

RECOVERY FROM A SEVERE PSYCHIATRIC DISABILITY: FINDINGS OF A QUALITATIVE STUDY

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A RESEARCH AND CREATIVE ACTIVITIES GRANT FROM CLEVELAND STATE UNIVERSITY FUNDED THE STUDY REPORTED HERE. THE AUTHOR PRESENTED HER PRELIMINARY FINDINGS AT THE 23RD ANNUAL CONFERENCE OF THE INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES IN ORLANDO, FLORIDA IN JUNE 1998.

The study reported in this article relies upon a qualitative analysis of the personal stories of recovery of 10 persons beset by persistent and severe psychiatric disability. An analysis of these 10 extended interviews yielded specific findings the author associated with such major themes as the meaning of recovery, turning points toward recovery, critical factors involved in recovery, barriers to recovery, and strategies for recovery. Despite some limitations in the study, including a small and homogeneous sample, the findings lead to provide practical suggestions for other persons embarking on their own journey of recovery and implications for mental health policy makers and practitioners.

Describing the meaning of recovery from psychiatric disability that interrupts and changes one's life, Anthony (1993) invoked the concept of paraplegia. As someone with paraplegia learns new ways to live with a damaged spinal cord, someone with a psychiatric disability finds new meanings in life, even as the disability remains. Recovery for both persons involves much more than learning to cope physically with their respective disability. It involves learning new ways to perceive and interact with their environment and to acquire new skills to negotiate such environmental elements as a system of service providers, family members, and friends.

Mental health consumers and professional observers agree that recovery is a uniquely personal experience in which one gains a sense of control and hope through a long and painstaking struggle

(Anthony, 1993; Davidson & Strauss, 1992; Deegan, 1988; DeMann, 1994; Houghton, 1982, 1993; Leete, 1989). But even though the process of recovery is a highly personal experience, all stories of recovery from a psychiatric disability bear common elements. The study described in this article informs those who work for recovery of persons with psychiatric disability, including consumers, family members and service providers, and points to productive changes in the mental health system.

The Aim of the Research

Adopting a qualitative research strategy, the author set out to adduce and enumerate common elements operating among the uniquely personal struggles for recovery from severe psychiatric disability. Strauss and Corbin (1990) defined qualitative research as research about persons' lives, stories, behavior,

organizational skills, social movements, or interactional relationships. They also found qualitative research particularly well suited to uncovering the nature of a peoples' experiences with profoundly personal phenomena like illness, addiction, and religious conviction. Conscientious qualitative researchers tend to present accurate descriptions of such phenomena and induce grounded theories that, in turn, provide frameworks for action. Accordingly, the author sought data to answer five research questions.

- (1) What is recovery?
- (2) When does recovery begin?
- (3) What critical factors are involved in recovery?
- (4) What are barriers to recovery?
- (5) What strategies can one who seeks recovery adopt?

METHOD

A consumer-operated agency receiving funds from a county mental health service system agreed to place an announcement in its newsletter calling for volunteers to participate in a study that relied upon their personal stories of recovery. The announcement stated that a university professor sought persons who considered themselves en route to successful recovery from a severe psychiatric disability, and it asked them to call a university number and arrange an interview. It also mentioned that participants would receive a cash payment upon completing an interview. Of the 15 people who volunteered, one person failed to appear for an interview. Another became physically ill and could not participate, and another appeared for an interview but declined to participate after meeting the researcher. Thus, a total of 12 persons participated in the study.

The author gathered her data during the personal interviews in her office located in an old mansion in downtown Cleveland. Uncharacteristic of a sprawling and busy urban university, the mansion and the office within provided comfortable surroundings for the participants. When they arrived for their appointment, the author explained the purpose of the study and obtained their consent for participation in the study and to the audiotaping of their interviews. The author used a semi-structured interview schedule to conduct the interviews. They lasted from 35 minutes to 2 hours and 20 minutes, with an average length of 1 hour and 40 minutes. Upon completing an interview, each participant received a payment. The author used QSR NUD*IST, a software package for qualitative data analysis, to analyze transcribed interviews.

RESULTS

Participant Characteristics

From among the 12 completed interviews, the author excluded two interviews from her data analysis. Although these two stories had idiosyncratic interest and presented challenges, the psychiatric problems they suggested fell into a different class of disorder than the other participants with severe mental and emotional disorders presented— notably schizophrenia, bipolar disorder and major depression.

The ages of the final 10 participants ranged from 38 to 60 years, with an average of 48 years. The participants included five men and five women. One participant was African-American, and the rest were Caucasian. All but one had at least some college education. In fact, one participant had a graduate degree, and another held a law degree. The fact that the announcement for participant recruitment came from the university may have contributed to the level of

education. Those with experience in higher education reported that the serious illness had struck them after they entered college. Their diagnoses fell into one of the three categories: schizophrenia, bipolar disorders, and major depression. All but one participant had been hospitalized from one to 13 times with an average of 6.2 times. All but one participant had been ill for more than 10 years. The longest duration of the disability was 42 years. In discussing findings, the author has protected the participants' identities. The participants described their experience with the disorder and the long process of recovery, from which five themes emerged.

The Meaning of Recovery

Recovery involves a long process of learning how to live with psychiatric disability while struggling toward positive goals. One of the obvious signs of recovery is an ability to control symptoms. This control generally begins with one's acknowledgment of one's own disability, and it can take some individuals a decade or more simply to make this acknowledgment. Recovery involves complex aspects of one's life, including finding the right medication, the right psychiatrists, the right friends and the right social activities. The goals of the journey include a sense of control, self-respect and an appreciation of life. Three participants made comments that illustrate what recovery means.

1. It is a long time. It sure is. But that's all part of the process. There are not many [people] that are ill for 2 or 3 years, and then go, "OK, I am mentally ill. Well, let's go find a mental therapist that loves medication. Fine, and then life is just perfect from then on." It just doesn't work that way, at least for a lot of people I know. Recovery is the most important factor in the whole process.
2. I would define it [recovery] as a lack of symptoms, and also being

able to control the symptoms, and thirdly learning to live with them.

3. [Developing] opportunities and resources to be a complete whole person, to be living a life, a whole life.

Turning Points Toward Recovery

Recovery begins only when one accepts one's disability. One can begin a journey of recovery once one develops a strong desire for changes in one's life. It took most of the participants interviewed for this study from 10 to 15 years after the onset of their disability to reach their turning points toward recovery. This process of recovery involved seeking help from professionals, friends and family members.

In general, the participants agreed that recovery began with the acceptance of their disabilities, and they admitted as well that it took a long time for them to accept their disabilities. The stigma of psychiatric disability they internalized within themselves seemed to prevent them from accepting the disability. Eventually, they came to acceptance when they determined that the disability had overcome their last effort to restore mental health without help from others.

1. The very first hospitalization, I was in tremendous denial because all these people I was in the hospital with were crazy, but I was just fine. Fortunately at the time, my doctor explained to me that I had clinical depression, so I took my medication regularly.
2. I had a difficult hospitalization back in, I think, 1991. It was at that point that I had stopped trying to cure myself and started to just give into what this conscious[ness] wanted. So, that was a turning point for me.
3. I perceived the process [of recovery] at one time as being a spiritual process, and it has been a part of the recovery process to accept that it wasn't so much spiri-

tual as it was chemical and therapy based. You know, when I went into [hospital name omitted] in 1991 or 1992, I had just a horrendous and just horrible hospitalization. I woke up one day and I said, "This is not working—this trying to cure myself, trying to beat the odds, trying to cheer myself up with this spiritual thing." It was not working, and I said, "That's all. I want out. I am going to take the medications. I am going to work with the therapists."

4. Well, I think if people were more understanding, it would be easier for individuals who are mentally ill to see themselves as mentally ill, and once you see yourself as mentally ill, that's when the recovery process starts. That's when the whole thing begins. You know, I spent like 15 years before that being ill.

Two participants reported their strong desire for change after being ill so long:

1. I didn't want to feel I was going to have to live my whole life like this, and I was having [a] major [crisis] over that thought. And I didn't attempt suicide, but I thought, "Lord, is this what the rest of my life is going to be like?" And I think it was then I said, "You got to do something about it, and you need to move forward on this."
2. My son left in 1992, and it was right about that time I decided to take medication. But I had made up my mind that I wanted to be normal again.

While the participants all took different routes toward the goal of recovery, all of them sought some sort of help from the outside world to start their recovery process:

1. I said, "I am going to take the medications, I am not going to take my-

self off the medications. I am going to work with the therapists."

2. I was living in one of those [apartments] with the plaster falling down. It was \$200 a month, and there was a raunchy bar downstairs and, you know, you hear the loud music on Fridays and Saturdays, so loud that you can't sleep. Then, going to work and not being happy all day, and then coming home and just sitting around the house, doing nothing. So, I moved into [a group home]. That was a big change living with people, you know, real nice, and I was on the kitchen crew over there [a club house].
3. I think that the turning point of my life was the Overeaters Anonymous. I had a twelve-step program, and I lost weight. I made friends, real friends for the first time.
4. Another thing happened during that time was that I latched onto a psychiatrist by the name of [name omitted]. I was with him for 13 years, and he was instrumental in my recovery.

Thus, the initial phase of recovery appeared to constitute acceptance, a strong desire for change, and help-seeking behavior.

Critical Factors Involved in Recovery

Once recovery gets started, one must maintain oneself in the course of recovery. The participants spent a great deal of time discussing how they stayed this course. Their stories yielded six factors critical for recovery: (a) the right kinds of medication; (b) a group of supportive people; (c) meaningful activities; (d) a sense of control and independence; (e) a strong determination to maintain recovery; and (f) a positive outlook on the present and future. The following section discusses each factor with examples of statements the participants offered.

Right kinds of medication. The majority of the participants agreed that taking medication regularly is one of the keys to successful recovery. Most of them insisted that one must keep searching for the appropriate medication through continued communication with the psychiatrist. They also admitted that it takes a great deal of courage to negotiate with the psychiatrist if one's relationship with the psychiatrist is less than amicable. A few participants kept replacing psychiatrists until they found a psychiatrist responsive to their requests. All the participants in the study reported a positive relationship with their current psychiatrists. Their observations regarding the central role of medication follow:

1. The medications got to be number one, got to be number one.
2. Oh, definitely, definitely I couldn't do without [medication]. I still can't do without it.
3. It helps 80 percent of the time, but the rest of the 20 percent is what you make of your life. If you have to be on them for the rest of your life, so may it be.
4. The most helpful I think is getting on the right medicine. The right medications are essential.
5. The wrong medication can be very destructive.
6. There are times when I tried out different anti-depressants, but for some reason the anti-depressant doesn't seem to help me, and when I hear about new ones, sometimes I call [my psychiatrist] and find out [their use] in my health.

A group of supportive people. The participants often surrounded themselves with supportive people, who many times helped their recovery. These supportive people included friends, colleagues, family members, clergy, case workers, psychiatrists, group home members, and any others who could

support their recovery. The participants were extremely selective in choosing those they wished to include in their support system:

1. Having a good psychiatrist was a lot of help. And friends, especially friends who understood. In other words, having a support, a support system [was important].
2. The main persons who helped with my recovery was my psychiatrist, my pastor and my medicine counselor.
3. My psychologist [and I] talked about everything I didn't want to talk about.
4. A strong support team. And when I say "support," I am referring to any and all professionals who assist individuals in recovery in the process of mental illness.
5. Besides the medication, it was friends, friends supporting me. I never had a group of friends like that before.

Strong debate flourishes among consumers over whether or not consumers need to develop friendships with persons outside the consumer community. The data this study produced confirms the importance of having friends who are also consumers, but value is also given for non consumer friends.

1. I think having friends who are consumers is really important, because I don't think that there's anybody you can really talk about this illness with who is going to understand somebody else who has an illness.
2. Working as a host in the drop-in center, working on the warm line (a consumer-to-consumer phone support program) for 9 months and talking to people who were suicidal, and doing advocacy—[I see that for] the majority of these people who have had this illness [for] a long time, the only relationships they have are with fami-

ly, which is sometimes very strange, or with other people with this illness. But 80 percent of my relationships are with people in the other world, that don't have this illness.

Meaningful activities. All the participants discussed the importance of becoming involved in activities that give positive meaning to life. Those activities included going to church, participating in support groups, engaging in such social activities as parties and hobby club meetings, and working. These activities offer a sense of personal fulfillment and connection to the outside world. Several participants expressed their strong desire for work, recognizing that society measures one's productivity by work. One participant emphasized, however, that the work must be suitable. Although this participant did not articulate how one can measure this "suitability," the author inferred a fit between the job and the person's occupational preferences. Five typical responses follow here:

1. I'd rather be with one or two people at a time. I'm not saying that I never had a good time at a party, but that's not the kind of social life that I really like a lot. I like to do things like going to the parks, and I love photography, and I like to write.
2. Once I got into that first program, I started getting involved in more programs. I remember I joined an astronomy club, then I started volunteering in the homeless services, and I started helping in AA meetings and NA meetings, and then I got involved with the Compeer where I am like a big brother to consumers.
3. I like to keep to myself, but sometimes it's good to have some means to a social life, whether it is going to church, it's going to mental health groups, it's going to the movies, or it's

being in a singles group, which I am. Find someone or something that you can relate to other than yourself.

4. Work is pretty important to me. Even when I was really having mental health problems, it was important to me to be able to work.
5. Well, if it's the right job that suits, that's fulfilling for me, that makes me more of a complete whole person, that would be good. If it tears me down and makes me put down this part of a person, that won't be good.

Sense of control and independence.

Most of the participants expressed some desire for an increased sense of independence, including financial independence. A sense of control and independence arises from confidence in managing one's daily living functions. Thus, the prospect of recovery seems to encourage persons to gain greater independence for themselves, leading to a motivation for gainful employment:

1. I never really had much money, and now it's like I dream about having money. What am I going to do with it? You can just be more dependable; you can be a better friend. You can meet more people and go more places.
2. Well, if you own your own place, manage your own affairs, or else it could be a compromise by living in a group home, and it would be compromising.

A strong determination to maintain recovery. All the participants expressed their strong determination to maintain their recoveries, and their refusal to relinquish control over their illnesses. A few reported that they derived their strength to remain healthy from spirituality. This quality resembles the "resiliency" construct discussed by many mental health researchers and practitioners, including Anderson (1997), Hetherington and Stanley-Hagan (1999), Jew and

Green (1998), Miller, Brehm, & Whitehouse (1998), Pierce and Shields (1998), and Zunc (1998). Here are four typical comments:

1. I just decided that I wasn't going to let this thing get in the way. It has been my goal all along to make sure that I minimize the effect the illness has on my life, and that's what I have pushed for years and years now. I have to give myself some credit, too, because I have taken a real ambitious or aggressive approach to my therapy. Recovery has been my wildest dream and now it's starting to happen.
2. [Speaking of a new job], I really never got out of Lakewood. Never drove freeways. And so I said, "Yes, I will." I needed to move on, and I needed to go through the anxiety and the fear because the only way to do it is to do it.
3. I can't have a physical and mental recovery without having a spiritual recovery first. That comes first. When that falls into place, then everything else does, too.
4. ... I have two other friends who are Christian friends of mine. I'm also a born again Christian.

A positive outlook on the present and future. A positive outlook on life reflects an optimistic appraisal of current circumstances despite continuing consequences of illness and a conviction that things will get better. This feature may be an outcome of, or a reflection of self confidence gradually developed over time:

1. [Speaking of my sister who is also a consumer], She lost a lot of self-esteem with her illness and never went back to work with her last episode [when she was in her forty's]. But even at the advanced age of [sixty], when

I came back [from illness], I came back with wholier, self-esteem and a lot of confidence because I had been successful intermittently. Plus, I have a great structure of friends who are incredible.

2. I think being holistic, living a whole life, being a complete whole person, being a complete natural self, I think things could work out.
3. [Comparing past and present social lives], I was just so obsessed with the idea of him, and I know it's because I didn't consider myself good enough for somebody to ask me to go on such a trip. Now, I consider myself good enough, but I'm not going on no trip [with him] anyway.

Barriers to Recovery

A number of environmental and individual factors present significant barriers to recovery, and the data derived from this study suggest the following five important barriers: (1) stigma; (2) symptoms; (3) lack of financial resources; (4) limited access to services; and (5) occasional eruptive responses to life pressures. The following paragraphs discuss each of these barriers and include illustrative statements.

Stigma. Based on Goffman's (1969) theoretical framework, Piner and Kahle (1984) defined stigmatization as "the process by which people who lack a certain trait denigrate people who possess it" (p. 805). Accordingly, people who suffer from a severe mental illness carry a burden of being seen as "different" in the general population (Penn et al., 1994). Moreover, persons with psychiatric disability readily tend to internalize this label of "being different" that the general population bestows upon them. Once affixed, this internal stigma is extremely difficult to dislodge. Thus, both theoretically and actually, the stigma

manifests itself in two dimensions: external and internal.

The participants in this study discussed both external and internal stigmas of mental illness as one of the most, if not the most significant barriers to recovery. The following four comments illustrate the difficulties.

1. Probably one of the worst parts of the whole thing [speaking of the media presentation of persons with psychiatric disability]: It is so hard to accept yourself as being mentally ill when that's the kind of picture that the society draws of you. Because I think that we're all looking for a little bit of acceptance, and when we are mentally ill, we get just the opposite.
2. Aside from the illness itself, it [the stigma] is the worst part.
3. But a stigma is terrible. It hurts people. And I ended up leaving that job because he [the employer] couldn't deal with the fact that I was on medication. He said that I would not be able to do my job. It hit me very hard because I said, "stigma!"
4. I don't care what you say about me because you can't damage me when I'm feeling well. Only how I process that information damages me.

Symptoms. Some symptoms can be controlled by medication, but many individuals suffer to some degree from residual symptoms of psychiatric disability, and many powerful psychiatric medications carry unpleasant or debilitating side effects. The visible consequences caused by either the illness or the medications remind persons with mental illness that they are "different" from others and this complicates their recovery. The participants in this study expressed their concerns either about uncontrolled symptoms of their illnesses or about the side effects of their medications. For ex-

ample, one participant continued to suffer anxiety attacks when she faced stressful situations, and she considered these attacks worse than her clinical depression. Another participant continuously experienced severe headaches for which he had to take high dosages of Motrin.

Three relevant observations follow:

1. The most difficult thing for me was to try my eye-hand coordination. That was a big problem. It's like your mind [is] off somewhere in another dimension and you have to cope with this one. Your body is touching here and your mind is off somewhere else.
2. Another problem had occurred because of the medication; my vision was really blurred for 10 years. That was the worst thing of what the medications did to me, and my illness still went on for 10 years, including with all these medications. I could only read headlines of a newspaper.
3. Well, this Tardive Dyskinesia where things keep poking me in the eye and making me feel like I am being programmed, contrary to my consciousness or something like that. I just try to tolerate it as best as I can.

A lack of financial resources. All participants received some sort of governmental benefits, mainly Supplemental Security Income (SSI), but those benefits provide recipients with insufficient funds to enjoy regular social activities. One way or another, most of the participants expressed concerns over their financial status. Here are three examples:

1. It's a really strange experience to be poor when you have never been poor before. I couldn't make friends with middle class people because I was poor and they didn't want to be around me. And the poor people were accepting of me, but I didn't have much to talk to them about.

2. I feel it's [SSI] enough for my basic needs, but I still feel transportation is a problem. If I had a car, it would be a different status, the world, I mean.
3. I was also worried about my financial future. I did not want to be a dishwasher for the rest of my life.

Limited access to services. Some participants expressed their frustration with the limited access to their psychiatrist or therapist, caused by their public assistance status. One participant who received services provided by a community mental health center as a nonpaying client expressed her frustration:

My doctor, at the center that I go to one day a week, I could only get appointments one day a week. And if he's booked up, then you wait and wait and wait until the problem either resolves itself or you kill yourself.

Another participant expressed strong disappointment with his inability to own a car, which limited his mobility. In fact, most of these access problems appeared to stem directly from their limited financial resources.

Occasional eruptive responses to life's pressures. During the course of life, everyone sooner or later experiences more pressure than they can handle all at once. But persons with mental illness in recovery are far more vulnerable to excessive pressure, since it can easily force them into another psychiatric episode and hospitalization. The participants in this study—all of them in the successful recovery phase of their illness—were nevertheless keenly aware of their own vulnerability and exercised precautions described in the next section. One participant purposely challenged difficult events to test the success of her recovery. She described her accumulated difficulties this way:

Something I'm doing right now which I expect to be a part of recovery: There are a lot of things going on in my family right now. My grandson is in a psychiatric hospital. He's only eleven. My daughter's going through a divorce right now and is separated from her battering husband.

Strategies for Recovery

The participants in this study discussed various ways to maintain their recovery, and their stories yielded 10 major strategies: (1) accept your disability; (2) believe in recovery; (3) ensure that you are stabilized; (4) accept your own responsibility for the disability; (5) establish a structure for your daily life; (6) seek support; (7) take care of yourself; (8) keep active; (9) to educate yourself; and (10) protect your recovery. Some strategies reported here were consistent with the reports discussed previously under the heading "critical factors involved in recovery." The following paragraphs discuss the 10 recovery strategies the author drew from her series of interviews.

Accept your disability. Recovery begins with the acceptance of disability. This acceptance does not imply surrender, but rather that one acknowledges the existence of the disability so that one can begin the process of coping and rehabilitation. As previously discussed, some participants spent as many as 15 years of resisting their state before acknowledging that they were, in fact, psychiatrically disabled. Indeed, this acceptance is the most difficult but necessary step toward recovery.

Believe in recovery. A common reason for denying the disability is the equation of the acceptance with a permanently grim future. But the stories presented here by study participants recovering from a severe psychiatric disability, provide additional testimony to the fact that recovery is possible. The participants emphasized the importance of believing that

they would eventually get better. Here are two illustrative interview extracts:

1. I think that "you have to believe in yourself" is probably the better way of starting that [recovery] out. You've got to believe that you've got what it takes to overcome the problem. . . . Realize that acceptance is a positive thing, and that recovery does exist. It's out there once they are ready to seriously consider the process of recovery. It's out there. It's possible. It happens all the time.
2. It is process, not so much as [linking] the two points between a and b, but it does get better.

Ensure that you are stabilized. It is extremely important for consumers to keep their symptoms under control. The participants continually asserted their awareness that right kinds of medication are critical for their stability. To find the right kinds of medication, you must cultivate and maintain a cordial relationship with your psychiatrist. A few participants advised that you should not hesitate to change a psychiatrist if you feel uncomfortable with the current psychiatrist. All the participants reported that they had developed a positive association with their psychiatrists. In addition, several participants reported that they maintained regular sessions with their therapist, which contributed to their stability.

Accept your own responsibility for the disability. The participants appeared to understand that taking stock of their illness was essential to their recovery: They stated that they had to do their share to get help from others and from the mental health system. "Their share" might include taking medication, keeping appointments with mental health professionals, and participating in meaningful activities, however difficult this might seem. Three typical observations follow:

1. You have to be willing to accept responsibility and that means taking medication, it means making your time with your therapist or psychiatrist, and being willing to work at the process. You can't change the fact that you are mentally ill and that's real difficult. It was very, very difficult for me.
2. That [recovery] is depending on me doing my part. And that's always been the difficulty in my treatment.
3. You can take your medication as it's prescribed; you can talk to your doctor if there is anything bothering you. And if it gets down to the worst, change doctors or any other people. You have to do it yourself. That's the main thing. You have to do it yourself. No one else. You are the number one.

Establish a structure for your daily life. The participants in this study reported that they carefully maintained their daily routine so as to remain in recovery. First, you have to establish a routine in your life, including setting times for getting up, cooking, eating, cleaning, doing laundry, calling friends, visiting drop-in centers, and other daily activities. Having set a schedule, you must follow it and repeat it until you engage in those activities without effort. Then, you are on the way to recovery:

[I] have to do something that day whether it's three simple things like get up and floss my teeth, make my bed, and make one phone call to hear another human voice.

Seek support. Participants sensed the importance in the initial phase of recovery of support-seeking behavior, as previously noted. Sources of support included such mental health professionals as psychiatrists, psychologists and therapists. Other sources included mostly friends, either fellow consumers or nonconsumers. Only one participant mentioned a family

member as a source of support. This participant reported that the very reason he had never been hospitalized was the unstinting support from his mother, herself a social worker, since the onset of his disorder. Here are two typical observations:

1. Keep an open mind about what you are going through, because a lot of times you are feeling this and you are thinking that. Sometimes you just need a warm body, a pair of ears to talk to. I have no room to complain whatsoever, because I got a real strong support. I go over to [name of a consumer-operated agency], and I was in a program there for a number of years, and I, at the present time, have a therapist and a psychiatrist, and they are just tops—very, very good at what they do.
2. I would tell them [other consumers] to be less judgmental of themselves. To accept their illness, not to be in denial. Talk as openly as they could about it. And find someone who would listen, really listen, who hopefully cares about them. And do all you can do.

Take care of yourself. The participants reported that they paid attention to their physical health so as to maintain mental health. They reported the following methods of keeping themselves well: (a) eat right; (b) exercise; (c) know what triggers symptoms; (d) get enough rest; (e) keep good personal hygiene; (f) get yearly physical check-ups; (g) avoid chemicals, drugs, caffeine, alcohol and cigarettes; (h) be good to yourself; (i) learn how to relax; and (j) learn to have fun.

Keep active. The participants reported that they kept active to stay in recovery. They agreed that continued contact with the outside world was essential, noting that isolation prompts depression and drives a person out of touch with reality. Three statements on this point follow:

1. Just being active, engaging the body or the mind or the thought process in some kind of activity, keeps, well, puts distance between you and symptoms.
2. They [the mental health centers] have a lot of activities for their clients to get involved. Do something, get busy, invite some people over, have a party, go to the movies.
3. I like studying art, and I like following sports, and since I was in school, I have been able to get a job at both of those places. Working at the art museum. I volunteered at Cleveland Public Theater so I get in free there and I am familiar with the other galleries.

Educate yourself. By “education,” the study participants meant that they continually learned about the latest medicines and research findings, and that they collected tips from other consumers on effective doctors and doctors to avoid. Gaining new information on relevant topics obviously contributes to the participants’ sense of empowerment, and enhances their negotiating power. The participants applied this equation in their daily schedules so as to enhance their quality of life. Two of them discussed the value of this educational activity:

1. I think the most important thing is to educate yourself. You need to know what medications are out there. You need to know the good doctors from the bad doctors.
2. [You learn] from notes from the pharmacy, looking at the pharmaceuticals books, the PDR (Physicians’ Desk References) and going to seminars. I’ve educated myself.

Protect your recovery. The participants all reported that recovery was so important to them that they had made changes

in their lives to accommodate steps toward recovery, protect their progress, and promote the goal of recovery. The accommodations include avoiding extreme stress and wisely selecting friends to be with and places to visit or avoid. Here are two typical observations:

1. I think [I am doing better because] I am more conservative about chasing around places than I used to.
2. I haven’t had a relapse but I worry about it. I am a lot more careful now about putting myself under too much stress. Now I know what can take place. So I really worry about having things that are unmanageable.

As all of the foregoing interview excerpts imply, recovery from psychiatric disability requires a long process of learning about disability and about ways to live with disability, as a means to maximizing the capacity to negotiate your surroundings. It requires that you right medication, the right psychiatrists, the right friends, and the right social activities, so that you can stay the course of recovery toward a sense of control, self-respect and appreciation for life. You can begin the journey toward recovery only when you accept your disability, and can best continue this journey with a strong desire to turn your life around, and by finding the support and help you need to promote recovery.

The major features of a successful recovery include the following: (a) right kinds of medication; (b) a group of supportive people; (c) meaningful activities; (d) a sense of control and independence; (e) a strong determination to maintain recovery; (f) a positive outlook on the present; and (g) optimism about the future life.

A person diagnosed with psychiatric disability should be alert to several barriers to recovery. Those barriers included the following: (a) external and internal

stigmas; (b) continuing symptoms; (c) lack of financial resources; (d) limitations on access to services; and (e) the danger of excessive social and personal pressure.

With these barriers in mind, however, a consumer can begin recovery by taking the following actions: (a) accepting the disability; (b) believing in recovery; (c) making sure that the disability is stabilized; (d) accepting a share of responsibility for addressing the disability; (e) establishing a daily structure; (f) seeking support; (g) taking care of one's physical health; (h) keeping active; (i) educating your self to medication and other information helpful for recovery; and (j) protecting recovery progress against elements destructive to recovery.

SUMMARY

Implications for Practice and Policy

The findings reported here provide practical suggestions for mental health consumers about how they can undertake and maintain recovery, and they indicate some practical issues for mental health service providers to address. For consumers, stories of other, similarly situated consumers offer genuinely empathic suggestions for beginning their own recovery. This strategy has been found to be effective for helping consumers who wish to recover and even those who may be ambivalent about embarking on the recovery process. For example, Boston University's Center for Psychiatric Rehabilitation offers courses in which consumers and professionals together use a recovery workbook to teach consumers strategies for recovery (Spaniol, Koehler, & Hutchinson, 1994).

For mental health professionals, the familiar and common themes that emerged from this study provide clues for enhancing and speeding their clients' recoveries. First, mental health professionals must realize that each per-

son reaches the beginning point of recovery at a different pace. They should remain alert for a propitious beginning moment so as to help their clients start their own journeys of recovery. They should know that they may well become the most important support their clients have. They can also help by pointing clients to community resources useful for their recovery. They should, themselves, believe in their clients' recovery prospects, knowing that their belief will, in turn, provide their clients with a sense of hope. Mental health consumers often experience setbacks in their recovery, but service providers should remain encouraged. Given dedicated support, the clients will resume the path toward recovery as soon as they feel ready again.

Concerted efforts now exist to enculturate mental health systems to promoting recovery among their consumers. For example, as guidelines for the implementation of "recovery" by its mental health service providers, the Ohio Department of Mental Health has issued recovery concepts that happen to include most strategies that most of the participants in this study suggested (Beale & Lambric, 1995). The challenge in such an effort is that the concept of recovery resides in the ideology of consumer empowerment, and it is difficult to foster this ideology in a mental health system, structured in the traditionally uneven power relations, favoring service providers over consumers.

The author extends at this point words of caution for readers who find the overall tenor of this study persuasive. Its participants included only a small group of volunteers willing to share their stories with a professor. As noted earlier, these participants were homogeneous: They were highly educated; they were mostly in their 40s and 50s; and all but one were Caucasian. Thus, one cannot generalize the findings to all people, particularly to people with different racial or

cultural backgrounds and ages. Despite its limitations, this study produced a series of intuitively reliable themes that provide a beginning phase for the development of a grounded theory of recovery—an essential component of any systematic cultural transformation in a mental health system newly dedicated to imparting services aimed at the optimal recovery for all consumers.

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