

By 1995, like a new word I'd just learned the definition of, recovery seemed to be popping up everywhere I looked. I still didn't really know what it meant, or how to use it myself, but it seemed to be an idea whose time had come. I figured it must be real if so many different people were independently coming up with the same idea.

Dan Weisburd at the Journal of CAMI highlighted this new idea by devoting an entire issue to creating "A Vision of Recovery." In some ways his cover illustration of a Magritte painting of a cloud entering an ajar door and his introduction captures the mood of the time. He wrote, "It starts right on the cover. A challenge to our perceptions – to what we know is so...something magic, something dream-like is happening." I was asked, along with other leading professionals, consumers, and family members from around the country to contribute an article.

Similarly to the "What Kind of Psychiatrist Am I?" article that opened Chapter 1, I took the approach of trying to bring together a wide variety of models, trying to incorporate both their theoretical and practical contributions. Perhaps not surprisingly, I ended up focusing the most positively on the psychosocial rehabilitation approach that I knew best.

Recovery: Changing From a Medical Model to a Psychosocial Rehabilitation Model

(1995)

Ever since Kraepelin defined schizophrenia, or dementia praecox, 100 years ago, as a chronic, unremitting, gradually deteriorating condition, it has been difficult to talk credibly about or work towards recovery with severe mental illness. The relationship between treatment professionals, patients and their families has frequently been frustrating, unsatisfying, and non-collaborative often to the point of coercion. Clients and families are often waiting for their illnesses to go away, or be cured, in order to go on with their lives. They are angry at professionals for not helping them, or doing anything for them, since their lives are not improving.

At present, most people on all sides have abandoned the process entirely out of despair. Very few psychiatrists treat the chronically mentally ill. Increasing numbers of patients are described as "treatment resistant" and families are "burned out" and disengaged. The result is the abandonment, neglect and deterioration we see all around us.

All this hopelessness exists despite clear evidence of the growing efficacy of our treatments and more benign outcomes than traditionally thought. I would argue that the problem may be as much in our conceptual model of treatment and recovery as in the inherent nature of the conditions. People with schizophrenia in third world countries are regularly reported to have better outcomes than here. Also people with schizophrenia who explain their conditions spiritually instead of medically apparently fare better.

The medical model tends to define recovery in negative terms. Symptoms and complaints need to be

eliminated. Illnesses need to be cured or removed. Patients need to be relieved of their conditions and returned to their premorbid, healthy, or more accurately not-ill state. A comfortable treatment relationship between powerful healing professionals and helpless patients complying with orders they need not really understand results in a clear recovery. This model tends to break down for chronic medical conditions. Striking examples can be found in most nursing homes.

Even with common illness like hypertension, recovery is difficult to conceptualize within this model. Has a person who takes blood pressure medication forever resulting in normal blood pressure recovered? How about a person who alters their diet, exercises, eats less salt, deals with stress better and normalizes their blood pressure without medication? Hypertension is often asymptomatic even untreated. How would we assess a person who has no treatment, lives a normal life, has high blood pressure throughout but never suffers any complications like strokes or heart attacks? If we were to move on to more complicated chronic illnesses like diabetes, psychiatrists' favorite medical analogy, the model would be even more inadequate in conceptualizing recovery.

For severe mental illness it may seem almost dishonest to talk about recovery. After all, the conditions are likely to persist, in at least some form, indefinitely. How can someone recover from an incurable illness?

The way out of this dilemma is by realizing that whereas the illness is the object of curative treatment efforts, it is the person themselves who is the object of recovery efforts. The medical model handles this by making it a 2-step process. First, treat the illness, and then rehabilitate the person. The net effect is often to delay personal recovery indefinitely while medical cures for the illness are being sought.

There is also discordance between the professionals focusing on the illness, while people focus on their entire lives. This often leads to a serious communication barrier with many people complaining that their doctors don't talk to or listen to them. The two processes of cure and recovery are, although interrelated, not absolutely dependent on each other, and can and should be pursued concurrently.

A broader perspective can be obtained by examining other established treatment models that conceptualize the recovery process and the helping relationship in very different ways than the medical model.

Within the 12-step model for treating substance abuse disorders, and increasingly other psychological conditions, people are "in recovery" if they admit they are alcoholic, stay sober, and work a program. Just being a "dry drunk" really is not enough. Put into more theoretical terms these elements of recovery are:

- 1) Accepting having a chronic, incurable illness that is a permanent part of them, without guilt or shame, without fault or blame.
- 2) Avoiding complications of the condition (e.g. by staying sober).
- 3) Participating in an ongoing support system both as a recipient and a provider.
- 4) Changing many aspects of their lives including emotions, interpersonal relationships, and

spirituality both to accommodate their illness and grow through overcoming it.

People must take responsibility for their own recoveries, helping themselves for their own benefit ("It won't work if you're doing it for someone else." "No one can do it for you"). Treatment professionals are eliminated entirely from the process replaced by "a higher power" and a network of sponsors and self-help groups.

Medical rehabilitation tends to conceptualize recovery more in terms of function than pathology. A person can recover from a stroke by being able to walk or talk again even though the brain cells are still damaged and can never be normal again. Similarly an athlete can recover from a knee injury, even if he had cartilage removed, exercises indefinitely and wears a protective brace, if he can play again. Neither permanent pathology, treatment, or adaptation invalidates a recovery if people have met their functional goals.

Treatment professionals are therapists who act as coaches helping to design a rehabilitation plan in which they support the patients' efforts to achieve a series of functional goals. Their relationship often focuses around motivating and focusing the patients' own efforts to help themselves. Within rehabilitation, there is more of a concordance between the professional and the patient, than within the medical model, because both are clearly focused on treating the person and not the illness. Patients can experience active recovery regardless of the state of their illness.

Spiritual healing is a more complex and diverse field. Recovery tends to depend upon first achieving internal changes conceptualized either spiritually (for instance "open your heart to God" or "purify your soul") or in terms of transcendent health and balance (either internally as in "balancing yin and yang" or "detoxifying your system" or externally as in "coming into peace with Mother Earth" or as in astrology). After achieving this state of "grace" or "balance" the illness is expected to be relieved automatically or "miraculously."

This process of first achieving transcendent health and then relieving the illness is the exact opposite of the medical model where first the illness is treated and then the person can achieve higher goals. In fact, treating an illness medically first is often equated with betraying spiritual faith and therefore antagonistic to God and spiritual healing.

In mental health we tend to overtly exclude spiritual aspects of life and treatment although they may be very important to our clients. Even still, many clients will attribute their recoveries to someone "really believing in me" or "seeing something inside me I couldn't" or "really caring about me not just because it was their job." These moments, whether conceptualized spiritually or not, clearly impart a state of acceptance and love, prior to relieving the illness. We may not even realize this is happening, and usually have not designed the treatment plan or relationship trying to maximize it, although it may be the most central factor in our clients' recoveries. Indeed, treating a person as a "case" or a collection of symptoms is generally perceived as highly dehumanizing and makes feeling "whole", "well", "loved", or even "understood" almost impossible.

Psychosocial rehabilitation is a growing movement in community mental health today. Many states,

especially in the east, have mandated it to be part of their systems. In California, interest has been fanned by the recent change in MediCal from the clinical option to the rehabilitation option. One of the main roots of psychosocial rehabilitation is the consumer movement which arose primarily as a reaction against the psychiatric establishment. The movement remains strikingly anti-medical model and many proponents are still very angry about the coercive, abusive, infantilizing, dehumanizing, isolating, condescending, stigmatizing, destructive aspects of traditional mental health systems.

They have progressed from self-help groups to clubhouses, many based on the Fountain House model, and their consumers have become "members". If not entirely member run, these programs generally have considerable member input with member governments, advisory board representation, and "consumer-staff". "Empowerment" is the central concept as people work to help themselves. They take self-responsibility for developing coping skills and adaptation to help them recover from their mental illness, to become "survivors". The focus is on strengths rather than weaknesses, people rather than illnesses.

The other main rehabilitation movement in mental health is psychiatric rehabilitation. As developed at Boston University, UCLA, and elsewhere, this approach features a "stress-vulnerability" model of mental illness. Clients are taught skills to overcome deficits and to reduce stress in order for their illnesses to become less symptomatic and for them to become more functional. Skills taught include symptom management, social skills, vocational skills, activities of daily life, educational skills, etc.

Vocational rehabilitation often emerges as a primary focus because in our society work is the single best way to obtain an identity other than that of a mental patient and to reintegrate into the community. Options often range from agency-run training job sites to competitive community supported employment with a "choose-get-keep" model. Supported education and housing have developed along similar lines.

These two movements, the often consumer driven psychosocial rehabilitation movement and the often professionally driven psychiatric rehabilitation, are beginning to merge into a recovery-rehabilitation model as they realize they are two sides of the same coin as seen from the respective perspectives of consumers and professionals, with many shared goals and techniques.

The Village Integrated Services Agency, in Long Beach, where I work, has expanded the psychosocial rehabilitation model to include both typical services like social, vocational, clubhouse and housing, and generally segregated services like money management/payee, substance abuse, case management teams, medication, crisis response and even hospitalization all within a managed care, capitated funding scheme.

The psychosocial rehabilitation model for treating severe mental illness can incorporate many useful aspects of the other conceptual models discussed while excluding harmful aspects of the medical model in its view of recovery and the nature of the helping relationship. Instead of viewing recovery negatively, in terms of symptoms to be relieved, illnesses to be cured, and treatment and medication to be ended, recovery can be viewed positively in terms of things to be actually recovered. These things

may be grouped into three broad categories:

- 1) Functions may be recovered - as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
- 2) External things may be recovered – as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc.
- 3) Internal states can be recovered – as in feeling good about oneself, satisfaction, self confidence, spiritual peace, self-identity other than mentally ill, self-responsibility, etc.

Unfortunately, even the word recovery has inherent negative connotations implying that people will get back things they used to have but lost due to their illnesses and ideally they will go back to the "good times". There are, in fact, many legitimate "recovery goals" that are to get things people never had before their illnesses (if there was a "before"). The "good times" may more realistically be attained by going forward to the future rather than backwards to the past.

Nonetheless, whether people actually had things their illness took from them or whether it took away the chance to get things that they had expected to get and visualized getting, they will often experience a strong sense of loss and victimization. Borrowing from the trauma recovery model, they must accept their victimization in order to stop being victims and become "survivors". Those people who either never had any vision of themselves as ever having anything, or who remain permanently in the victim role will have great difficulty recovering. The medical model tends more often to perpetuate the idea of being a permanent victim of "a chemical imbalance" and to take away hopeful visions of the future, (e.g. "you'll never be able to work") than to promote recovery.

These positive sets of objectives on the path to recovery are clearly more associated with quality of life than the medical model objectives. In fact, symptom levels and severity of illness levels bear little relationship to function or quality of life. Similarly, the common goal of getting off medication is often particularly counterproductive in attaining a higher quality of life. Positive recovery objectives are also, in large part, able to be worked towards actively and collaboratively, and are generally observable and accountable, nonstigmatizing, humanizing, and hopeful.

Although professionals are excluded from 12-step programs, most spiritual recovery programs, and even most psychosocial rehabilitation and consumer-run mental health programs, these models do not require this exclusion. What does need to be excluded, instead, are the heavily ingrained medical model traits of professional: professional distance, emotional detachment, absolute authority, strict hierarchies and guilds, invulnerability, etc. What does not need to be excluded is special knowledge, training, skills and experience, caring and even healing spirit.

Nevertheless, we have generally created a separation of the "clinical" and "rehabilitation" mental health services, treatment plans, and teams. This approach fails to take advantage of the much more powerful effects the two treatments can have if used together. As alluded to before, psychosocial rehabilitation can help people recover regardless of the state of their medical/clinical treatment. Clinical treatments can be powerful recovery tools if adapted.

The professionals must always be aware of the dual effects they are having on the illness, on the one hand and on the person, on the other. Medication, psychotherapy, and case management can all be successfully adapted to the recovery model. Medication prescription becomes a process of education, consultation and collaboration. Psychotherapy becomes a variety of therapeutic relationships in more natural settings and within more adult-to-adult relationships. Case management becomes personal service plan goal setting, support and facilitation. There is a need for more professionals to work in recovery settings to learn how to adapt their clinical treatment methods to the recovery model.

Many consumer groups speak of the need for "exits" from the mental health system and want to get out of treatment. This "negative recovery goal" is difficult to reconcile with the substantial ongoing benefit from treatment and medication many clients receive. This conflict often leads to agonizing results.

From a "positive view" of recovery those same "exits" are actually "entrances" to our community. The need is not so much to leave treatment of medication as to enter life. "Community integration", something most programs do very poorly, if at all, is the door they are looking for.

At the point of walking through that door we should find ourselves alongside our clients working to fight stigma and improve our deteriorated communities. The relationship between service provider and client (and family) needs to be fluid and to change depending on the goals being more actively pursued. The service provider may need to be medical consultant, coach, mentor, friend, peer, advisor, sponsor, student, customer, fellow patient, political activist, or even confessor to best help a person recover. As we use various aspects of ourselves, clients will be exploring, rediscovering, even recovering, various aspects of themselves and becoming whole people. These multifaceted, flexible relationships often feel more real, more human, and more reciprocal than the traditional professional-patient relationships. The client feels more valued and the service provider feels less drained.

Almost all people with severe mental illness are not permanently incapacitated, infantile, helpless beings we need to protect and take responsibility for. They may occasionally need that, but for the most part they can have dreams, hopes, plans, choices, and responsibility for the consequences. Often times what we are preventing or protecting from is actually the opportunity for change, growth, experiencing reality, self-confidence and ultimately recovery.

Every other aspect of their person besides their "incapacitating illness" is often ignored and invalidated, and withers away from neglect. The "high risk-high support" and "focusing on strengths instead of weaknesses" philosophies of the recovery model reverse these harmful trends.

This may sound like a retread of old deinstitutionalization, or worse yet, labeling theories, and to be fair some of it is. Some of the failure of deinstitutionalization may well be because professionals have never really been deinstitutionalized themselves, either in the places they work or in the medical model they use if they came to the community. The two main frustrations of deinstitutionalization, medication noncompliance and substance abuse, simply have not responded to a coercive, compliance oriented, medical model in the community. The flaw in those past theories, however, was to minimize, or even totally ignore, the reality of the impairments and sufferings severe mental illnesses cause. Ignoring

illnesses, as many clients learn, do not make them go away. Taking responsibility for living with illnesses, adapting and coping with them, and strengthening the healthy parts of clients does often lead to recovery. Community living with the freedom, choices, and lack of external control it implies, requires a model that incorporates "collaboration" and "empowerment" as tools to promote self-responsibility.

To move to a collaborative, multifaceted relationship, massive rethinking and retraining will be needed on all sides; professionals, clients, families, and even society in general. Although the medical model has frustrated and failed us, it is extremely strong, entrenched and pervasive. It is stunning how many of us, whether neighbors, police, teachers, landlords, crime victims, doctors, store owners or whoever, refuse to relate to people with severe mental illnesses as anything but walking symptoms and to mental health programs as anything but places to contain and control them. Maybe all of us would be less demoralized and avoidant if we did.

I think it is time for us to talk credibly about and work towards recovery together with our severely mentally ill community members.

This article today strikes me as anything but magical. It feels to me like I got entangled in a complex comparative religion article trying to find God in the commonalities of the various approaches and though the scenery was interesting, I mostly lost my way.

Ten years later, in 2004, SAMSHA took the same tack bringing together for several days over a hundred leaders in the recovery movement attempting to define recovery. (I was going to criticize them for not including Tibetan monks, Christian Scientists or Kabalistic Jews until I realized that I hadn't included any psychotherapy models of recovery in this article) They ended up with the vague enough to please everyone, "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." At this point, I think that's a good outcome. I think any precise definition would create winners and losers, forcing many good people out when we need everyone to be actively involved if we're going to achieve transformation. To find our way we don't have to all be in agreement, but we do have to be heading the same direction.

The Dalai Lama was once asked if we should make a new religion that included all the wisdom of every religion. He replied something like, "The world already has plenty of religions. What we need is more people genuinely practicing them." I think almost all the therapeutic models can create recovery if we genuinely focus on creating recovery as our goal while we're practicing them. That doesn't mean we're all already doing recovery. It means that, with adaptations, we all could be heading that direction.

Martha Long, the Village's director, kept distributing this article long after I had discarded it. She valued most the three categories of things that may be recovered - functions, external things, and internal states - because they create a simple, practical link between our psychosocial rehabilitation practices and values and recovery based goals. Looking back, that is the strongest part of the article because it's centered on what I was already practicing. It's a clear statement of how psychosocial rehabilitation

workers can head in the direction of recovery.