture or, at least, more accurately assess the dynamic and varied nature of this phenomenon.”

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Recovery is a common experience.

Recovery is coming to terms with the mental illness and having a life for yourself.

Recovery is a deeply and intensely personal, unique process of adjusting or changing one’s attitudes, values, feelings, perceptions, beliefs, skills, roles and goals in life.

Recovery is a deeply emotional process.

Recovery is not just recovery from the illness.

Recovery from mental illness does not mean that one was not really mentally ill.

Recovery is seeing yourself, treating yourself and responding to others as a person rather than as an illness.

“Recovery means no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a positive sense of self. Rather

than being shaped by a psychiatric diagnosis, a person needs to see one's self in the larger picture, the picture that exists beyond the diagnosis. Thus, psychiatric problems are only a part of life. Recovery makes it possible to see yourself in a positive sense, to feel important to someone or something, and to realize that you are a valuable person.

One of the elements that makes recovery possible is the regaining of one's belief in oneself." (Chamberlin, 1997)"

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Recovery is breaking through denial and achieving understanding and acceptance.

"A normal reaction to a psychiatric diagnosis or recognition of psychiatric problems is denial, to avoid dealing with them. However, learning what the challenges are and how to deal with and overcome them is an important part of recovery."

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Recovery is a journey from alienation to a sense of meaning and purpose.

"Prior to recovery, there is a great sense of being alone, being alienated from the world around you. Mental health treatments are often barren, boring, and lifeless and hence contribute to this alienation. However, consumers who wrote these narratives agreed that although they were able to find personal meaning in meeting their won personal goals, they also found deep meaning and purpose in helping others who experience psychiatric disabilities."

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Recovery is moving from withdrawal to engagement and active participation in life.

Isolation is one reaction to a psychiatric diagnosis and symptoms. It is also the pattern of some closed program environments. It is described

as “numbness” and “a perpetual suspended animation that is better than never-ending pain” (Unzicker, 1989, p. 71). People may have to push themselves into socializing with others-and finding ways to do this-to break out of the isolation. Consumer narratives indicate more comfort with people with similar interests and experiences. They also highlight employment or educational situations where one can relate to fellow employees or students.

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Recovery is psychological wellbeing.

This is experiencing the present with both its satisfactions and its limitations as a personally meaningful and acceptable condition.

“An important construct in recovery as a process is psychological wellbeing. Rather than being a symptom free and without disabilities, recovery here is more concerned with a sense of meaning in life and personal comfort. Intellectual work in this area has focused on such important ideas as validation of personhood, recognition of common humanity, and tolerance for individual differences.” (Campbell, 1992; Campbell & Schraiber, 1989)

Recovery is about empowerment.

“An essential element of recovery as a process is empowerment. People must have the power to act on their decisions to produce an optimistic future that reflects their personal goals. Research has shown empowerment to be a complex phenomenon that includes a sense of personal control over one’s environment and a feeling of agency in one’s world.” (Rogers, Chamberlin, Ellison, & Crean, 1997; Segal, Silverman, & Temkin, 1995)

Recovery is about a restoration of hope.

Hope is looking toward the future with the promise of continued satisfaction and achievement despite the limitations that life may bring.

One of the purposes of recovery as a movement that emerged from consumers, survivors, and ex-patients was to re-inject hope into the lives of people diagnosed with these disorders.

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Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort.... I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us.” (Leete, 1988)

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This birth of hope that is such a central theme in recovery narratives almost always occurs in the context of relationships and resources beyond the self, and often occurs through encounters with the experience, strength, and hope of others in recovery.

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People who experience mental illness often lose the belief that they are able to make their own decisions. This is the focus of Chamberlin’s (1997) comment: “One of the elements that makes recovery possible is the regaining of one’s belief in oneself” (pg. 9). Hope is the theme of Leete’s (1988) comments—hope to overcome symptoms, hope to live independently, hope to contribute to society: “Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort....I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us”

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“Recovery is reawakening of hope after despair. A psychiatric diagnosis can lead one to despair, particularly when accompanied by common negative expectations and stereotypes of lifetime disability from an incurable illness. Hope is found in many ways: through the support and love of family, through learning about and from other recovering individuals, and by finding out that there is employment and life beyond the diagnosis.”

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Recovery is a spiritual thing.

Spirituality is looking beyond the exigencies of immediate world for inspiration and guidance.

“Spirituality is a potentially important but often ill-understood ingredient of the recovery process (Sullivan, 1994). The roll of spirituality to provide hope, to neutralize stigma and shame, and to bolster strength and courage is frequently notes in recovery narratives.” (White, 1996; Young & Ensing, 1999)

Recovery is about connectedness.

Recovery is the process by which people with psychiatric disability rebuild and further develop connectedness with themselves, with others and with their environments.

Recovery takes place in community.

A person’s recovery from mental illness is considered to be an interactive process that involves transactions between the:

1. Person
2. His or her immediate support system
3. Treatment system
4. Community
5. Sociopolitical
6. Culture
7. Variables (Onken et al., 2002).

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Recovery is not accomplished alone; the journey involves support and partnership.

“Recovery does not happen in a vacuum. Family, friends, peers, and mental health providers are all important because they “cheer” a person on their road to recovery. Sometimes this support consists simply of being there and never giving up; at other times, it is encouragement to participate in self-help or other self-stimulating activities. Providers who believe the client can improve his or her life are important components in the recovery journey. However, all of the “cheerleaders” in a person’s life must strive to be just that, and not to attempt to assume control.”

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Recovery has been described in the consumer literature as something that you do with other people (Deegan, 1988, 1993; Fisher, 1994; Lovejoy, 1984; Unzicker, 1989).

Recovery may or may not involve medical treatment.

Recovery can be facilitated by treatment in two ways: assertive treatment early in the course of the disorder and comprehensive, well-coordinated services when the disorder is more chronic (Lieberman et al., 2002).

Recovery is a complex and nonlinear journey.

“Recovery is accomplished in small, concrete steps, and not in one big leap. Leete (1989) felt accomplishment when she crossed things done off a list. Deegan (1988) began by “simple acts of courage” such as taking a ride in a car or talking to a friend for a few moments each day. Recovery is an evolving process and does not follow a straight course. There may be setbacks after which one must begin again on the journey.”

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Recovery is ongoing.

Stocks (1995) points out that recovery is not static, that it is “an ongoing process of growth, discovery, and change”

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Recovery is active coping rather than passive adjustment.

It is important for the individual to take personal responsibility for his or her own well-being. To do so requires self-awareness including paying attention to sources of stress and positive reinforcement. People need to keep in touch with their own feelings and deal with difficulties as quickly as possible.

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Recovery can involve relapse and mistakes.

Recovery can be claimed only by the person in recovery, and that ownership includes the right to take risks, make mistakes, and learn from one’s experiences (Deegan, 1992).

Recovery is akin to resiliency.

When we are talking about recovery, we need to start thinking about recovery as a type of resilience, a drive to wellness, a self-righting capacity, a resourcefulness that people who were historically seen as vulnerable and afflicted can somehow bring to bear on their own recovery. (Deegan, p. 38)

Recovery is transformation.

Recovery does not refer to an end product or result. It does not mean that one is “cured” nor does not mean that one is simply stabilized or maintained in the community. Recovery often involves a

transformation of the self wherein one both accepts one's limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and a way of approaching the day's challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time. ("Recovery and Conspiracy of Hope," Deegan, p. 13)

### Recovery is a dynamic interaction.

"Recovery is a product of dynamic interaction among characteristics of the individual (self-agency, holism, hope a sense of meaning and purpose), characteristics of the environment (basic material resources, social relationships, meaningful activities, peer support, formal services and staff), and the characteristics of the exchange (hope, choice, empowerment, referent power, independence, interdependence). Each of these emergent domains/themes contain a rich and complex network of helping and hindering elements."

(Approaches To Recovery by Rethink)

### Recovery is necessary part of life.

The process of working through recovery is necessary to achieve the outcomes of a normal, healthy life.

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### SCHIZOPHRENIA ANONYMOUS Principles

*Recovery is possible and all people can engage in recovery regardless of symptom severity or other circumstances.*

*Recovery consists of changing one's attitudes, beliefs, and approach to life.*

*People have inner strength and resources that can be used in their recovery and the recovery of others.*

*Recovery can only be achieved with the help of others.*

*Recovery is an ongoing process with ups and downs.*

Examples of attributes and experiences that may be associated with individuals who are progressing toward, but have not yet achieved, recovery include hope, self-responsibility, de-stigmatization, empowerment, self-acceptance, insight and awareness, collaboration with professionals, sense of autonomy and self-control, and participation in self-help and con-sumer run programs.

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“Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again.... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to life, work, and love in a community in which one makes a significant contribution.” (Deegan, 1998)

## **5. What Are People Recovering From?**

Members of the Provincial Advisory Council on Mental Health in Manitoba responded to this question with the following:

- \*Mental Illness
- \*Trauma
- \*Stigma
- \*Hopelessness
- \*Losses
  - Sense of self
  - Goals
  - Social relationships/Supports friends & family
  - Potential
  - Income/Housing
  - Power/Position
- \*Community discrimination
- \*Stereotyping
- \*Lack of self esteem
- \*Grieving/Loss
- \*Changed world internally & externally
- \*Relationships
- \*Education
- \*Potential
- \*Lifestyle
- \*Friends
- \*Mental health system
- \*Side effects (meds)
- \*Injustice
- \*False expectations & beliefs
- \*Inadequate services
- \*Disappointment/disillusionment
- \* Loss of Libido

### **A person with mental illness wants and needs more than symptom relief!**

“Franco Basaglia, the noted mental health reformer, asserted that we cannot really know yet what mental illness is because most of the difficulties we see in people who have been diagnosed with it are the effects of institutionalization and the social stigma that is its legacy (rather, that is, than effects of the illness per se) (Scheper-Hughes & Lovell, 1986).”

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**Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.**

“That is, much of what we currently find to characterize the challenges people with serious mental illness encounter in their everyday lives can be attributed to the effects of stigma, poverty, alienation, chronic unemployment, political oppression, and discriminations, and the demoralization and social isolation that result from their effects (Davidson et al., 1997).”

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**People are recovering from the mental health system.**

“Spaniol and Koehler (1998), through their work with individuals with mental illness, identified specific treatment practices that traumatize individuals. These include negative professional attitudes, lack of appropriate assisting skills of professionals (e.g., undermine self-determination), devaluing and disempowering programs, and lack of enriching opportunities (e.g., valued work or social roles). Although mental health programs and treatments are designed with good intentions, the beliefs about mental illness and recovery communicated by these settings are often pessimistic and disempowering. They do not help consumers develop personal understandings of recovery that, in turn, allow them to move forward with optimism and to deal with the challenges posed by a serious mental illness.”

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**Stress is an important factor.**

This {the Stress Model Approach} approach holds that social structural positions influence the distribution of stress, in terms of the chronic strains (e.g., poverty, conflicted marriages/ relationships, job overload), negative life events (e.g., deaths, divorce, unemployment, criminal victimization), and daily hassles (e.g., traffic jams, trouble-some neighbors) that create

disruption and threaten psychological functioning. (Perlin, Menaghan, Lieberman, & Mullan, 1981)

## **6. What Helps or Hinders Recovery?**

“Why don’t you ever ask me what I do to help myself?” -*Woman with schizophrenia talking with interviewer* (Strauss, 1989) (p. 182)

“Factors that may impede or promote recovery from schizophrenia:

- Family
- Substance Abuse
- Duration of Untreated Psychosis
- Good Initial Response to Neuroleptics
- Adherence to Treatment
- Supportive Therapy With a Collaborative Therapeutic Alliance
- Neurocognitive Factors in the Prediction of Recovery
- Presence of Negative Symptoms
- Premorbid History
- Access to Comprehensive, Coordinated, and Continuous Treatment.”

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“A growing body of empirically based, clinical research shows that recovery from schizophrenia can be multiplied manifold over traditional estimates if four conditions are met:

1. The disorder is treated early in its course with assertive outreach and optimal services.
2. Flexible levels of consumer-oriented case management are used.
3. Families and other natural supporters and caregivers are involved as partners in the treatment process.
4. Later stages of more chronic, relapsing, or refractory forms of the illness are treated for lengthy periods with comprehensive, well-coordinated, and continuous bio-behavioral treatments that are keyed to the phase of illness (Barrowclough & Tarrier, 1998; DeSisto, Harding, McCormick, Ashikaga & Brooks, 1995; Glynn et al., 2002; Harding, Brooks, Ashikaga, Strauss & Breier, 1987; Lieberman et al., 1993).

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By Ruth O. Ralph & Patrick W. Corrigan. p. 102.)

In a review of recovery literature prepared as background for *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999), four dimensions of recovery found in personal accounts were identified (Ralph 2000):

1. *Internal factors* are those factors which are within the consumer such as the awakening, insight, and determination it takes to recover.
2. *Self-managed care* is an extension of the internal factors in which consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face.
3. *External factors* include interconnect-edness with others; the supports provided by family, friends, and professionals; and having people who believe that they can cope with and recover from their mental illnesses.
4. *Empowerment* is a combination of internal and external factors, in which internal strength is combines with interconnect-edness to provide self-help, advocacy, and caring about what happens to ourselves and to others.

“The goal of empowerment becomes one of people gaining power and control over their lives through access to meaningful choices and the resources to implement those choices. Or findings document the crucial role that choice plays in empowerment. Having information on, and access to, a range of meaningful and useful choices and options fosters recovery. Participants are empowered when they make the choices regarding where they live, housing, finances, employment, personal living/daily routine, disclosure, who they associate with, self management and treatment.”  
 (“Mental Health Recovery: What Helps and What Hinders?”)

### **What are barriers?**

Barriers are obstacles; things that stand in the way. They interfere with our ability to reach goals and move ahead.

Barriers can slow us down, complicate our lives or block us completely.

There are two main types of barriers to recovery: internal and external.

Internal barriers are barriers that are imposed upon oneself, while external barriers are those imposed by society or an outside force.

### **Internal Barriers (Personal)**

Internalized negative beliefs are the most difficult internal barriers and can be immobilizing. These ideas come from our society, family, media, or mental health system.

Implied or spoken barriers such as “you’ll always need medication, or low stress employment” for example, can lead to negative self images and result in immobility toward recovery from psychiatric difficulties.

### **External Barriers (Environmental)**

These are barriers that are imposed by outside forces that create difficulties or impossibilities for people with psychiatric disabilities to be independent and dignified community members.

Examples of these external barriers are:’

- lack of desirable and safe housing
- lack of fulfilling job opportunities
- public stigma
- poverty
- segregation
- violations of privacy and confidentiality
- lack of transportation access
- adequate resources and supports to help people live more independently

See “Recovery Model Chart” by Ruth O. Ralph, PhD. (External & Internal) and “External Influences.”

7. What Are The Stages Of The Recovery Process?

THE PROCESS OF RECOVERY

(The Journey of Recovery, CMHA, Winnipeg)

SHOCK

DENIAL

DEPRESSION/DESPAIR/GREIVING

ANGER

ACCEPTANCE

HOPE

ADVOCACY

C O P I N G  
EMPOWERMENT

## The Negative Impact of Severe Mental Illness

Stages:	I. Impairment	II. Dysfunction	III. Disability	IV. Disadvantages
<b>Definitions:</b>	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
<b>Examples:</b>	Hallucinations Delusions Depression	Lack of work adjustment 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.**

The Four Stages of Recovery  
Dr. Mark Ragins, “The Road To Recovery”

## **HOPE**

During times of despair, everyone needs a sense of hope, a sense that things can and will get better. Without hope, there is nothing to look forward to and no real possibility for positive action. Hope is a great motivator, but for hope to be truly motivating, it has to be more than just an ideal. It has to take form as an actual, reasonable vision of what things could look like if they were to improve. It’s not so much that people with mental illness will attain precisely the vision they create, but that they need to have a clear image of the possibilities before they can make difficult changes and take positive steps.

## **EMPOWERMENT**

To move forward, people need to have a sense of their own capability and their own power. Their hope needs to be focused on things they can do for themselves rather than on new cures or fixes that someone else will discover or give them. To be empowered, they need access to information and the opportunity to make their own choices. They may need encouragement to start focusing on their strengths instead of their losses. Sometimes they need another person to believe in them before they’re confident enough to believe in themselves.

Readiness” often occurs only in retrospect after they have done something successfully, so waiting until a person with mental illness is ready to move on can often be stagnating and disempowering. Often people have to experience success before they believe they can be successful.

## **SELF-RESPONSIBILITY**

As people with mental illness move toward recovery, they realize they have to take responsibility for their own lives. This means they have to take risks, try new things and learn from their mistakes and failures. It also means they need to let go of the feelings of blame, anger and disappointment associated

with their illness. This is a particularly difficult stage for people with mental illness and their caregivers. Old patterns of dependency must be broken, and mental health professionals need to encourage clients to take charge instead of settling for the ease and safety of being taken care of.

## **A MEANINGFUL ROLE IN LIFE**

Ultimately, in order to recover, people with mental illness must achieve some meaningful role in their lives that is separate from their illness. Being a victim is not a recovered role, and frankly, neither is being a survivor. Newly acquired traits like increased hopefulness, confidence and self-responsibility need to be applied to “normal” roles such as employee, son, mother and neighbor. It is important for people to join the larger community and interact with people who are unrelated to their mental illness. Meaningful roles end isolation and help people with mental illness recover and “get a life”.

Both professional training and public education campaigns designed to reduce the stigma associated with mental illness carefully teach that schizophrenia is a genetically based, chemical brain disease that isn't anyone's fault. Unfortunately, this message gets translated to mean that every one is helpless when it comes to treating or overcoming mental illness.

“Researchers at the Boston University Center for Psychiatric Rehabilitation have described four stages of recovery: overwhelmed by the disability, struggling with the disability, coping and living with the disability, and establishing a lifestyle beyond the disability. (Spaniol, Wewiorski, Gagne, & Anthony, 2002).”

“These authors identified a number of factors that appear to be associated with progression through these phases such as a supportive social network, effective treatment with antipsychotic medication, and religious faith. “

**(RECOVERY IN MENTAL ILLNESS *Broadening Our Understanding of Wellness***

By Ruth O. Ralph & Patrick W. Corrigan. p. 106.)

## **SEE RECOVERY MODEL: CHART**

There are several parts to the model [all parts of the Recovery Model are available on the Web at [http://www.nasmhpd.org/spec\\_e-report\\_fall04measures.cfm](http://www.nasmhpd.org/spec_e-report_fall04measures.cfm)].

## **8. How Do You Begin To Move Towards a Recovery-Oriented Mental Health System?**

*The goal of the mental health system is to create an environment where recovery can take place.*

“What is recovery? It is a process, sometimes lifelong, through which consumer achieves independence, self-esteem, and a meaningful life in the community. Recovery can be facilitated by particular features of care and the care system; it can also be inhibited by other features. *Hence, we can speak of recovery-oriented planning and recovery-oriented services.*”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

### **Changing attitudes!**

By Mark Ragins, M.D. The Village.

To become a recovery community, the Village had to change its focus of care from its patients’ symptoms to its members’ lives. Changing this focus changed everything. All of us at the Village had to break out of the walls of the medical model to work with people’s lives instead of just their illnesses. We had to break out the walls of professional distance to create long-term, caring and emotional relationships. We even had to break out of the walls of our building to work in the community at large. And, ultimately, we had to break out of the walls of our internal stigma and prejudices.

As a psychiatrist, I had been taught to manage serious mental illnesses with a set of assumptions that if articulated would sound something like this: “People with chronic mental illness are permanently disabled. Medicate them and forget them. They are weak and need to be taken care of. They can’t hold down jobs. They have no significant role to play in society. The possibility of them having a meaningful life is slight. Their prognosis is essentially hopeless.”

### **Seeking consumer participation!**

“Among the many goals of the ex-patient’s movement...is to play a part in devising mental health policy rather than to be merely the passive objects of policies designed by others...Unless planning groups and councils are made up of at least one-third mental health consumers, they are failing to live up to

what we consider the mandate of the [Mental Health Planning Act (Public Law 99-660) which required states to plan the implementation of community-based systems of care incorporating the input of various constituency groups].”

(Judi Chamberlain & Joseph Rogers, 1990)

### **Hiring visionary leadership!**

“If we are serious about the vision of recovery, then the mental health system of the last century-which for the most part was a system characterized by low expectations, control, and no consumer-based vision-must disappear. Massive system changes must occur if the vision of recovery is to become a reality for an ever-increasing number of people with severe mental illnesses. For this very different vision to become reality, brilliant leadership is required.”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

### **Ensuring recovery values!**

“Under girding the vision of recovery are several key values around which consensus has emerged (Farkas, Gagne, Anthony, & Chamberlin, in press). Four of these values are:

1. Self-determination/choice
2. Full partnership
3. People first
4. Growth potential

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

“For example, a system mission characterized by the recovery values of self-determination/choice, people first, and growth potential would be:

‘To assist people to improve their functioning so that they are successful and satisfied in the environment of choice.’

A system mission that is unresponsive to all the recovery values might be:

‘To provide continuous and comprehensive services to mentally ill clients.’ ”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

“Similarly, a policy consistent with all four recovery values might be:

‘People will have the opportunities and help necessary to choose and plan for those services they want to promote their recovery.’

“Conversely, a policy not passing through the recovery funnel might be:

‘People must be on psychiatric medication in order to access any residential services used by the mentally ill that are funded with state dollars.’ ”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

“Another policy example that is consistent with all the recovery values is:

‘Any person with a severe mental illness who wants vocational services will receive them’

“In contrast, negative policy example with respect to self-determination/choice and full partnership might be:

‘People will undergo a specific test battery before being accepted into vocational services.’

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

“A clinical process that values self-determination cannot co-exist with a management process that values obedience and control.”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

### **Providing tools for recovery!**

“To me the recovery-oriented system helps the person to not only understand what his disorder is, but it also shows him how to manage it while using the tools of recovery, said Kirk. The tools can be medication, diet, therapy-any number of things to manage the illness. It is the consumer’s choice, and they have to be part of the journey. It’s not us doing it for them, it’s us doing it with them.”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

### **Asking the right questions!**

“Given the call for such profound change, mental health administrators across the country are asking questions such as: What services and supports are important in a recovery-oriented mental health system? What recovery-facilitating practices are currently underdeveloped in our system? Where are the people we serve on their journey of recovery? How well are we facilitating people’s potential for resilience and recovery? The Recovery Enhancing Environment measure (REE) was designed to provide empirical answers to such pressing concerns.”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

“One of the keys to understanding recovery is that services should be a means to an end—living a full and meaningful life in the community, with relationships enmeshed with the world of commerce, employment, and education. To me, rehabilitation is about services, technologies, professionals, advisors, or experts that people with psychiatric disabilities can consult with, can receive guidance from, can involve themselves with about shared decision making. Recovery is a person-centered phenomenon. You can’t ‘do recovery’ to someone. You can’t ‘do services’ that will force someone to recover. Recovery-based services will always be one small part or one small ingredient for a person with psychiatric disabilities to achieve a meaningful life in the community.”

(NASMHPD/NTAC e-Report on Recovery, Fall 2004)

### **Changing language!**

“I believe that we need to be extremely conscious of language. I did a brief survey of staff and clients from a very typical mental health service setting. I asked for examples of times when you heard someone who was being disrespected, or a time when you were being respected. These weren’t evil staff and they weren’t particularly awful clients. They were just typical. Their answers included words and phrases like: crazy, nut, psycho, retarded, whacko, nutjob, stupid, sick, creepy, screwy, back-to-the-nut-house, child, drama queen, time-for-the-rubber-room, lazy, get-a-life, substance abuser, loser, for-a-schizo-you’re-doing-very-well, my-taxes-pay-for-your-SSI, [etc]. These are just some examples of micro-aggression. This is the kind of stuff that is going on daily in programs. Over time, this begins to wear down people and their hope. It creates a culture of hopelessness and despair. In terms of educating people on language and other aspects, we need to begin to operationalize the recovery-based approaches. (Deegan, p. 35)

### **Removing barriers!**

“We must commit ourselves to removing environmental barriers which block people’s efforts towards recovery and which keep us locked in a mode of just trying to survive. For instance, I would suggest examining the following questions:

1. Are the people we work with overmedicated?
2. Are consumer/survivors in both community based and hospital programs involved in evaluating staff work performance?
3. Are program participants and hospital inpatients receiving peer skills training on how to participate in and effectively get what they want from a treatment team?
4. Are there separate toilets or eating space for staff and program participants?
5. Who can use the phones? Who makes what decisions? Who has the real power in this program?
6. Do we understand that people with psychiatric disabilities possess valuable knowledge and expertise as a result of their experience?
7. Have we created environments in which it is possible for staff people to be human beings with human hearts?
8. Do we work in a system, which rewards passivity, obedience and compliance?
9. Have we embraced the concept of the “dignity of risk” and the “right to failure”?
  
10. Are there opportunities within the mental health system for people to truly improve their lives?”  
 (“Recovery and Conspiracy of Hope,” Deegan, p. 10-11)

Recovery oriented mental health systems must structure their settings so that recovery “triggers” are present. (William Anthony)

**Providing essential services!**

**Essential Client Services in a Caring System**

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

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

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By Ruth O. Ralph & Patrick W. Corrigan. p. 138.)

Material compiled by Chris Summerville, Executive Director, Manitoba Schizophrenia Society, Inc. 3-1000 Notre Dame Avenue, Winnipeg, Manitoba. [Chris@mss.mb.ca](mailto:Chris@mss.mb.ca) . December, 2005