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The road to recovery

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Author(s)	Cleary, Anne;Dowling, Maura
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ABSTRACT

Internationally, recovery in mental health has attracted considerable attention. However, recovery is complex and difficult to untangle because it encompasses many concepts. Recovery is also both a process and an outcome requiring internal and external conditions. This review of the literature on recovery in mental health discusses the following key concepts of recovery in mental health: empowerment, hope, non-linearity, and risk taking. Furthermore, the importance of interpersonal skills, collaborative working, and sharing knowledge by mental health professionals are explored.

Key words: recovery, mental health, empowerment, risk-taking

Introduction

This literature review aims to untangle the complex concept of recovery in mental health. Recovery is irreducible to a simple construct and while its competencies are now part of everyday language in mental health, there are instances where they are not implemented into practice (Ridgway, 2001).

Recovery emerged as a guiding vision for mental health service delivery in the USA in the 1990's (Ralph *et al* 2002), in New Zealand since 1998 (O'Hagan 2001), in the UK since 2001 (Department of Health 2001), and more recently in Ireland (Department of Health and Children 2006). Recovery has its roots in the consumer/survivor self help movement dating back to the 1930's (Onken *et al* 2007). The revival of the present recovery movement continues to be consumer driven, and became more prominent in self-help writings and through social movements during the 1960's and 1970's (Boevink 2006, Ridgway 2001). The consumer/survivor movement has created a powerful platform for the recovery experiences of people using mental health services, which has challenged therapeutic pessimism of previous decades (Watkins 2007).

Literature review method

The search for information concentrated on all aspects of recovery in mental health with a particular focus on its defining attributes and the role of the mental health professional in promoting recovery. A literature search was undertaken for papers published 2002-2008 on CINHAL, MEDLINE, Medscape and PsychoINFO. Key words used were “recovery,” “mental health,” “mental illness,” combined with “knowledge” and “attitudes”. Recovery associated with addictions was excluded as the primary focus was on recovery from what is often referred to as ‘serious mental health problems’. In addition, manual searching of relevant references and secondary sourcing of relevant papers was undertaken.

Defining recovery

Recovery in mental health is difficult to define because there is no succinct or universally accepted definition. Professional definitions of recovery distinguish between complete clinical recovery, which has a complete absence of symptoms, and social recovery that allows people to live independently even if symptoms persist (Social Care Institute for Excellence [SCIE] 2007). Whitwell (2005) however, notes that the use of such definitions would see fewer recover from long-term mental health problems.

This review of the literature reveals that recovery in mental health encompasses the following themes: empowerment, hope, non-linearity, risk-taking, and interpersonal skills, collaborative working and sharing knowledge. These themes overlap but are presented separately here in order to untangle the complex nature of this concept.

Empowerment

Inextricably interwoven in the conceptualization of recovery is the notion of empowerment. Many of the concepts that underpin recovery are related to empowerment, such as self-esteem, personal worth and feeling in control (Young and Ensing 1999). Moreover, similar to recovery, empowerment reflects a non-linearity in its process. In essence, there can be no recovery without empowerment.

However, difficulties with the use of empowerment in mental health are evident where traditionally power has been with the professional. An important issue to consider therefore is “not only how the powerless” attempt to take power but also how the “powerful” release power (Gibson 1991, p.355). Barriers to empowerment include an unwillingness to listen and share power coupled with fear of the unknown ((Linhorst *et al* 2002). This view is supported in a study of mental health professionals within a community mental health team (CMHT). Warne and Startk (2004) report that “consistently the consultant psychiatrist was identified as the most powerful member of the team who had ultimate power, generally most other staff involved in the care of service users were seen as subordinate to the psychiatrist” (p.657). Furthermore, it is argued that mental health professionals use empowerment as an intervention to produce compliance and is a “coercive strategy that is used, justified by its outcomes” (Powers 2003, p.227). However, recovery is not something that professionals do to a person; it is something service users do for themselves (Anthony 1993).

Hope

Hope and optimism are also key components of the recovery process and in their absence, recovery is less likely. However, hope is generally depicted as an elusive concept in the literature. Its elusiveness is evident in its definition; which describes hope as “a multidimensional construct having the same purpose for all people” (Sachse 2007, p.1549). Parse (2000), however, more helpfully, describes hope as enmeshed with health and quality of life, offering anticipated possibilities in each day.

Hope in people with mental illness is no different from that of the general population. For instance, in a qualitative study reported by Noh *et al* (2008), participants hoped for a sense of meaning in their lives, to be loved, to have fulfilling relationships with families and communities and feel included. Hope is particularly important at the initial contact stage with mental health services and one of its most important characteristics is determined by its interpersonal nature. The relationship between clinician and service user is therefore a central hope inspiring strategy, and it is this interpersonal relationship which acts as a conduit for inspiring hope (Koehn and Cutcliffe, 2007). This relationship

is described as the skill of connecting in a meaningful way through active listening, acceptance, and trust that serves to rekindle hope (Cutcliffe 2000). Mental health professionals should therefore reflect on their role of hope providers for service users.

Non-linearity

Hope and the non-linearity process of recovery are also inextricably linked. Recovery is a process, not an end point destination, exhibiting problems and possible setback along its way. Its non-linearity is encapsulated in the description of recovery offered by Chamberlain (1995) who views recovery as a series of small steps with the course often being unpredictable as people falter, regroup, and start over again with the process. Professionals facilitate the non-linearity process by having realistic expectations for service users and instilling hope. Where professionals have low expectation for service users, they delay the recovery journey and in fact encourage learned helplessness (Roberts and Wolfson 2004).

It is also appropriate here to highlight that the narrative literature of service users frequently discusses recovery without reference to illness, symptomatology, or treatment. Moreover, principles of recovery involve building a meaningful satisfying life defined by the individual, irrespective of the fact that there may or may not be ongoing or recurring symptoms (Shepherd *et al* 2008). A stage of recovery therefore, can be visualised as re-conceptualising the illness as part of oneself, not a definition of the whole. This has been highlighted in outcome studies in schizophrenia which show favorable results where the individual has the ability to differentiate the self from the diagnosis (Harding 2003).

Risk-taking

Risk-taking is also essential to the recovery process. A central tenet of current practice is to empower people who use mental health services to take control of their lives and illness, including the right to make mistakes. However, risk is commonly regarded as something negative and to be avoided and frequently defined in terms of physical harm to self and others (Ryan 2001). Risk therefore requires professionals to accept and

encourage a trial and error approach, with meaningful feedback and being prepared to rescue service users if necessary (Yurkovich *et al* 1999).

Risk taking is the core of community care (Harrison 1997). Holloway (2006) emphasises the value of the therapeutic relationship in managing risk, particularly where there is a trusting relationship. Conversely, risk avoidance can interfere with the therapeutic working relationship, and defensive practice over therapeutic risk taking should be avoided (Harrison 1997).

Central to the concept of risk taking is the acknowledgment of consumer choice and self-determination, which are key features of recovery. The dignity of risk is based on the observation that double standards prevails for people with a mental illness. People who are not affected by mental illness are free to make risky choices without interference from authorities to protect them from the consequences of such choices. Moreover, intertwined to the concept of dignity of risk is the opportunity for growth, irrespective of the potential for failure. It is argued that all people learn through a process of trial and error (Parsons 2008); that risk is inevitable and healthy, and without risk, progress is stagnated (Roberts and Wolfson, 2006).

A difficulty with the concept of risk-taking is that it means different things to different people. Moreover, the management of risk needs a comprehensive multidisciplinary approach to care with good communication and information sharing and clear lines of responsibilities and accountability (Wright and Stockford 2001). However, there is a dearth of literature promoting therapeutic risk taking otherwise referred to as positive risk taking (Stickley and Felton 2006). Another difficulty is the tensions that exist between policies and practice. On one hand is the promotion of choice and freedom, and on the other, the endorsement of control is evident (Barker 2000). Therefore, professionals are placed in the difficult position between two competing forces of positive risk taking and risk management. This tension is particularly evident in cases of acute relapse where promoting autonomy and protecting the public appear to conflict. This necessitates the

individual's right to freedom being balanced with society's right to protection (Stickley and Felton 2006).

Interpersonal skills, collaborative working, and sharing knowledge

The importance of the interpersonal relationship between professional and service user is well documented in the literature. Central to this relationship is the need for an equal relationship between professional and service user, where reciprocity is embraced (Dorrer and Schinkel 2008).

The skills required by mental health professionals in promoting recovery are inextricably linked to the skills needed to promote empowerment. Recovery challenges professionals to develop practice changes such as being less formal in professional roles. Moreover, professionals need to be able to manage their own personal anxiety as service users are allowed take risks and are respected for their expertise by experience (Schrank and Slade 2007). This re-conceptualisation of role includes an understanding that the professional role "will become facilitative rather than directive in nature, hope inspiring rather than pessimistic, and autonomy enhancing rather than paternalistic" (Sowers 2005, p.770).

Recovery orientated practices therefore calls for a redefining of the role of the professional from outside expert on the illness to mentor and companion on a journey accepting equal partnership with the service user (Forchuk *et al* 2003) as a starting point. However, such process requires service providers to be imaginative in engagement with alternatives in treatment (Buchanan-Barker and Barker 2008).

Discussion

The concepts of empowerment, hope, non-linearity, risk-taking, interpersonal skills, collaborative working and shared knowledge, are also evident in a grounded theory framework on recovery proposed by Ochocka *et al* (2005). Their framework arose from a longitudinal study with a sample of 28 Canadians who experienced severe mental health challenges. Ochocka *et al* (2005) describes the following four themes: "the drive to move

forward”, “the spiral of life struggles”, “the context of recovery” and “how people move forward”.

The theme “the drive to move forward” draws on the importance of the components of hope and optimism, determination, faith in a higher power, and awakening or a turning point in helping the person move forward. The drive to move forward is viewed as a starting point of the recovery journey where motivation to change is nurtured. While the motivation is often fuelled by renewed hope, equally, significant relationships in the service user’s life can convey hope and optimism. When professionals take on this role they do more than their professional role, which Higgins and McBennett (2007) refer to as the blossoming of the petals of recovery because they show their belief in the service user when she/he is unable to do so.

Self-determination is also seen as one of the prerequisites to a recovery process. Having a spiritual belief has also been reported by Ochocka *et al* (2005) as giving strength and motivation to move forward and also in supporting people in finding meaning and purpose in life, which is a key element of recovery.

The theme “the spiral of life struggles” embraces the notion of recovery being a non-linear process where service users experience accomplishments and setbacks. Examples of positive accomplishment reported in the literature indicate service users having improved relationships, feeling included in their community, feeling confident and assertive and in more control of their mental health treatment (Nelson *et al* 2001). Setbacks include feeling isolated, difficulties in relationships, financial and work related difficulties (Ochocka *et al* 2005).

The theme of “the context of recovery” occurs on two levels; within the individual and in the external environment. Moving forward in recovery necessitates gaining mastery over their internal state and feelings which nurture feelings of empowerment. In addition, recovery is viewed as profoundly a social process, where service users need to feel connected to communities and society (Smith 2000). Conversely, external factors such as

lack of support, insufficient housing, and unemployment, and unresponsive or inaccessible services all hinder the recovery process (Smith 2000).

Ochocka *et al* (2005), refer to the final theme of “how people move forward” as the dialectic process of negotiating between the reality of what service users are experiencing internally and the world they reside in. To move forward involves using accommodation orientated negotiation strategies, where the service user acknowledges the limitations the symptoms of mental health place on them. They learn to set personal boundaries and aspire to realistic personal goals. Service users also move forward by drawing on action orientated negotiation orientated strategies encompassing positive thinking and taking control of the various aspects of their lives.

Longitudinal studies continue to confirm the prospects of recovery in severe mental illness. Such studies reveal that improvement in well-being is an expected goal, and that this can happen with or without service practitioners and formal service initiatives (Warner 1994, Topor 2001, Davidson 2003, Davidson *et al* 2005, Ralph and Corrigan 2005).

Harding (2003) refers to seven international long-term studies where at least 50-60% of each intact cohort studied across two to three decades significantly reclaimed their lives, in spite of persistent beliefs that this would be impossible, revealing further evidence in support of recovery. However, in order to facilitate service users’ recovery, mental health professionals require certain competencies. These competencies are outlined in the New Zealand guidelines on recovery competencies for mental health workers (cited in Roberts and Wolfson 2004) and include an understanding of recovery principles, an appreciation of service users’ rights and a comprehensive knowledge of community services and resources.

The recovery competencies for mental health workers reflect the central role played by the service user/professional relationship. The Recovery Alliance Theory (RAT) proposed by Shanley and Jubb-Shanley (2007) in mental health nursing, offers potential

in delivering recovery based care through the therapeutic relationship. The philosophy of the RAT shifts away from using labels and diagnoses, thus avoiding conflict between nurse and service user. Alternatively, it promotes the service user understanding of their experience as the starting point, thus ensuring a paradigm change in how the nurse and service user relate to each other in their roles (Shanley and Jubb-Shanley, 2007). While this theory's focus is for nurses, it has the potential as a vehicle for a working alliance between service user and any professional discipline, if the professional is willing to embrace a high level of collaboration and mutuality in the therapeutic alliance.

Conclusion

The challenge for mental health professionals is to embrace the various components of recovery in their approach to care. Recovery orientated services represent a philosophical approach to service delivery that complements other specific interventions provided to ameliorate the symptoms of illness. The attitudes of all mental health professionals are also very important in shaping environments which facilitate recovery.

It is also vital to stress that recovery cannot be an “add on” to existing services, supports or systems (Davidson *et al* 2007, p.31). It must be seen as neither the latest fad nor trend in delivering mental health care. Appropriately, Glover (2005) warns that many services would be satisfied if a “recovery model” of working could be packaged as a “how to do it” manual for implementation, and she cautions that:

“The risk of doing so would serve further to reinforce the dominant objective based service delivery and take away the uniqueness and flexibility required in discovering and supporting a recovery space.....our need or desire to package and model recovery will be one of the major threats to embracing an authentic recovery based framework, one driven by wisdom; put simply recovery orientated practice cannot be franchised” (p.4)

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