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Phases of the Recovery Process From Psychiatric Disabilities

LeRoy Spaniol, Ph.D.

LeRoy Spaniol, Ph.D. is a psychiatric rehabilitation consultant and
Consulting Editor of the Psychiatric Rehabilitation Journal, Boston University, Boston, MA.
Address: 159 Selden Hill Drive, West Hartford, CT 06107.
Email: lspaniol405@comcast.net

Nancy J. Wewiorski, PhD

Nancy J. Wewiorski, PhD is a Research Associate at the Mental Illness Research Education
and Clinical Center (MIRECC), Bedford VA Medical Center, Bedford, MA 01730

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Abstract

The purpose of this paper is to describe the phases of recovery from psychiatric disabilities and their implications for interventions. The paper identifies the many variables at work in recovery, including phases that occur over time, areas of development within which people change, developmental tasks and processes, and turning points that represent important shifts within the phases and within the developmental dimensions.

Key Words: psychiatric rehabilitation, recovery, mental health

Introduction

This article describes recovery as a neurobiological, psychosocial, spiritual, and developmental process. Through these complementary perspectives, we can understand how people with psychiatric disabilities change, and how positive or negative internal and external factors influence these changes. These new perspectives of how people are impacted by a wide variety of life situations and how they recover (Davidson, Harding, & Spaniol, 2005 & 2006; Moller & Zauszniewski, 2010; Spaniol, Wewiorski, Gagne, & Anthony, 2002) can enhance the more traditional medical and symptom focus of many mental health professions.

The findings of recent research on people who self-described themselves as recovered identifies the recovery process as taking place in phases (Spaniol, Wewiorski, Dunn, & Chamberlin, draft paper, 2011). This current perspective is consistent with the authors' previous five-year study of people who were in the early phases of their recovery process (Spaniol et al., 2002). The concept of phases is reinforced by these two studies, as well as by some of the earliest research on recovery conducted by Davidson and Strauss (1992); Harding et al., (1987); and Strauss, Hafez, Liberman, and Harding, (1985). The phases tend to be overlapping and cyclical, representing the general flow of the recovery process. As these phases are described in the present article, they are integrated with self-reports of the recovery process as reported by people with psychiatric disabilities and by the large body of research literature on recovery. The four phases described in this article are:

- Phase 1: Overwhelmed
- Phase 2: Struggling
- Phase 3: Living with
- Phase 4: Living beyond

This article describes each phase of recovery. Personal quotes by participants in our most recent study are followed by suggestions for useful interventions that have been developed by the authors, based on research literature and self-reports. Turning points in all the phases represent important positive or negative shifts in attitudes and behavior by people in recovery (Estroff, 1989; Davidson & Strauss, 1992; Rakfeldt & Strauss, 1989; Topor, Svensson, Borg, Bjerke, & Kufas, 2000; Table 1). These turning points are influenced by a variety of internal and external factors (Lucksted, 1997). People may also remain in a particular phase without moving forward for a variety of reasons, including inadequate medication or treatment, lack of opportunities, negative attitudes of people in their lives, need for time to integrate important experiences, and untreated substance abuse or trauma experienced prior to or after the onset of the disability (Kramer & Gagne, 1997; Onken, et al, 2007).

Phase 1: Overwhelmed

Phase 1 begins at the time of onset of people's symptoms and can last for many months or even years. During this phase daily life often becomes a mental and physical struggle as people try to understand and manage what is happening, yet feel confused, disconnected from themselves and others, out of control, and powerless over their lives. People also often lack self-confidence because they fear becoming overwhelmed by internal or external experiences.

There are four major turning points of this phase of the recovery process. The first is the onset of the early stage, sometimes called the prodromal stage, which can continue for many years before an actual breakdown occurs (Cornblatt, Heinssen, Cannon, & Lencz, 2003). The second is the breakdown itself, when people finally become overwhelmed by symptoms and the accumulated loss of functioning across the developmental dimensions (described in Table 1). The third turning point is the stabilization of symptoms. The fourth entails moving beyond feeling overwhelmed and beginning to reclaim a sense of self and successful functioning (Estroff, 1989; Davidson& Strauss, 1992; Moller & Zauszniewski, 2010).

Early Phase (prodromal)

Frequently, an intense struggle begins long before the formal diagnosis (Corcoran, et al., 2003). This struggle may include any of the following experiences: increasing distress, problems with school or work, difficulties in relationships, lack of a direction in life, mood swings, low self-esteem, loss of a sense of self, anxiety, substance abuse, and a gradual decrease in people's ability to manage their lives. At some point, they may experience a shift toward positive symptoms, such as hallucinations or delusions. Both the behavioral disturbances and the psychiatric symptoms are often rationalized or denied by people and those in their environments. However, these distressing experiences continue to accumulate over time, becoming more and more difficult to deal with. Confusion and disbelief often develop, intensifying people's levels of distress. The experience of the prodromal phase, and subsequent breakdown, may leave emotional scars and behavioral adaptations (Post Traumatic Stress Disorder and interrupted development) that cannot be reduced directly by medication alone. A 53-year-old white woman, with a diagnosis of depression which began quite early in her life, stated:
... I think I always suffered from depression... My mother... would talk about, once I was an adult,... she would

talk about how I would go DAYS as an infant without eating anything, and she would call the doctor, and say "What should I do?" And he'd say, "Oh, don't worry. When she's hungry she'll eat." … So, I think there were signs that if, if today, you know, a parent said, "My baby's not eating, hasn't been eating for days...," they would, you know, look more into that.

Breakdown. As people become overwhelmed by their symptoms, a serious breakdown or downward shift in functioning occurs. They lose control of their thoughts, actions, and feelings. If they do not seek help, it is often forced upon them. Daily life becomes a mental and physical struggle. People often feel confused, disconnected from themselves and others, out of control, and powerless to control their lives. They lack self-confidence and fear becoming overwhelmed by their emotions and their experiences. They may become suicidal as they despair of healing their pain and frustration. Established relationships with family and others often become fragile or broken, heightened by the distress and confusion everyone feels. New relationships can be difficult to establish and are often transient. They are often unable to articulate clear goals or they have goals that are not well anchored in reality. Many people adopt the strategy of withdrawal in a desperate attempt to survive. They are inevitably confronted with the reality that something is happening or are forcibly hospitalized. For example, a 42-year-old white man, who struggled alone with early manic symptoms and was eventually hospitalized, stated:

And it was in my second semester of my freshman year that I first became seriously ill, and I, I, I went into a depression. It's a long story as to how the depression came about, but... uh, and then, um… I, um, I became ill, and I stopped going to classes, and I was put on academic suspension and I left (College), and I joined the Navy, and then, then I became manic, and left the Navy and hitchhiked... went AWOL from boot camp and hitchhiked to, um, Montreal from... from... just off of Chicago. And then, uh, for... then I went back into the Navy, and, um... I, um... took some LSD and I was hospitalized for the first time, that was in '74. ... All I knew was that I was falling apart.

Stabilization. Stabilization through medication and support takes time. The stabilization process can be very emotional because people's feelings about themselves often fluctuate widely. Even when medication is working, people may discontinue it four or five times over several years, relapsing repeatedly. Accepting that what one is experiencing is overpowering and extended is a difficult process. Self-blame, prejudice, and discrimination are barriers to acceptance. They lead to disbelief or even denial because it is hard to accept aspects of their lives that they and others devalue. As the disability continues and the reality of the experience begins to become real, acceptance becomes possible. Acceptance involves people acknowledging and framing what is happening, from their perspectives, in a way that helps them to move on with their lives. Acceptance involves both emotional as well as cognitive aspects of people's experiences. For most, acceptance is not simply a matter of making a decision. It involves resolving this decision on an emotional level and acting on it over time.

Stabilization is not a linear process. While people are becoming more stable they may become more vulnerable to relapsing (McCrory et al., 1980). In general, this vulnerability intensifies during a change process. A 34-year-old black woman, with a diagnosis of schizophrenia and a long history of struggling to stabilize her symptoms, stated:
I think I... I sat down with the psychiatrist and talked with him and my social worker, at separate times... about my wanting to get out, and my acknowledging that I had a mental illness, and the only way out was to cooperate. Again, I was hearing "cooperate." And the medication was to help me, and to try it out and see if it actually helped and see if it made me feel better. And to try it out to see if... it showed any improvement to the professionals. …And within a month's time... within a month's time, everything had turned around for me. My, I had a quick... uh, reaction, turnaround reaction, response to the medication. Really quick [snaps fingers], like, within a month's time I was so... mentally and, um... mentally clear...

Moving Beyond the Overwhelmed Phase.

At this turning point people develop confidence in their ability to act in their own interest. They begin to develop a preliminary explanatory framework for understanding their experience, often using medical or psychosocial terms. Framing the experience helps people move on with their lives (Spaniol, Wewiorski, Dunn, and Chamberlin, draft paper, 2011). They recognize the need for coping strategies to develop lives that are satisfying and stable. At this stage, people often accept medication, even when it does not completely manage their symptoms. Some are unable to work, while others can work even when they are highly symptomatic. The disability is still a very present and persistent reality, so the fear of relapse or failure often remains intense. People may not feel fully confident in managing their disabilities or building lives for themselves. They may continue to define themselves as patients and see the disability as controlling their lives. They may even question whether a life is possible with this disability. However, as people recover, their disabilities become less important than other aspects of their lives. A 34-year-old white man describes his experience of “moving beyond the overwhelmed phase” when he states:

I just couldn’t function, I couldn’t think right. Um, so at first, I was in a very bad state. But as the weeks went by there, I was put on Lithium, and it seemed to help a great deal. And by the time I was discharged, I was feeling pretty much normal... um, whatever normal means. So, I was functioning much better. So... so then, um... I came back, I went back to school, and this time I lived at home and that worked out better. I would take one or two classes at a time ...

Useful Interventions by Phase and by Developmental Dimension: Phase 1

The foci of interventions for this phase include stabilization, education for people with the disabilities and their families, conveying hope and an expectation for recovery, building trust and confidence through human connection and activities, treating co-occurring disorders such as substance abuse or trauma, connecting people with their peers, and helping them to become successfully established in the community (for further evidence-based interventions see APA/CAPP task force on serious mental illnesses and severe emotional disturbance practice grid, 2005).

Physical Dimension:

- Provide rapid involvement in treatment and rehabilitation.
- Provide access to ongoing comprehensive, coordinated, and continuous treatment and rehabilitation.
- Encourage adherence to treatment. Failure to take medication can hamper short- and long-term stabilization (Liberman, Kopelowicz, Ventura, & Gutkin, 2002).
- Provide treatment for co-occurring substance abuse, if present. People who use drugs or alcohol have been found to be more symptomatic while hospitalized, relapse more frequently, have poorer psychosocial functioning, and poorer prognosis for recovery. Active abuse affects more areas of life than just the psychiatric disability. It often leads to the loss of important resources and supports for coping with the psychiatric disability such as stable housing and supportive relationships with family, friends, and providers. Effective management of a dual disability requires integrated treatment, more resources from the formal service sector, a stronger informal support network, and greater resilience and stamina within the individual. Integrated treatment of psychiatric disabilities and substance abuse has been shown to be more successful than parallel systems of treatment. Integrated treatment means treatment within the same facility, cross-training of staff, rehabilitation interventions, and a long-term commitment to people (Mueser, Drake, & Noordsy, 1998).
- Provide treatment for co-occurring trauma, past or present. Many people have experienced physical or emotional trauma either prior to or after the onset of the illness. Untreated trauma is a major barrier to moving on in one’s recovery (Spaniol, et al., 2002).

Cognitive Dimension:

- Provide or refer to family education. Early referrals to family education should be considered by all mental health professionals. Family education that includes the family member with the disability shows reductions in relapse rates, symptom relief, improving the well-being of the family member with a disability, and increasing participation in vocational rehabilitation. Research also shows that people with psychiatric disabilities who are involved in family education have better social functioning and require less overall medication (Dixon, McFarlane et al., 2001; Spaniol, 2010). The Family-to-Family educational program of NAMI, for example, has been highly successful in reducing family stress and increasing coping capacity of family members without a disability (Dixon, Stewart, et al., 2001).

Emotional Dimension:

- Provide ongoing support, acceptance, warmth, understanding, encouragement, expectations for improvement, a sense of hope, and abundant reinforcement for the gradual progress of recovery (Liberman et al., 2003).
- Providers should respond constantly and actively to the healthy aspects of people Spaniol, Gagne, & Koehler, 1997).
- Provide opportunities for expressive therapies and rehabilitation interventions that focus on strengths and build self-esteem and confidence. Encouraging the natural creative and healing process can build hope and confidence (Malchiodi, 2012).
- Encourage involvement with peers throughout treatment including during the process of deciding on hospitalization, treatment, rehabilitation, discharge planning, and rehabilitation in the community (Mead & Copeland, 2000; Mead & Hilton, 2003). Peers who have experienced recovery can instill hope in the possibility of recovery for those who are just beginning their recovery process.

Phase 2: Struggling

This phase is characterized by a continuing struggle with the disability, prejudice, discrimination, and feelings of hopelessness and loneliness,. However, these barriers may be balanced by treatment and rehabilitation interventions along one or more of the developmental dimensions, i.e., emotional, social, vocational, physical, cognitive, and spiritual (Table 1). During this phase people may find themselves spiraling up or down in their recovery. Spiraling means that as successful experiences occur, more will likely occur. And, when unsuccessful experiences occur, more unsuccessful experiences are likely to occur. Thus, people often experience significant spurts of growth or decline in functioning at various periods during this phase. These shifts represent important turning points in their recovery.

Acceptance. At this phase, people have reached a point where they accept that what is happening to them requires help. They frame what is happening in various ways. The most common construct is to view their condition as an illness that requires medication. Others may see it as a life force or energy that requires modification. For some, the condition is perceived as a spiritual crisis (Jacobson, 2001). It is important that people frame their experiences in ways that help them to move on with their lives. For example, a 34-year-old white man who decided, after much struggle, to accept his need for medication, stated:

In '92, it was in the summer, in July when I was at the ... hospital. I wouldn't take my medication for about, I think it was four or five days, and finally, I started getting paranoid that the staff there were... that were, they were out to get me, and so I had to do something and I said, "Okay. Maybe I need this medication." So I tried, and I decided I would take it, and I... as soon as I took it, I felt much better, I felt much more relaxed, um... it was, it was like I finally realized that I needed medication. I was one of those people that needed it. I don't think EVERYONE needs it, but I need it.

Prejudice and Discrimination.

These two socio-cultural factors, often described as stigma, make it especially difficult for people to accept their disabilities. These factors can come from within people with the disabilities as they begin to accept what is happening, for example, people may feel uncomfortable identifying with other people with psychiatric disabilities. Or, the prejudice and discrimination may come from other people in their environments who lack a

sense of hopefulness and are unaware of the possibilities of recovery. In addition, people with disabilities may question their ability to rebuild their own lives, wondering "Can I have a life with this disability?" Knowledgeable and caring professionals, family members, and peers are important sources of connections and hope at this phase of the process. For example, a 34-year-old white man struggling with his new identity, stated:
I didn't want to be with the people at the... peer support center, well, that wasn't in existence, but the mental health center people would gather around there. I didn't want to be with THOSE kind of people. Little did I know that... they were just like me. 'Cause I was prejudiced against them, which was amazing because, uh... you know, that's a form of pride. You know? That's no good.

And, a 49-year-old white man with a long experience of coping with his disability in the community, stated:
People discriminate against me, they're prejudiced against me... they treat me unhanded... uh, unjustly…Um... they patronize me. ...These are the forms of stigma that I see and experience. ...And that are written about... in the press. And, uh, and at times, especially when I'm feeling low, I feel rather poignantly. ...And, uh, sometimes it'll take I don't know what before this lets up! And often, talking to people, my... especially my peers, will reorient my morale to the point where I'm thinking, "Well, I'm really not the scum that people think I am..."

Moving Back Into Life

Many people are cautious about starting new activities because they fear losing their tenuous stability. They must develop sufficient confidence to manage their symptoms and the complexities of living their lives. Coping strategies can be useful for managing symptoms such as confusion, hallucinations, depression, and anxiety. These strategies include: activities such as taking medication as directed, connecting with peers and providers, work, exercise, sleeping, talking to a friend, or conversely, reducing activities, avoiding stress, or changing medication. Medication can be very helpful, but usually it is not sufficient for progressing beyond this phase. If people have experienced trauma, either prior to the onset of the illness or during its treatment, people will need to address this. Untreated trauma can be a major barrier to recovery (Cusack, Frueh, & Brady, 2004). Substance abuse and serious health conditions can also hinder recovery (Hutchinson, Skrinar, & Cross, 1999; Mueser et al., 1998; Skrinar, et al., 2005). Some people continue to struggle with distressing side-effects of medication or experience acute symptoms that are not fully relieved by medication. If they have not yet developed confi¬dence in being able to manage their symptoms, prejudice and discrimination, or the general stresses of building their lives, they may avoid helpful actions because the fear of risk may outweigh potential benefits. For example, a 49-year-old white woman, who was struggling to maintain her achievements in her community, reported:
Um, when I first started my job, I relapsed on, on drugs. And after a couple of months, I crashed really bad and I told my board what was going on, and they supported --- I went into the hospital for three weeks --- they supported me on that, and then I had like a... I think a month off, after that, and they supported me, they paid me, and everything. .... because that's part of this industry, you know, is that you have to work with people who have issues like that. So they were great. I mean, they stuck by me, and now they say they're glad they did. But, um... you know, again, that's SO important... to have people there, willing to work with you.

Peer Support

During this phase many people begin to actively develop peer supports, especially helpful relationships with other people who have a psychiatric disability. Peer support, mentoring, and modeling can be important factors in helping people to frame what is happening to them, to remind them that they are not alone, and to develop coping strategies. Peers can be effective in helping them to manage prejudice and discrimination, develop friends and acquaintances, find meaningful work and problem-solve the daily struggles of life. Connecting with peers can also provide an opportunity to share with other people with psychiatric disabilities what they have learned from their own experiences (Chamberlin & Rogers, 1996). A 53-year-old white man, who had received peer support and now worked in peer support, stated:

... I found help in peer support. I've always found help in peers... you know, other sick people. ...We always rallied together, and I'd get jokin' around, and people'd be laughin' and havin' a good time. You know? And we'd... sort of auspicious thing... always felt comfortable with my peers.

Developing Meaningful Roles
Most people slowly develop meaningful and consistent roles in their lives. Assuming typical societal roles enhances their self-esteem and confidence and is very helpful for maintaining a sense of hope. Opportunities to become involved in life help people build confidence and competency. Lack of opportunity to assume a role presents a significant barrier to moving on. For example, a 47-year-old white man with a dual diagnosis, who was strongly motivated to work and proud of his ability to care for his stepmother, stated:
I worked six days a week, six hours a day in a restaurant, uh... took care of this big house that had like five or six bedrooms in it, and a formal dining room and library. Uh, did all the grocery shopping, and uh, I think my step-mother and I sort of took care of each other.

Accepting Responsibility
A turning point occurs when people develop strength and confidence in their ability to act in their own interest. They gradually become aware that they can have an impact on their lives, accept responsibility for their decisions and actions, and take charge of their lives. For example, a 49-year-old white woman, who originally depended on the mental health system to cure her, reported:
And I remember saying, "WHAT???" (Chuckles) I'm like, "NO! That's your job. You have to fix me." He said, "I'm sorry." He said, "I can't do that." And I was... floored! I was just like, "What? I have to do something?" And, that, again was another turning point when, you know, I realized that... I had to do it, you know? And I had to make the changes.

Useful Interventions by Phase and by Developmental Dimension: Phase 2

The foci of interventions for this phase include some of the same interventions as Phase 1, as well as additional actions. These interventions include education for the people with disabilities and their families concerning mental illnesses and coping skills, conveying hope and an expectation for recovery, building trust and confidence through human connection and activities, treating co-occurring disorders such as substance abuse, trauma, or physical illnesses, connecting with peers, acquiring skills to manage symptoms and to cope with the many barriers to recovery, and building skills across the various dimensions of recovery based on self-determined need (Table 1).

- **Table 1: Turning Points: Developmental Dimensions, Tasks, and Processes**

Turning Points: Emotional Dimension: Developmental Tasks and Processes

- Developing a sense of efficacy and taking charge
- Developing a sense of self and identity
- Developing hope
- Coping with the effects of physical or sexual trauma
- Accepting the illness or what is happening
- Developing confidence and self-esteem
- Dealing with prior trauma

- Developing active coping skills
- Developing meaningful, satisfying, and contributing roles
- Taking risks
- Finding a comfort zone
- Pride in accomplishments
- Creativity
- Having fun
- Realizing one is not alone in how one feels

Turning Points: Social Dimension: Developmental Tasks and Processes

- Developing sustaining friendships
- Developing intimacy
- Contributing to others
- Developing family relationships
- Coping with prejudice and discrimination
- Coping with the system
- Developing peer relationships
- Developing relationships with providers
- Feeling a valued member of my community

Turning Points: Vocational Dimension: Developmental Tasks and Processes

- Developing job skills
- Developing and actively completing educational goals
- Finding work
- Developing a career
- Making a career change
- Returning to a desired career

Turning Points: Physical Dimension: Developmental Tasks and Processes

- Coping with the illness
- Developing physical health and fitness

- Coping with symptoms
- Developing a crises plan
- Developing stress management skills
- Managing substance use
- Coping with medications
- Finding the right combination of medications
- Healthy lifestyle
- Having the “things” of life

Turning Points: Cognitive Dimension: Developmental Tasks and Processes

- • Developing new beliefs and ways of thinking
- Challenging self-defeating thoughts
- Acquiring new knowledge
- Developing an explanatory framework
- Developing personal advocacy skills
- Weighing the benefits and costs
- Trying to understand what is happening

Turning Points: Spiritual Dimension: Developmental Tasks and Processes

- Developing meaning and purpose
- Practicing within a religious faith
- Connecting with someone or some thing beyond oneself
- Prayer
- Meditation

Emotional Dimension:

- Provide assistance for setting personal goals and develop steps to achieve them.
- Provide opportunities for building confidence and self-esteem through development of meaningful roles.
- Provide opportunities for taking risks, developing advocacy skills, and having fun.
- Provide ongoing support, acceptance, warmth, understanding, encouragement, expectations for improvement, a sense of hope, and abundant reinforcement of gradual progress.
- Encourage choice as a personal value with opportunities to express it. Choices empower people because choice gives them a sense of control over their lives. However, meaningful choice without options, resources, and support may not feel very real to people. Professionals need to resist the urge to take over while providing

people with useful options.

- Provide continued outreach to people and their families, using a direct yet empathic approach, self-disclosure, and encouragement of education about the illness and its impact. Many studies have corroborated the value of supportive therapy in reducing relapse and improving social lives (Coursey, Keller, & Farrell, 1995; Ruocchio, 1989).
- Encourage self-determination and assuming responsibility for one's life. Many people reach a turning point in their recovery where they acknowledge that if they are going to recover, they are going to have to make the effort to change (Caswell, 2003; Deegan, 1996).

Social Dimension:

- Provide skills and opportunities for developing satisfying friendships and intimacy, contributing to others, developing family relationships, coping with prejudice and discrimination, and coping with the system.
- Provide skills in areas of self-determined need. People with psychiatric disabilities can learn skills despite their symptoms. Learning skills increases rehabilitation outcome. A person's level of skills is actually a better predictor of rehabilitation outcome than diagnostic variables (Anthony, Cohen, Farkas, & Gagne, 2001).
- Refer to self-help opportunities. The active presence of other people who have recovered is very motivating. There is much research supporting the value of self-help across all disability groups (Chamberlin & Rogers, 1996). Referral to self-help programs should be a routine procedure in mental health facilities. Peers should also be available at all points of the treatment and rehabilitation process—from initial intake, to hospital stay, to discharge planning, to treatment, and to rehabilitation in the community. Have qualified people with psychiatric disabilities on staff at all levels of the program.
- Involve family members in the treatment and rehabilitation process. There is much research supporting family involvement as useful to recovery (Clark, 2001; Bogart & Solomon, 1999; Mueser & Fox, 1998; Spaniol, Zipple, & Lockwood, 1992).

Vocational Dimension:

- Provide skills and opportunities for developing job skills, finding work, maintaining work, developing a career, and continuing education. People with psychiatric disabilities have been found to be working at all levels of employment (Russinova, Wewiorski, Lyass, & Rogers, 2003).

Physical Dimension:

- Provide skills and opportunities for developing physical health and fitness, coping with symptoms, developing a crises plan, developing stress management skills, managing substances, dealing with trauma, addressing physical illnesses, and coping with medications.
- Provide ongoing, long-term, integrated treatment of substance abuse and psychiatric disability.
- Provide active involvement in wellness programs such as nutrition, weight management, regular exercise, and good physical health care (Hutchinson, et al., 1999; Skrinar et al., 2005).
- Provide ongoing treatment of trauma related symptoms—trauma that has occurred prior to or after onset of the mental illness. Untreated trauma is a major barrier to recovery. Rosenberg et al. (2001) have stated that "Exposure to trauma, particularly violent victimization, is endemic among clients with severe mental illness." A large percentage of the most difficult to reach women have had a history of sexual or physical abuse (Gearon, Kaltman, Brown, & Bellack, 2003). This is also not uncommon among men.

Cognitive Dimensions:

- Provide skills and opportunities that help people develop new beliefs and ways of thinking, challenging self-defeating thoughts, acquiring new knowledge, developing an explanatory framework, developing personal advocacy skills, weighing the benefits and costs of actions, and understanding what is happening.
- Provide training in writing a relapse management plan, and advanced directives. Also, the Wellness Action Recovery Plan (Copeland, 2002), the Recovery Workbook (Spaniol, Koehler, & Hutchinson, 2009), and other interventions (see APA/CAPP task force on serious mental illnesses and severe emotional disturbance practice

grid, 2002) have been found to be very helpful.

- Provide education in self-monitoring. Self-monitoring includes side-effects and medication but also becoming an observer of one's own positive and negative thoughts and actions, e.g., recognizing them, experiencing them without responding to negative thoughts and actions (Siegel, 1999; 2010). When people become curious about the validity of their perceptions and can observe them without acting on them, then, they have more choices for responding to their perceptions (Podvoll, 1990). Having a friend or family member serve as an additional monitor and "check step" can also be very helpful.

Spiritual/Philosophical Dimension:

- Provide skills and opportunities for developing explanatory framework, e.g., medical, psychosocial, political, spiritual, or some combination, and for developing meaning and purpose. While developing larger meaning and purpose is helpful, people also need to identify their own personal purpose in life. A personal purpose often involves activities or relationships which make people feel useful and valued.

Phase 3: Living With

In this phase of recovery people come to terms with their disabilities and feel confident about managing them. While they may still feel limited by their disabilities, they have found niche in their worlds. They report a strong sense of self and a feeling of confidence in having some control over their lives. They have learned that a satisfying life is possible despite having a disability. People utilize effective coping strategies to deal with their disabilities and assume a number of meaningful roles. They experience more consistency and security in the people, roles, and environments in their lives. Over time, people tend to accumulate possessions such as housing items, clothing, housing, and cars. This ownership helps them to feel like members of society, builds their self-esteem, and increases their sense of being part of their community. People who had been cut off or distant from their families frequently reconnect with them during Phase 3. Although, some may have previously cut off relationships with family because of stress or disagreements, connection with family remains a very deep longing, even when relationships have not gone well. In some instances reconnection is not possible or possible only with some family members.

Finding a Niche. During this phase people come to accept their disabilities, feel confident about managing them, and realize that although some of their medications may reduce their symptoms, this does not by itself create happiness or satisfaction with life. People accept responsibility for developing their lives because they have gained a deeper awareness of their abilities to control their lives. They continue to grow across the developmental dimensions, although growth along one or more dimensions may dominate their attention at any given time. While many may still feel limited by their disabilities, they have found a place in the world that feels appropriate to them. For example, a 34-year-old white man with a diagnosis of paranoid schizophrenia and a strong spiritual focus, stated:

It's a path. A spiritual path. You know? I feel like, sometimes I feel like an urban monk. It's like, you know, all of life is a path, but... to have peace, to have peace -- that's what it's brought me. It's brought me peace.

Work

During Phase 3 most people in this phase are working at least part-time. The role most frequently sought since early recovery is that of "worker." Work has a powerful meaning to people. Working builds self-esteem and helps people to feel a part of their community. Other roles that are valued include parent, friend, student, caretaker, spouse, homeowner, and renter. The acquisition of these roles does not seem to be especially influenced by level of symptoms, but by people's ability to manage their symptoms well enough to carry out their new roles successfully. Active participation in various rolls in the community is very predictive of positive recovery (Kaplan, Salzer, Brusilovskiy, 2012). For example, a 34-year-old white man with a diagnosis of paranoid schizophrenia responded:

I've had my own business for three years, now, which has been... I didn't think it would last this long. You know, I work with computers. I train people in software... with the software titles.

Having a Life

People discover that having a satisfying life is possible. They learn to utilize effective coping strategies consistently. They adopt meaningful living, learning, and working roles. People become increasingly self-confident as their experiences of the people, roles, and environments in their lives become more consistent. Unlike Phases 1 and 2, in Phase 3 people's disabilities interfere much less with their ability to have satisfying and contributing lives. They feel connected to self, to others, and to various living, learning, and working environments in their communities. As a consequence, they attain a sense of meaning and purpose. For example, a 49-year-old white woman described the meaning of her experience of disability by stating:

You know. But... how can I say this .... I feel very strongly that one of the reasons that I have this illness -- and I've gone through this -- is to help other people. You know? And I consider myself very lucky to have gotten, you know, to where I am because I think THIS is what I was meant to do.

Useful Interventions by Phase and by Developmental Dimension: Phase 3

The foci of interventions for this phase include some of the same interventions as Phase 1 and Phase 2, depending on a person's need or request. One important turning point occurs when people assume control over their own treatment by using the mental health system and medication as a resource in their recovery rather than feeling dependent on them. Also, while people during Phase 2 will often accept any job to build their confidence and self-esteem, during Phase 3 they focus more on finding work that fits their unique skills and interest.

Emotional Dimension:

- Provide ongoing support, acceptance, warmth, understanding, encouragement, and abundant reinforcement for gradual progress.
- Encourage people to surround themselves with positive people and environments that support their growth.
- Continue building support and skills along the developmental dimensions.

Phase 4: Living Beyond

In this phase of recovery the disability is a much smaller part of people's experience and does not significantly interfere with their having a satisfying and contributing life. They feel well-connected to themselves; to others; to various living, learning, and working environments, and to a sense of meaning and purpose in life. Functioning well in multiple dimensions of life. People have moved beyond struggling with building meaningful lives to focusing on their present and plans for their future. They experience significant growth along all the developmental dimensions. For example, in describing their current lives, people talk about working, enjoying friendships, and satisfying living arrangements. In general, their lives appear to be well-balanced and stable (Spaniol, Wewiorski, Dunn and Chamberlin, draft paper, 2011). For example, a 41-year-old black man who struggled with both schizophrenia and substance abuse for many years related with a sense of pride:

I had difficult, some difficulties, and rose above, and rose above them to be living in an adequate, normal life, is what I would say about myself

Empowerment

A sense of empowerment often helps people feel in control of their lives. People who feel empowered typically have a sense of responsibility, active coping mechanisms, and an ability to set limits. They have good self-esteem, a personal purpose and meaning, and enjoy contributing to the lives of others. They also have the ability to solve daily problems and stresses successfully. While they may depend on others at times, they see themselves as capable of making important decisions by themselves. For example, a 45-year-old black man with a diagnosis of paranoid schizophrenia and alcoholism described the importance of assuming responsibility for himself by stating:

So I found out in recovery that I wasn't unique, and MY difficulties could be handled if I stopped doing a few things and alleviated some problems, and... basically, was more responsible for myself than just letting it be put off on somebody else..

Contributing to life

In Phase 3 people typically want to share what they have learned from their experiences. Some join self-help or peer-support programs. Some may also want to be contributing members of their broader communities, for example, by volunteering, becoming part of a religious belief, taking academic classes, or joining a bowling league. A 49-year-old white woman with a diagnosis of manic-depression who described her interest in teaching others, by stating:

I really, you know, I'm here for a reason. You know, and I have plenty to share, and I have these gifts, and that's very important to share now, and you know, whatever the pain or the stigma is, or... that's just never gonna outweigh... you know...

Resources to meet life's challenges. People have a willingness to take risks because they know they have the internal and external resources required to meet them and to cope with the stresses they may encounter. Resources described include confidence, effective medications, family, friends, peers, a significant relationship, professionals, and spirituality. Practical problem-solving skills have been developed and are available. Relationships are often enjoyable and enduring. People value others and work in various ways to improve, support, and have fun with them. Although some continue to use disability income as a financial resource, they are able to build a satisfying life at the same time. They may remain vulnerable to emotional stress but also retain the ability to continue developing satisfying lives. A 33-year-old black woman with a diagnosis of schizophrenia and a strong religious belief responded:

I think so. I think it makes you stronger, 'cause you have that foundation of belief in God, and a belief that you're not alone, even in the hardest of the times.

Disability management

People come to terms with their disabilities and feel confident about managing them. The disability does not significantly interfere with their having satisfying and contributing lives. People realize that they are not defied by their disabilities because they have developed their own unique strengths and limitations. They describe themselves in terms of their personhood and not their illnesses. Those who remain connected to the mental health system use it for their own advantage. A 49-year-old white woman with a diagnosis of manic-depression described the importance of being knowledgeable about her medications for her recovery, saying:

... you gotta learn about meds. I mean, I just think it's very important to learn as much as you can rather than just take their word for it. Um, sometimes information is a BAD thing (chuckles)... you know, 'cause it confuses you, or you might not have good information. But I think it's important for people to educate themselves about their illness. I am not one -- I hate documenting, I hate journaling -- but I think it's very valuable if someone's learning about their triggers and all that?

Community integration

People now have roles, interests, activities, work, and long-term relationships. Work has become an important aspect of their self-esteem. Most have work they enjoy, and jobs that meet their skills and interests. Many actively participate in community activities, such as theaters, movies, parties, religion, and volunteer activities (Kaplan, Salzer, Brusilovskiy, 2012). For some, their primary community consists of other people with psychiatric disabilities. For example, a 34-year-old white man with schizophrenia who was developing a small business responded:

I've had my own business for three years, now, which has been... I didn't think it would last this long. You know, I work with computers. I train people in software... with the software titles.

Framing the experience of their mental illness. People accept and frame their disability in a variety of ways

that allow them to move on with their lives. Most attribute it to a neurobiological disorder. Yet, some have never adopted the identity of a "mental patient.” They perceive their experience in other ways, such as one young man who could not identify what had happened to him, but described "it" as now gone. Others experience their disability as more psychosocially based. Some view it as a spiritual experience or a natural transition in their lives. For example a 59-year-old white woman with a diagnosis of schizophrenia, who had a strong spiritual orientation, described her experience as:
Oh, what am I seeing it as? A chance for people WITH mental illness to understand that they’re not too something or they’re not defective, or they’re not lacking something, they’re shamans in disguise.

Inner Drive
People have goals, determination, resilience, and actively endeavor to create their lives. They have a sense of inner strength and can recognize and are confident about meeting their own needs. They are self-motivated and want to contribute to society. Many people engage in personal or political advocacy. A 49-year-old white woman, who felt very good about her determination to survive and succeed, reported:
I just... I’m happy that... that I stuck with it, and that I trusted people, and I had faith, and it came out exactly the way I had hoped. You know? But I also know that I’ve got enough strength that, no matter how it turned out, I’d be... I’d survive it?

Hope
Optimism and hopefulness about the future fuel ambition and goals. People describe a sense of potential and anticipate further opportunities for progress in their lives. They report personal goals they believe they can achieve with reasonable effort. They regularly associate with people who care about them and give them hope. For example, a 33-year-old black woman with a diagnosis of paranoid schizophrenia, whose life was steadily moving forward in a direction she chose, responded:
I'm making plans...in 2007; I'd like to be back in California. That's the one goal that I made for myself. ...And between now and then, I plan to get another job...which, very likely, may be just this one job at Logan, and pay off my student loan....

Satisfaction with current life
People report their current life as fulfilling and satisfying, recognizing that they have found a niche in their communities. They describe using effective coping strategies consistently and adopting successful living, learning, and working roles that make their lives meaningful. They also describe feeling more secure and becoming consistent in their various roles and environments. They have aspirations and goals for the future, and feel pride in their accomplishments. A 27-year-old white man with a diagnosis of paranoid schizophrenia, who described his happiness with his current place in life, responded:
... all I can say is, I'm happy. And, uh.. You know. And I think I'm actually trying to find a way that can help other people, um... through my experiences, 'cause I really feel like, you know... they didn't give us any hope, but somehow it just all worked out from somewhere...

Useful Interventions by Phase and by Developmental Dimension: Phase 4

During this phase interventions are absent or minimal. People may want continued monitoring of medication, involvement with a therapist, or peer support groups. However, they are dealing successfully with the ordinary problems of living a life. They are likely to be having fun.

Conclusions

Recovery involves growth across the developmental dimensions. This growth can be represented by phases and turning points in the recovery process. Understanding the developmental dimensions, phases, and turning points of recovery can give hope to people with psychiatric disabilities, their loved ones, and those who care about them.

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