

## Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery

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### Abstract

**Background:** There is an increasing global commitment to recovery as *the* expectation for people with mental illness. There remains, however, little consensus on what recovery means in relation to mental illness.

**Aims:** To contribute to current efforts to tease apart the various aspects of recovery appearing in the psychiatric literature by describing two conceptualizations of recovery from and recovery in mental illness.

**Method:** Review of empirical literature on recovery and use of the term in clinical and rehabilitative practice.

**Results:** Two potentially complementary meanings of recovery were identified. The first meaning of recovery from mental illness derives from over 30 years of longitudinal clinical research, which has shown that improvement is just as common, if not more so, than progressive deterioration. The second meaning of recovery in derives from the Mental Health Consumer/Survivor Movement, and refers instead to a person's rights to self-determination and inclusion in community life despite continuing to suffer from mental illness.

**Conclusions:** The implications for practice of each of these concepts of recovery, as well as for that group of individuals for which neither concepts may apply, are discussed.

**Declaration of interest:** None.

**Keywords:** *Recovery, civil rights, self-determination, social inclusion, outcome*

Every Sunday we used to go to grandma's house for Sunday dinner before I became mentally ill and it hasn't been the same [since]. So I would like to do that.

I like living alone and I like things like taking care of myself and not having people watch me take my medicine 'cause I can take it on my own.

These two quotes from people living with serious mental illnesses were elicited in response to the question: "What would recovery look like for you?" Chosen from among many such statements derived from a decade's worth of qualitative research, we take these statements to represent two broad categories of recovery. In this paper, we describe each of

these conceptualizations of recovery, mindful of the preliminary nature of these notions, the non-linear nature of processes of recovery, and the fact that these categories refer not to people but rather to the nature of a person's relationship to mental illness. In fact, we go so far as to suggest that both of these forms of recovery can co-exist in any one person, with considerable fluidity across the permeable parameters we propose below. If there is such fluidity across these conceptualizations, and if these two types of recovery can co-exist within any one individual over time or even at the same time, of what possible use are these notions? Why, in other words, would we bother to suggest such overlapping constructs?

We offer two justifications for our efforts. As the subtitle above suggests, we first hope that distinguishing between these various notions will help to lessen the confusion that continues to plague use of the term recovery in relation to mental illness. In the first section below, we offer a brief historical account of the origins of this confusion. We then begin to address the different implications of each of these conceptualizations of recovery from and recovery in for clinical and rehabilitative practice. With the recommendations of the President's New Freedom Commission on Mental Health (DHHS, 2003) and subsequent *Federal Action Agenda* (DHHS, 2005), recovery has been mandated as the overarching aim of mental health care in the United States. This unprecedented advance in US policy is reflective of an increasing global interest in recovery as *the* expectation for people living with mental illness. It remains the case at this time, however, that there is little consensus on what recovery means in relation to mental illness or what is to be entailed in transforming mental health services to promote it (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). We consider these aims to be of sufficient urgency and import to warrant dissemination of admittedly preliminary efforts to tease apart the various and at times contradictory aspects of recovery and recovery-oriented practice appearing increasingly in the literature (e.g., Andreasen, Carpenter, Kane, Lasser, Marder & Weinberger, 2005; Corrigan, Salzer & Ralph, 2004; Kelly & Gamble, 2005; Liberman & Kopelowicz, 2005; Resnick, Fontana, Lehman & Rosenheck, 2005; Roberts & Wolfson, 2004).

The fact that these efforts remain preliminary after a decade's worth of research leads us to our second justification. Like mental illness itself, the notion of recovery represents a multi-dimensional set of phenomena which may share nothing more than a Wittgensteinian sense of "family resemblance". As Estroff (1994) pointed out over a decade ago, dynamic interactions between the complexities involved in serious mental illnesses with those complexities involved in the human beings who suffer from and recover from these illnesses result in an extremely complex terrain, about which we still know very little. When so little is known in the face of such complexity, there is no way to progress other than through provisional and inadequate, but hopefully still useful, efforts which can then be superseded by the more well developed ideas which result from the dialogue which these first efforts stimulate. It is with this intention of stimulating further dialogue that we offer the following concepts of recovery from and in serious mental illness, beginning with a brief historical introduction.

### **A brief history of recovery**

One source of the confusion surrounding the concept of recovery in relation to serious mental illness is the fact that it is the product of the convergence of at least two very different forces. Beginning with the International Pilot Study of Schizophrenia launched by the World Health Organization in 1969 (WHO, 1973), there have been a series of rigorous longitudinal studies conducted around the world which have demonstrated a broad heterogeneity in outcome for serious mental illness (Carpenter & Kirkpatrick, 1988). Specifically, this line of

research has documented partial to full recovery in between 25–65% of each sample. Recovery in this context has been defined as the amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social, and vocational activities within what is considered a normal range. What these studies suggest is that at least one quarter, and up to two-thirds, of people diagnosed with a serious mental illness will achieve this form of recovery from the disorder and its effects (e.g., Ciompi, 1980; Davidson, Harding, & Spaniol, 2005; Davidson & McGlashan, 1997; Harding, Zubin, & Strauss, 1987; McGlashan, 1988).

This was not the only sense of recovery to emerge from research on course and outcome, however. Heterogeneity was not only discovered in the course and outcome of illnesses across people, but also across various domains of functioning within any given individual and over time. That is, not only did serious mental illness prove not to be a permanent condition for many people, but it also was found not to pervade the entirety of the person's life. Instead, researchers discovered that mental illnesses were multi-dimensional disorders composed of several domains of functioning which were both conceptually and empirically distinct. Some people were able to recover functioning in one or more of these domains (e.g., live independently and work), while simultaneously experiencing impairments or symptoms in other domains (e.g., hearing voices). Others may no longer experience psychotic symptoms, but still have moderate functional impairments in social relationships and/or employment. Taking into account the fact that these distinct domains are only “loosely-linked” (Strauss & Carpenter, 1977), concepts of symptomatic recovery, partial recovery, and social recovery began to be used to describe various outcomes.

Offering living proof of recovery, the 1970s also witnessed the early advocacy efforts of those individuals who have since come to refer to themselves as ex-patients, survivors, or consumers or users of mental health services. Having left or been released from mental hospitals, these advocates both demonstrated by example and argued forcefully that people with serious mental illnesses can, and should be entitled to, have a life beyond that of a “mental patient”. As advocates intent on reforming mental health policy and practice, leaders of this movement had little interest in the conceptual or empirical distinctions employed in psychiatric research drawing more from their own first-hand experiences of illness and recovery.

In the life experiences of these advocates, the categories of abnormal and normal, illness and health were not nearly as black and white as traditional diagnostic practice had suggested. In fact, the lines between these categories seemed fuzzy and permeable at best and arbitrary and political at worst (this was, for instance, during the Cold War, when many Soviet dissidents were placed in mental hospitals). As a result, their agenda was not so much recovering from or getting over a mental illness such as psychosis as it was figuring out how to live a safe, dignified, and autonomous life given whatever hand they had been dealt by fate. For guidance in this process, they looked beyond the mental health system to examples of other populations who had faced adversity and overcome marginalization and discrimination. It is within the context of this agenda and appeal outside of mental health that a second major concept of recovery emerged.

This second major form of recovery in relation to mental illness, what we refer to as “recovery in” as opposed to “recovery from” has its origin in the Independent Living and Civil Rights Movements of the 1960s and 1970s. It also has been influenced by the notion of recovery that is integral to the self-help community in addiction, as exemplified by abstinence-based 12-step groups such as Alcoholics Anonymous and its derivatives. This sense of recovery does not require remission of symptoms or other deficits, nor does it

constitute a return to normal functioning. Rather, it views mental illness as only one aspect of an otherwise whole person. Unlike in most physical illnesses, people may consider themselves to be “in” this form of recovery while continuing to have, and be affected by, mental illness. Recovery refers instead to overcoming the effects of being a mental patient – including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization – in order to retain, or resume, some degree of control over their own lives. Given the traumatic nature of being treated as a mental patient, advocates have argued that return to a pre-illness state is impossible, emphasizing instead the gains the person has had to make to manage and overcome the disorder (Chamberlin, 1978; Jacobson & Greenley, 2001; Roe & Chopra, 2003).

The fact that these two different meanings of the term have grown up in parallel over the previous 30 years helps to account for some degree of the confusion surrounding this term. The convergence of these two perspectives within the past few years has now contributed to a situation in which recovery has come to mean different things to different people, resulting in a remarkable degree of inconsistency in how the notion is used to inform practice. To begin to reduce this inconsistency, we offer a framework for identifying and understanding the implications of each of these two central notions for recovery-oriented care.

### **Recovery from serious mental illness**

I like to stay productive, keep in touch with people, write letters and just like how it used to be, write letters, have a job, clean my room, do laundry, walk to the store.

The longitudinal psychiatric research described above involving large samples and utilizing rigorous designs and standardized rating scales for assessing symptoms and functioning over time has now demonstrated consistently over 30 years that there is a broad “heterogeneity” in outcome for serious mental illnesses (Carpenter & Kirkpatrick, 1988; Davidson, Harding & Spaniol, 2005). Specifically, these studies found that while some people diagnosed with serious mental illnesses did show a classic Kraepelinian deterioration in functioning over time, they accounted for only about 25% of each sample. Equally prominent were individuals who fell at the opposite end of the spectrum, showing no observable signs or symptoms and no residual impairments from the disorder between 2 and 32 years after onset, accounting for an additional 25% of each sample. For these individuals, the notion of recovery may be considered a synonym for cure, implying that the person has been restored, through whatever means, to the same presumably normal condition that existed prior to the onset of the illness.

But what about the remaining 50% of the sample? If 25% of the sample resides at each end of the spectrum ranging from severe and persistent disability to full recovery, what is the fate of the remaining half? The term “heterogeneity” was selected, and has since been accepted, to refer to the fact that people have experienced illnesses which fall anywhere and everywhere along this continuum. Depending upon where the study was carried out, at least 45% and up to 65% of each sample were found to experience partial to full recovery, meaning that their functioning and symptom levels improved over time. On the whole, then, this body of research has established not only that recovery is possible, but that partial to full recovery is at least as common an outcome in serious mental illness, if not more so, than severe, persistent impairment.

With this reversal in expectations (from deterioration over time to improvement) we come to our first major meaning of the term recovery in relation to serious mental illnesses: a sense

we refer to as “recovery from”. Recovery from serious mental illnesses involves the amelioration of symptoms and the person’s returning to a healthy state following onset of the illness. This definition is based on explicit criteria of levels of signs, symptoms, and deficits associated with the illness and identifies a point at which remission may be said to have occurred. This definition thus has many advantages from clinical and research perspectives, as it is clear, reliable, and relatively easy to define, measure, and link to dysfunctions or well-being in other areas of life. People who enjoy this sense of full recovery could be considered to have recovered from psychosis in the same way that other people may recover from an infection, a broken leg, or, in the case of recovery over a longer period of time, asthma.

The similarities between this form of recovery from serious mental illnesses and recovery from other health care conditions such as asthma extend to its implications for practice. That is, mental health care that promotes this form of recovery bears the most resemblance to other forms of health care for other, primarily physical, conditions. Those who recover from a severe mental illness appear to be able to access, utilize, and benefit from mental health care the way other people are able to access, utilize, and benefit from primary health care. For these individuals, recovery from a major depressive or psychotic episode may involve seeking an evaluation and diagnostic assessment from a qualified health care practitioner, being educated about one’s condition and the various treatments and other interventions available to address the illness, participating in those interventions which hold the most promise while posing the least side effects, and benefiting sufficiently from their effects to be able to return to one’s previous state of health or relative well-being. As in the two quotes we have chosen to represent this form of recovery, people describe resuming the kind of life they had prior to the onset of the illness, whether this is characterized by returning to work or being able once again to go to Grandma’s house for Sunday dinner.

As this last example suggests, there may of course be more to recover from in this form of recovery than merely the effects of the illness itself. We may infer that the woman quoted above was not only impeded in her wish to visit her Grandmother by the effects of her illness, but that perhaps her family no longer welcomed her at these gatherings as well. Even some people who suffer from one episode of mental illness and recover fully in terms of an abatement of symptoms and restoration of functioning may still also have to recover from the social impact of the illness. They may be concerned about the repercussions of other people finding out about their history of hospitalization, or they may choose to remain active in advocacy or other issues in order to address the discrimination they had to face. Either way, in this form of recovery the illness itself becomes an increasingly small part of the person’s life, is relegated to his or her past, and no longer presents difficulties or poses an impediment to the person’s aspirations and ongoing pursuits.

### **Recovery in serious mental illness**

To clean my own house, to do my own laundry. Not to drink, to stay clean. And just try to make myself as happy as possible.

For the remaining 35–75% of a given sample who do not recover in this first sense of the term, we suggest that there are at least a couple of possibilities. From the perspective of mental health care, we can continue to attempt to treat the illness, hoping to reduce its deleterious effects until the person has eventually recovered. For the foreseeable future, however, there will be individuals for whom treatment will produce only limited success in containing the disease similar to the way in which repeated doses of Tylenol do little in the face of an infection. It is these individuals, for whom existing care is relatively ineffective,

who some practitioners have in mind when they worry that using the term “recovery” offers false hope and sets people up for failure and disappointment (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006). We suggest, to the contrary, that a different use of the term recovery presents an alternative, and more constructive, approach to meeting the needs of precisely this population.

This alternative involves accepting for the near future that these conditions may not go away and focusing – *in addition* to treating the condition – on how the person can learn to live with it. This is the sense of recovery *in* which was first introduced by people “in recovery” from addiction, and which has since been borrowed by the mental health community. To be “in recovery” from addiction and/or mental illness refers to the process of living one’s life, pursuing one’s personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse. A central part of this form of recovery is the person’s use of his or her own strengths and remaining areas of health and competence, along with the acceptance of caring others and a supportive environment, in managing the disease and compensating for its effects, all the while holding out hope for an eventual cure.

What mental health advocates appear to have found most appealing in this sense of recovery is that people with long-term conditions could work towards reclaiming control over their own lives and destinies while exploring ways to minimize the destructive effects of an enduring condition (Roe, Chopra & Rudnick, 2004). As we mentioned above, in addition to borrowing this term from the self-help addiction community, this sense of recovery has been informed by both the Civil Rights and Independent Living Movements. For the Mental Health Consumer/Survivor Movement, these other movements have been viewed as crucial due to the fact that many of the more formidable barriers to this form of recovery do not stem from mental illness per se. For advocates who had been hospitalized against their will, for example, it was evident from early on that their struggles were as much social as they were personal in nature.

As a result, this concept of recovery refers primarily to a person diagnosed with a serious mental illness reclaiming his or her right to a safe, dignified, and personally meaningful and gratifying life in the community while continuing to have a mental illness. It emphasizes self-determination and such normative life pursuits as education, employment, sexuality, friendship, spirituality, and voluntary membership in faith and other kinds of communities beyond the limits both of the disorder and of the mental health system, and consistent with the person’s own goals, values, and preferences. It is perhaps for this reason that both of the quotes we selected to represent this form of recovery emphasize the role of the person’s own sense of agency, as in the woman quoted here who wanted to clean her own house and do her own laundry, or the man quoted at the beginning of this article who wanted to live alone, take care of himself, and not have people watch him take his medication, because he could do so on his own.

What implications does this form of recovery have for clinical and rehabilitative practice? We understand recovery “in” mental illness to refer to a process of minimizing the destructive impact of the illness while simultaneously identifying and building on a person’s strengths and interests in order for the person to have an identity and a life beyond that of “mental patient”. To the degree that this form of recovery involves managing symptoms, it benefits from current clinical practice. To the degree that this form of recovery also involves re-establishing a full and meaningful life in the community in the presence of enduring disability, it also benefits from much of current rehabilitative practice. Advocates argue that this concept finally extends beyond the usual parameters of both clinical and rehabilitative practice, however, in order to address fundamental issues of human and civil rights, or the

lack thereof, in determining the everyday lives, opportunities, and health of people with serious mental illnesses.

It is perhaps easier to appreciate the central importance of the issue of rights in the lives of people with mental illness if we appeal to an analogy drawn from the broader disabilities field. As we noted above, the Independent Living Movement led by people with physical disabilities was one source of inspiration for this form of recovery. Examples drawn from the broader disability field provide a concrete glimpse into what this concept of recovery adds to current approaches. In the case of paraplegia, for instance, several things need to be in place for the person who has lost his or her mobility to resume the activities he or she enjoyed prior to his or her trauma. The most obvious, but also perhaps the most often overlooked, requirement is that the person should not wait to regain his or her mobility before pursuing these and other activities. This is occasionally referred to as “acceptance” of her or his disability, but for many people such a notion of acceptance connotes resignation and despair. The same has been true in mental illness, with many people refusing or being reluctant to accept the diagnosis of psychosis because of the helplessness and hopelessness – as well as the stereotypic pessimistic prognosis – associated with it (Roe & Kravetz, 2003). We prefer, then, to refer to the fact that the person will not have to wait to regain his or her mobility in order to resume his or her life. While not preferable, it is nonetheless possible to have a life without use of one’s legs.

Once the person acknowledges that he or she cannot simply sit around and wait to regain his or her mobility, a next step would be to be fitted for, and learn to use, prostheses or other compensatory strategies such as a wheelchair. No matter how well a person learns to maneuver his or her wheelchair, however, certain activities remain extremely difficult, if not impossible, to resume unless environmental accommodations are made. This is why lobbying for legislation requiring public spaces to be accessible to wheelchairs, for example, has been so central to the Independent Living Movement. Without curbs cut into sidewalks and handrails installed in bathrooms, the world remained restricted for people who used wheelchairs. Similarly, without Braille signs posted on doors and elevators, and without the mandate that service dogs be allowed in public spaces, people who had lost their vision would be very limited in their access to the opportunities and activities that make up the lives they want to lead in the community. For people with these disabilities, access and accommodation are not considered solely part of their rehabilitation but are viewed rather as fundamental to the rights and responsibilities of exercising citizenship. While they do not restore the person’s mobility or vision, they can and do restore the person’s life as a valuable and contributing member of society.

This approach is what is implicit in our notion of recovery *in* serious mental illness as well. Advocates make this case explicitly in emphasizing that the recovery movement was first and foremost a civil rights movement, but this emphasis is quickly overshadowed in clinical settings where the focus gravitates initially to disorder, deficit, and disability. These issues may then become relevant as the person’s condition improves and clinicians begins to view the person as ready to begin a re-integration process into community life. But from the perspective of the person with the psychiatric disability, focusing solely on deficit and pathology is not only overly narrow and limited in its utility, but it misses the very point of the civil rights argument. It would be pointless for society to accord individuals with disabilities the rights and responsibilities of citizenship if exercising those rights and responsibilities was made contingent on the person overcoming his or her disability first. It is in the presence of enduring disability that these rights become most pressing and most relevant.

Similarly, it is when people with mental illnesses are most disabled by the illness that their human and civil rights and responsibilities become most pressing and relevant. In an

analogous fashion to physical disability, recovery in mental illness speaks primarily to the person's rights of social inclusion and self-determination despite the severity of his or her psychiatric condition. Recovery refers to the rights to access and join in those elements of community life the person chooses, and to be in control of his or her own life and destiny, *even and especially while remaining disabled*. This means that people can make their own decisions, follow their own dreams, and pursue the activities they enjoy or find meaningful in the settings of their choice (with available resources) *as they are*. Similar to the decision a person with paraplegia may need to make not to wait to regain his or her mobility in order to resume his or her life, a person with a mental illness needs to be able to have a meaningful, gratifying, and self-determined life while continuing to have a psychiatric disability.

If recovery in mental illness involves in this way living a full, free, and self-determined life with one's condition, then recovery-oriented care necessarily focuses on enhancing the person's capacities for living with, managing, and pursuing his or her own life in the presence of disability, as well as on removing barriers to the person's exercising of these same capacities. Like other approaches grounded in a disability paradigm, it also attends to making environmental accommodations and enhancing community supports, thereby improving person-environment fit (Chinman, Weingarten, Stayner, & Davidson, 2001). While we have much still to learn about what such care involves, some particularly promising approaches are emerging out of the first-hand experiences of people in recovery themselves. As more people figure out ways to reclaim their lives in the presence of on-going disability, the field as a whole learns more about what such processes of recovery involve and ways in which these processes can be promoted.

Prominent examples of approaches derived from the lived experience of recovery include peer support and peer-run programs and businesses (Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 1999; Davidson, Chinman, Sells, & Rowe, 2006) as well as self-help strategies such as Copeland's *Wellness Action Recovery Planning* (2002) and *Pathways to Recovery* developed by Ridgway and colleagues (2002). Based on an appreciation of the fact that recovery *in* mental illness is made up of the same innumerable small acts of living we all enjoy, these strategies focus on activities like walking a dog, playing with a child, sharing a meal with a friend, listening to music, or washing dishes. Such interventions aim to enhance the person's pleasure and competence in everyday life activities as much as managing illness and remediating deficits – and this because *health is not promoted by reducing disease alone, just as life cannot be lived solely by minimizing dysfunction*.

### **Is everyone then already “in recovery”?**

If recovery in mental illness is to be found in such everyday activities as walking one's dog or washing one's dishes, are we suggesting that everyone who experiences a mental illness is already “in recovery”? If we understand recovery in mental illness to refer to the wish and effort to have a safe, dignified, and meaningful life in the face of enduring disability, would this not be true of everyone? Who would choose not to pursue his or her own aspirations or interests, or not to participate in those activities he or she finds enjoyable or gratifying? On the other hand, as analytic philosophers taught us many years ago, if a statement cannot be shown to be false, then it cannot be shown to be true either. If recovery can be taken to mean anything, then it comes to mean nothing at all (Roe, Rudnick & Gill, 2007). So what is it that people *are* doing when they appear not to be taking up “the work of recovery” (Davidson & Strauss, 1992), when they do not appear to be trying to cope with, manage, or have a life in the face of mental illness? And what implications does our answer to this question have for recovery-oriented care?

Despite the advances of the last half-century, serious mental illnesses remain potentially lethal diseases, regardless of whether death is attributable to suicide, to co-morbid conditions to which people with these illnesses are at much greater risk (e.g., diabetes, hypertension), or to the consequences of impaired judgment or increased vulnerability (e.g., victimization, exposure). Due most likely to a combination of the severity of illness, devastating life experiences (e.g., trauma, poverty), duration of untreated psychosis, and personality traits, we appreciate that there currently are people for whom both of these senses of recovery will remain distant possibilities for the foreseeable future, if not for the remainder of their lives. How are we to conceptualize their relationship to recovery?

We suggest that to this question there are at least three possible answers. In each case, we acknowledge that there are individuals who are neither recovering from mental illness nor in recovery. In the first case, we suggest that this may be because the person has yet to take on the work of either recovering or “getting into” recovery, has yet to begin to differentiate the illness and its effects from the remainder of his or her life, and has yet to begin to figure out how to live a meaningful life in the face of enduring disability. There may be many reasons for this, of course, including previous negative experiences with mental health care, intolerable side effects, or the fact that it is too painful or costly for the person to acknowledge that he or she is ill and/or needs the kind of assistance being offered. In any event, a person’s recovery is something that he or she needs to pursue actively, and there are individuals who have yet to take up this challenge. For them, recovery-oriented care needs first to attend to this challenge, the ways in which the person is currently understanding and dealing with his or her situation, and the ways in which taking up the challenge of recovery promises to offer a more effective or adaptive route to reclaiming his or her life than his or her current efforts.

A second possibility is that the severity of the illness is overwhelming the person’s resources and rendering his or her best efforts to cope relatively ineffective. At this end of the illness spectrum, people are doing their best to survive on a day-to-day basis, and are largely at the mercy of the illness and those practitioners entrusted to serve them. As is the case with the care of other individuals with severe illnesses, we suggest that care for these persons be oriented to ensuring their comfort, safety, and dignity, and to enabling them to make optimal use of their remaining areas of health and competence. We suggest that a key focus of this process involves eliciting and honoring the person’s drive to self-determination. Even care for terminal illnesses does not require sacrificing one’s right to self-determination. Preserving this right as much as possible is rather one of the areas most emphasized by hospice providers, for example, yet it is sorely missing in the care of many people with serious mental illnesses.

When we have asked the few individuals remaining in long-stay hospitals in our state what would make their lives better, for instance, they have not said more or better treatments, the acquisition of more or better insight or skills, or being cured of their illnesses. What they have said are things like going out to the movies and for pizza a couple of times a month, or having a part-time job, or seeing their family more often, or having friends with whom to go to church or shopping, or a lover with whom to have sex. One participant in one of our studies reported that for him, recovery would involve things like picking up his neighbor’s trashcan if it fell into the street or being in a position to give fatherly advice to kids on his block (Davidson, 2003). The wishes these people have had for how they would like to spend their time have not been that different from those of people who have other disabilities or chronic illnesses, with the possible exception that, given their history of institutionalization, they may more often focus on “giving back” to others (e.g., picking up the neighbor’s trashcan). For people whose illnesses have impeded their efforts to establish a life beyond

their disability, we suggest that the challenge of living a meaningful and gratifying life within the limits imposed by the disability remains in this way a productive avenue for exploration.

Finally, and despite our best efforts, there will of course continue to be some people with serious mental illnesses who will choose not to manage their conditions, just as there are people with lung cancer who continue to smoke, or people with diabetes, cardiac disease, or tuberculosis who defy all health care providers' admonitions to take better care of themselves. In addition to a basic human vulnerability to denial, helplessness, or lack of a sense of efficacy to impact one's condition, we suggest that there is another issue to consider specific to mental illness. This issue stems from the fact that most communities do little to educate people about the nature and prevalence of mental illness, not to mention the care available for them should they need it. As a result, most families are unprepared for the onset of a mental illness in one of their loved ones, and have no idea what is happening to them when they first begin to have difficulty (Corcoran, Nickou, Miller, Malaspina, McGlashan, & Davidson, 2001). To make matters worse, psychiatric practice has lagged behind other forms of medicine which care for people with long-term illnesses, having yet to embrace a disease management model. Concluding that people with serious mental illnesses lacked insight during an era in which we did not believe in educating them about their illnesses (Roe & Davidson, 2005), we have believed that people with mental illnesses must be treated before they can learn to manage their own conditions. The process which results, in which we do things *to* people first before educating them and asking for their consent, has been described in first person accounts as driving people away from the very care they have needed and sought (Davidson, Stayner, & Haglund, 1998).

These considerations have led us to suggest that until information about mental illness and its treatment is offered routinely through schools and community education programs, as is just beginning to happen in Australia (e.g., Wright, Harris, Wiggers, Jorm, Cotton, Harrigan, Hurworth, & McGorry, 2005) and Norway (e.g., Friis, Vaglum, Haahr, Johannessen, Larsen, Melle, Opjordsmoen, Rund, Simonsen, & McGlashan, 2005), people will remain ignorant to, and unprepared for, the work of recovery. And until practitioners begin to treat people suffering from mental illnesses in ways similar to how people suffering from others illnesses are treated (i.e., with dignity and respect for their autonomy), psychiatric care will continue to be viewed as a last recourse in the person's struggle to recover from, or to live his or her life despite, mental illness.

## Conclusion

We mentioned at the outset that there remains considerable fluidity between the two conceptions of recovery from and recovery in mental illness, and that they can even co-exist within a given individual. In our own clinical experience, for example, we have found that assisting someone to learn how to live with a particular symptom of their illness not only leads to their living a fuller and more satisfying life but at times also contributes to the reduction of the symptom itself; a finding thus far confirmed in the case of auditory hallucinations (Chadwick, Birchwood, & Trower, 1996). We thus are not proposing these constructs as hard and fast or as mutually exclusive, but as speaking to two different aspects of mental illness. Serious mental illness is something that can go away over time – partly in response to effective care and partly in the absence of any care – but it also is something that many people can learn to manage and to live a safe, dignified, and gratifying life despite. Having these two options available should only serve to increase hope among people with serious mental illnesses, broadening their perspective on the variety of options that may be available to them.

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