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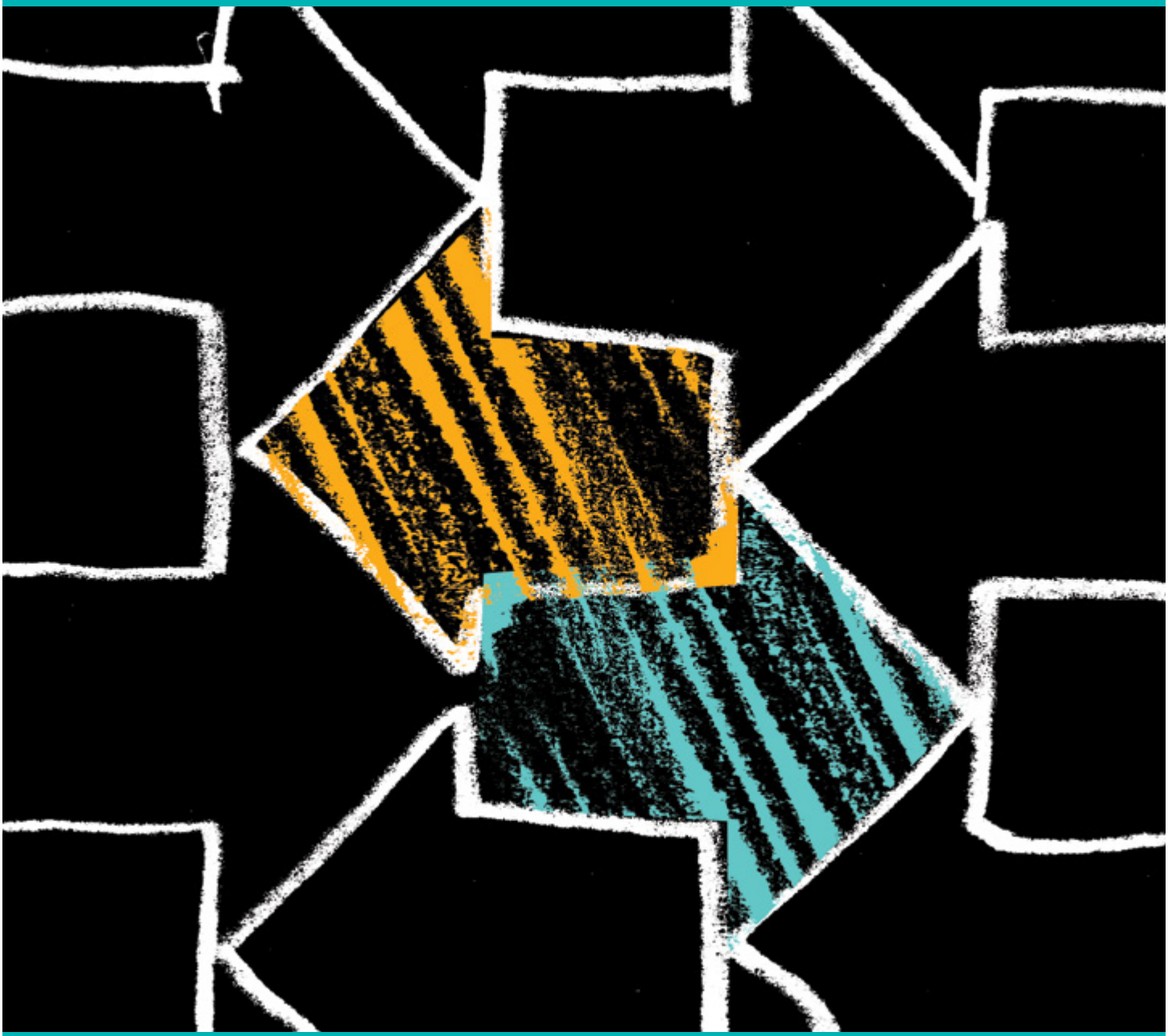
INFO EXCHANGE
ARTICLE #21

RECOVERY

What does successful recovery look like?



centre *for*
suicide prevention

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re·cov·er·y

noun,

1. A return to a normal state of health, mind, or strength.

—*Oxford English Dictionary*

“...recovery means not a narrow definition of ‘cure’ but rather a broader concept of a journey toward a meaningful life, an adaptation, an acceptance, and a focus on strengths despite limitations.”

—*David Goldbloom*

IN THIS ARTICLE

What does recovery look like?

When we are talking about mending a broken leg, suffering a stroke, or even battling a disease like cancer, clinical recovery is often equated with the Oxford English Dictionary (OED) definition to the left. It is essentially a return to – or a restoration of – one's former, healthy self.

It is the goal of the medical model: get people back to their original state, relieve the symptoms, help them heal. Should the physical recovery not go exactly as planned, the bones do not set properly or the cancer recurs, we usually respond with more vigorous care and compassion. We wouldn't think of placing blame or judgement on the recovering individual or the health care providers, rather, we would increase treatment and support in an attempt to hasten health.

Sadly, this is not the typical response people receive when recovering from mental illness, addictions and suicidality. As with physical recovery, the path to mental recovery is not always linear. Mental illness, addictions and suicidality are complex – they involve more than physical symptoms – often the psychological, biological, social, and spiritual areas of the individual are affected. However, when people experience relapse or setbacks, rather than being met with increased treatment or support, they are often blamed, marginalized and isolated as others are fearful and frustrated with the perceived lack of progress, or, recovery. We cast judgement about how much of the affliction is under the person's direct control and how much can be classified as disease and this influences our view of the illness and the person. Further, mental disorders are still stigmatized based on fear and misunderstanding. When we add in this additional factor, the notion of recovery becomes even more confusing and frustrating—for patients, practitioners, and the general public alike.

Addiction

The debate about how much control an individual has over their illness is particularly prevalent in addiction. Addiction to alcohol and other drugs is a complex and often misunderstood condition.

Historically, addiction has been viewed as either a failure of will power, a moral flaw, or even a sign of weak character and in order for people to "successfully recover" they must completely abstain from their drug of choice for the rest of their life: anything less is considered failure. Many hold to this belief still today and do not recognize how damaging it can be to some individuals: this is an unrealistic trajectory for most people. How many of us can attest to failed diet attempts or un-used gym passes? Does this mean we are forever unable to lose weight or get in shape? Or do we see our "lack of success" more as a setback, one that can be overcome with increased attempts, support from others and self-empowerment? To compare again with physical illness: cancer patients experiencing recurrence of their disease are typically offered further and sometimes even more aggressive treatment while the traditional view of addictions-recovery is closer to a tough-love approach: relapsed patients are dismissed from treatment programs with some health policies going as far as full denial of treatment for recurring substance abuse perpetuating the misperception that true recovery for addicts is not possible.

So where do we begin? How can we apply recovery to mental illness, addictions and suicidality as holistically as we do to physical health?

First, we must adopt the view that recovery is possible. Next, relationships between patients and mental health professionals must be improved and maintained, relationships that put the well-being of the patients and their families at their core. Recovery needs to be thought of as "a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness" (Mental Health Commission of Canada, (MHCC), 2009, p.27). We need a model that views the person in recovery realistically, wherever they are at the present moment, as opposed to prescribing idealized outcomes that might be unattainable. The very concept of recovery should be reimagined as a process - a fluid concept that is not bound by either space or time (Amering and Schmolke, 2009).

Recovery Movements—A Short History

Recovery models matching these descriptions have been around for several years. They start with treating symptoms and then move to building strength and resilience by fostering a sense of "hope, acceptance, control, basic needs, and meaningful activity" in recovering individuals (National Survivor User Network, 2015, p.4).

Patients' rights movements in the 1970s can be credited with starting this move toward a more enlightened view of recovery. The "golden age" of identity politics that gave birth to black power, women's liberation, and gay rights also gave us the "Mental Patients Liberation" movement and "Mad Pride". By the 1980s, new ideas involving advocacy, self-help, peer support, and lived experience were expanding the field of mental health in unprecedented ways (Black Creek, 2004).

These new developments began to appeal to academics and mental health practitioners and, more significantly, they began to wield a strong influence on the creation of new government policy and the mandates of mental health organizations (Black Creek, 2004). In the United States, for example, the New Freedom Commission recently argued for recovery to be adopted as the overarching aim of all mental health services. Similarly, the Mental Health Commission of Canada has named goals such as fostering hope, enabling choice, encouraging responsibility, and promoting dignity and respect in its mental health strategy (MHCC, 2009).

Progressive Approaches to Recovery

Scholar Nora Jacobson researched what progressive approaches to recovery should look like, drawing heavily on what was already unfolding in the world of advocacy.

She proposed that there are certain conditions that affect one's ability to recover. These include one's sense of **hope** toward recovery, the ability to **heal** – with or without a return to "normal" health – and an emphasis on the individual's own **active participation** in their recovery. When patients experience a sense of empowerment over their recovery, it often leads to their building positive social connections that, in turn, foster a fuller recovery.

Other conditions of recovery, she posited, must be viewed in terms of individual rights and justice. The patient must be treated with dignity and respect by mental health service systems, and they must experience a positive culture of healing. The relationship between caregiver and patient is reciprocal with each taking a role in the recovery process (Jacobson, 2001).

Other academics have found that recovery involves a self transformation, where one accepts their own limitations and at the same time discovers a new world of possibility (Amering and Schmolke, 2009). Patricia Deegan observed (both as researcher and as someone experiencing schizophrenia) that those who undergo this transformation come to realize that "recovery is a process. It is a way of life (Deegan, n.d., p.13).

> "Recovery is a process. It is a way of life"
>
> **PATRICIA DEEGAN**

Deegan was also an early representative of the "lived experience" movement, which gives the same importance to evidence gathered from the personal experience of living with mental illness, having an addiction, or being suicidal, as it does to the research into these areas. In the past, these personal narratives have been discounted and discredited, but now these narratives are gaining the attention they deserve, and reaching a larger audience.

The growing importance of the lived experience voice can be partly attributed to the idea of "personal empowerment", which is one of the hallmarks of the progressive recovery model. This personal empowerment means that individuals are directly invested in their own recovery - they evolve from being passive to active participants in their own recovery process (Amering, M. and Schmolke, M., 2009).

Recovery from Addiction is Possible

As earlier noted, substance addiction is a complex and often misunderstood condition. Because of this, a progressive approach to recovery allows alcoholics and addicts the opportunity to "create a situation where a meaningful life with maximum control becomes possible" (Amering and Schmolke, 2009, p.11). Essentially, they are encouraged to reinvent themselves.

Many drug addicts and alcoholics do recover and go on to lead healthy, productive, and contented lives. To ensure that they have a greater chance of recovering, though, we need to rely less on a "one-size-fits-all" approach, and move toward one that better meets the personalized and unique needs of each individual (SAMHSA, 2012). Currently, treatment options are limited, and the vast majority are based on 12-step programs* that, although successful for some people, are not a good fit for everyone. There is an urgent need for caregivers to offer a variety of recovery programming to reflect the diverse needs of the community.

Patients afflicted with major mental illnesses and suicidality often also find their recovery options fraught with obstacles; mainly, stigma.

Addiction, Mental Illness, and Suicide

People with addictions and mental illnesses are at-risk groups for suicide, and those who attempt suicide and survive often encounter attitudes from others that make recovery even more challenging.

Their attempt may not be taken seriously and may be subject to the widely held, disturbing belief that they are "crying wolf". Even more callous is the tendency of some people to "write them off" and, in doing so, state that if they are intent on dying then no amount of help will dissuade them from their decision. To be clear: these are both unfounded and wrongheaded myths. It is crucial that an attempt survivor be given mental health supports as quickly as possible because a major risk factor for future suicide is a previous attempt (American Association of Suicidology, 2016).

One important way that an attempt survivor can reduce future suicidality is to attempt to change their perspective. Some suicidal people cling to the idea that suicide is always there as a last resort. If things get too bad or the pain gets too intense, they believe suicide is always there as an option.

This can be a dangerous coping mechanism, but changing this mindset from one focused on suicide and death to one that embraces life can be incredibly challenging. For some this "suicide as mistress", as it has been called (Bergmans, et al. 2008, p.11), can be extremely painful to leave behind. It may even be the most difficult decision that they can make, but it is a transformation from chronic suicidality that could save their lives. Challenging as it is, recovery from suicidality is possible. While ideation may continue intermittently throughout someone's life, with appropriate caregiver support, social connectedness and hope, people can recover from suicidality (Player, et al., 2015).

PEER SUPPORT SUBSTANCE USE PROGRAMS

Alcoholics Anonymous- http://www.aa.org/

Narcotics Anonymous- https://www.na.org/

Smart Recovery- http://www.smartrecovery.org/

Recovery from Mental Illness

Despite major recent improvements in the treatment of patients who are mentally ill, the routine relationship between practitioner and patient can still be less than ideal.

As recent as 2009, people experiencing schizophrenia, for example, were still often pressured to take harsh medications developed decades ago even though more effective and modern treatments are available. This is often because traditional thinking prevails: those who are mentally ill cannot recover. Believers in the "myth of incurability" postulate that psychosis cannot be overcome, so it is in everyone's best interest to keep the patient on heavy medication for life, instead of exploring more progressive and current treatment approaches (Amering and Schmolke, 2009).

In fact, for many people with schizophrenia, these treatment medications can be worse than the disorder itself. Deegan, in *Recovery in Mental Health*, recounts how she initially began sharing her mental health experiences. She reveals how her psychiatrist told her that "her fate with schizophrenia was already sealed", there was no hope for improvement, and lifelong maintenance of her condition was the only answer. She was shocked at how little her psychiatrist understood or even cared about her illness, and resolved not only to educate herself about it but also to become an advocate on behalf of all schizophrenics (Amering, M and Schmolke, M., 2009, p.72).

The standard treatments for people with schizophrenia can be so oppressive - and the stigma toward the condition so strong - that "10% are dead within 10 years of diagnosis, most by suicide, and at least 40% of those diagnosed with schizophrenia attempt suicide" (Mardon, 2015, p. 17).

We must explore more progressive and current treatment approaches

CASE STUDY

A Story of Recovery

The intense stigma toward mental illness among mental health professionals is illustrated by the story of Bart Andrews.

Andrews, a psychologist, describes how he encountered stigma on three different levels: as an alcoholic, a mental health professional, and a suicide attempt survivor. He believes that this intense exposure to stigma initially affected his attempts at meaningful recovery. He kept his past to himself. He recounts, "This is often the life of an addict and a suicide attempt survivor: tell no one" (Andrews, 2014). He only disclosed his alcoholism when it began to threaten his well-being, but revealing his suicide attempt was unthinkable. Disclosing this part of his past became an all-consuming fear, and he worried about the threat of professional reprisal.

Eventually, Andrews met a mentor who convinced him that coming forward as a mental health professional who was also an attempt survivor was of paramount importance. His disclosure would help address and alleviate the stigma that relentlessly clings to the topic of suicide, and would also help inspire other struggling mental health professionals to seek the assistance that they may desperately need. After a great deal of contemplation and soul-searching, he eventually agreed. He told his story and never looked back (Andrews, 2015).

What can recovery from suicidality look like?

Though suicidality can be intermittent throughout a person's life, it is neither preferable nor practical to treat a person in an acute care facility long term. Truly, most people who experience suicidality will never enter a hospital or see a mental health clinician. And yet, recovery is still possible, it is the goal.

At Centre for Suicide Prevention, we believe that anyone can help people in suicidal crisis in such a way that urges them towards a path of recovery. Research tells us that people in suicidal crisis report feeling more hopeful when someone actively listens, reserves judgement, and promotes self-empowerment (Gould, 2013). Being a friend and a skilled listener helps people move out of crisis towards recovery: we all have a role to play.

The type of intervention mentioned above can be learned through the ASIST (Applied Suicide Intervention Skills Training) workshop. This award-winning workshop was first developed in the early 1980s, here in Calgary. It is now used around the world and adorns best practice registries internationally. The philosophy of this workshop embodies our beliefs at CSP: suicide is preventable, recovering from suicidality is possible and we all have a role to play in reducing suicide in our community.

Most people who consider, attempt or die by suicide do not actually want to die: they want the pain of living to end. Given an option, they would choose life. However, when someone is considering suicide they no longer see any other options. It is the role of the people surrounding the person in crisis to illuminate hope. Anyone can help someone at risk of suicide.

Learning about and Supporting Progressive Recovery

So why is it so important to learn about and support these progressive recovery models?

Posed another way: Why is it important for people to know that mental illness does not equal inevitable ruin, that there are ways in which services can be designed to help people lead more meaningful lives, and that even the most marginalized people can empower themselves? (Jacobson, 2003).

There are many good reasons to support this model. The first argument is economic: community-based, progressive recovery approaches are less expensive than funding long-term clinically-based treatment. In Alberta people who require treatment for mental illness and addictions and suicidality have very few choices and face extremely long wait times. The vast majority of programs are inflexible, clinic-centred and even clinician-focused. There is place and great need for increased community-based, client and family-centred programming focused on client outcomes as reported by clients and families. Community-based care operates at a fraction of the cost of acute care.

What is holding us back from embracing community care? Arguably, it is stigma. It is the prevailing view that recovery from mental illness and addictions is elusive and only possible under the constant care of a specialist. While there will always be a need for acute care and highly trained medical professionals, most of the recovery journey can take place in the community if we are only willing to allow it. When our understanding of mental illness, addictions and suicidality increases sufficiently that our fears are allayed, we will be more able to adopt a broader view of recovery.

People experiencing persistent or recurring mental illness, addictions and suicidality need our support: it is the ethical, compassionate, "right" thing to do. Humanitarians from as far back as Samuel Johnston in the 1700s, to Mahatma Gandhi in the early 20th Century, to the inspiring advocates working in our communities today, present us with the same profound idea: the overall health and compassion of a society is ultimately measured by how well it treats its most vulnerable citizens.

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I think that the momentum and willingness to change is spreading from heath care practitioners and academics to the general public. This shift is prompted by the notion that improved mental health treatment for those who need it will benefit us all and not just those who are most visibly afflicted. Although we are in the early stages of this shift, the important thing is that the shift is beginning to happen. Direction is more important than distance; we are moving in the right direction.

The overall health and compassion of a society is ultimately measured by how well it treats its most vulnerable citizens.

References

American Association of Suicidology. (n.d.). Retrieved from http://www.suicidology.org/ncpys/warning-signs-risk-factors

Amering, M. and Schmolke, M. (2009). Recovery in mental health: Reshaping scientific and clinical responsibilities. Chicester, UK.: Wiley-Blackwell.

Andrews, B. (2014, December 29). Providers willing to share. Retrieved from http://attemptsurvivors.com/2014/12/29/providers-willing-to-share/

Bergmans, Y., et al. (2008). *Exploring the meaning of recovery from recurrent suicide attempts*. Retrieved from http://www.wellesleyinstitute.com/wp-content/uploads/2010/06/Exploring_the_Meaning_of_Recovery_final_report.pdf

Deegan, P. (1996). *Recovery, rehabilitation and the conspiracy of hope*. Retrieved from https://www.patdeegan.com/sites/default/files/files/conspiracy_of_hope.pdf

Goldbloom, D. and Bryden, P. (2016). *How can I help? A week in my life as a psychiatrist*. Toronto, ON.: Touchstone.

Gould, M., Coss, W., Pisani, A., Munfakh, J. & Kleinman, M. (2013). Impact of Applied Suicide Intervention Skills Training (ASIST) on national suicide prevention lifeline. *Suicide and Life-Threatening Behavior,* 43(6), 676-691.

Jacobson, N. and Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services,* 52(4), 482-485.

Jacobson, N. (2003). Defining recovery. *Network,* 18(3), 6-9.

Mardon, A. (2015). Acceptance equals compliance: Our lived experience with a husband who has schizophrenia. *Health Ethics Today,* 23(2), 14-18

Mental Health Commission of Canada. (2009). *Toward recovery and well being*. Retrieved from http://www.mentalhealthcommission.ca/English/system/files/private/FNIM_Toward_Recovery_and_Well_Being_ENG_0.pdf

National Survivor User Network. (2015). *The language of mental wellbeing*. Retrieved from http://www.nsun.org.uk/assets/downloadableFiles/4Pi-LANGUAGEOFMENTALWELLBEING.V42.pdf

OED: Oxford English Dictionary. (2016). Retrieved from http://www.oed.com/

Player, et al. (2015). What Interrupts Suicide Attempts in Men: A Qualitative Study. *Plos: One*. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128180

Substance Abuse and Mental Health Administration. (2012). *Working definition of recovery*. Retrieved from http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf

Usar, O. (2014). *Psychiatric system survivor/consumer advocacy: A critical literature review*. Retrieved from http://www.bcchc.com/download/Final%20Report%20-%20Consumer%20Survivor%20Advocacy%20Literature%20Review.pdf

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