

Providers' Hope-Inspiring Competence as a Factor Optimizing Psychiatric Rehabilitation Outcomes

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This article examines the role of hope in the process of recovery of people who have psychiatric disabilities. An original model outlining the dialectical relationship between hope and recovery is presented. From this perspective, the author introduces the concept of mental health and rehabilitation providers' hope-inspiring competence and identifies its main dimensions. Practitioners' ability to inspire and maintain hope in clients with psychiatric disabilities is viewed as playing a central role in providing the motivational resources necessary for the recovery process to occur. Thus, providers' hope-inspiring competence is identified as a crucial factor that contributes to optimizing mental health and rehabilitation services outcome.

Advances in both modern psychopharmacology and psychiatric rehabilitation technology and the intensified activism of consumers of mental health services have increased optimism regarding the treatment and outcomes of people who have experienced the disabling effects of a serious mental illness. This encouraging perspective has provided the opportunity to further conceptualize and operationalize the phenomenon of recovery of people with psychiatric disabilities. This article conceptualizes the critical importance of hope in the recovery process. More specifically, it examines the role of hopefulness of mental health and rehabilitation practitioners as an essential factor in promoting recovery.

The Recovery Paradigm

Recovery from severe and persistent mental illness is the guiding principle for both psychiatric rehabilitation services delivery and outcome evaluation. In the 1990s, the notion of recovery has been also transformed into the vital core of mental health consumers' self-help movement. While currently a consensus about

the nature of recovery from serious mental illness is still missing (Blanch, Fisher, Tucker, Walsh, & Chassman, 1993; Ralph, 1998), a rapidly growing number of consumers and practitioners are embracing the belief that people with psychiatric disabilities can recover and lead meaningful lives. Recovery is permeating the services delivery practice and research and the consumers' self-help movement and is becoming a leading paradigm in the understanding and the treatment of severe and persistent mental illness. Anthony's (1993) prediction that recovery would be the guiding vision of the mental health system in the 1990s has become a reality in the eve of the new millennium.

The recovery paradigm integrates the strengths perspective (Saleebey, 1997) and the empowerment perspective (Lee, 1994), both of which lately have been gaining popularity in the field of human services. These perspectives are quite different from the deficit approach which has prevailed in the mental health field for decades. From a recovery perspective, the development of client's skills for engaging in meaningful activities and for rebuilding a deeply wounded self becomes the treatment priority rather than symptom management and relapse prevention. Thus, the focus of service delivery changes from treating the disorder to treating the whole person. The development of the person's strengths becomes the road to overcoming the limitations of the illness and to recovery.

Initially, the concept of recovery emerged in the writings of people who have experienced a serious mental illness and who were able to master its negative impact to a significant point and build more satisfying lives for themselves (Deegan, 1988; Leete, 1989; Lovejoy, 1982; Unzicker, 1989). Based on consumers' personal accounts, Anthony (1993) conceptualized recovery from mental illness as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and roles. Recovery means that the person is able to live a satisfying and meaningful life even with the limitations caused by the illness. Recovery is conceptualized as a process of improving people's impairment, dysfunction, disability and disadvantage during which the person develops new meaning and purpose in life and grows beyond the catastrophic effects of the mental illness (Anthony, 1993). Recovery from psychiatric disability is understood as a significant improvement in the person's functioning and not as a complete "cure" from the illness (Anthony, 1993; Deegan, 1996), although

the notion of recovery does not exclude the potential for a full recovery from a disabling mental illness (Fisher, 1998).

The recovery perspective in understanding and treating psychiatric disabilities is grounded in mental health consumers' personal accounts and in recent empirical findings. Harding and Zahniser (1994) found that existing empirical data challenge pessimistic beliefs about the prognosis of severe and persistent mental illness. For example, the ground-breaking longitudinal study conducted by Harding and her colleagues (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987) emphasized that people with schizophrenia do recover, can be successfully employed, and can have meaningful lives. Such findings have been validated by a large scale national survey conducted by the Center for Psychiatric Rehabilitation at Boston University that examines the professional achievements of people with psychiatric disabilities (Ellison & Russinova, 1998). Preliminary results from this study suggest that people with psychiatric disabilities have been able to maintain successful careers at a professional or managerial level of employment, as more than 70 percent of the study participants had been employed full-time either in the health and mental health fields or in non-helping professions. Thus, the findings from this study challenge the myth that people with psychiatric disabilities can get and keep only entry-level jobs.

In the context of the recovery paradigm, consumers and practitioners increasingly acknowledge the importance of hope as a major factor facilitating the recovery process. Understanding how people remain hopeful in the face of difficult circumstances and how professionals can instill and maintain hope in mental health consumers is a crucial avenue for optimizing the effectiveness of mental health and rehabilitation services. From this perspective, practitioners' hope-inspiring competence is examined as a core component of their professional skills needed to promote the recovery process of people with psychiatric disabilities. A brief review of the nature and the characteristics of hope as an essential human experience is followed by a conceptualization of the mechanism relating hopefulness and recovery from psychiatric disabilities. The dimensions of mental health and rehabilitation practitioners' hope-inspiring competence are also discussed.

The Role of Hope in the Process of Recovery

Traditionally hope has been considered to be an elusive and "soft" concept (Farran, Herth, & Popovich, 1995). However, more recently two dominant approaches attempting to outline the nature of hope have emerged. The first approach, presented by Stotland (1969), defined hope as an expectation of goal achievement in the future and as an action-oriented motivational force related to a sense of the possible in the future. Snyder, Irving, and Anderson (1991) state that most authors accepting this approach define hope as an overall perception that goals can be met.

A more recent approach to the understanding of hope as a multidimensional concept was initiated by Dufault and Martocchio (1985), who defined hope as "a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a personally significant goal" (p.380). The authors distinguished two major types of hope: a) generalized

hope which conveys a sense of some future beneficial developments but is not linked to any particular concrete goal; and b) particularized hope which is related to a specific valued outcome, good, or state of being. Both types of hope are characterized by the following six dimensions: affective, cognitive, behavioral, affiliative (relational), temporal, and contextual (Dufault & Martocchio, 1985).

One of the most important characteristics of hope is determined by its interpersonal nature. Most authors studying the nature and the manifestations of hope examine hope as a relational process (Farran, et al., 1995). Hope is something that occurs between persons in the context of a relationship; it is a shared experience between giver and receiver. In the field of psychiatric rehabilitation, Anthony (1993) emphasizes the relational aspect of hope and its connection to recovery: hope emerges when there is a person one can trust, a professional who believes in better outcomes—even when clients do not believe in themselves. The relational nature of hope determines the important role of practitioners' hopefulness in promoting the recovery of people with psychiatric disabilities.

Research has demonstrated that positive thinking and expectations promote psychological and physical well-being, while negative thoughts and expectations contribute to the development of illness, stifle efforts to cope, and interfere with social support and medical recovery (Snyder, Irving, & Anderson, 1991; Peterson & Bossio, 1991). Promoting positive thinking and creating opportunities to enhance coping skills have proven successful in medical practice with terminally and critically ill patients (Herth, 1990; Miller, 1989). In addition, research has been conducted to identify the manifestations of hopefulness/hopelessness and its relationship to numerous variables such as depression, anxiety, suicidal intent, locus of control, self-esteem, social support, psychosocial adjustment, coping, life satisfaction and many others in populations of healthy adults and individuals with numerous medical problems (Farran et al., 1995).

Evidence has also been accumulating on the empowering potential of hope in the process of recovery from serious mental illness. Hope is recognized unanimously by consumers as one of the most important determinants of recovery (Deegan, 1988; Lovejoy, 1982; Orrin, 1997; Ralph, 1998; Weingarten, 1994b). Lovejoy (1982) emphasized that recovery cannot occur without hope as hope provides the person with all the essential elements of recovery: the courage to change, to try and to trust. Based on personal experience, Deegan (1988) described the process of recovery as a transition from despair, anguish, and pessimism to a new hope that life can be different, a hope born out of the presence of another person ready to provide support and care.

A number of leading clinicians including Menninger (1959), Frankl (1963), and Frank (1968) had recognized the value and the powerful treatment potential of hope in the field of mental health. Lately, an increasing number of authors have emphasized the importance of the provider's hopeful stance in the treatment process (Nunn, 1996; Kanwal, 1997; Kirkpatrick, et al., 1995; Woodside, et al., 1994). In the field of psychiatric rehabilitation, hope has been recognized conceptually as an intrinsic component of the process of rehabilitation of people with psychiatric disabili-

ities. Anthony, M.R. Cohen, and B.F. Cohen (1983) described hope is an essential ingredient in the practice of psychiatric rehabilitation.

Hope stimulates recovery not only through the maintenance of more positive expectations for improvement but also through counteracting depression and diminishing the risk for suicide among people with psychiatric disabilities. A number of studies have identified the correlation between hopelessness and the potential for suicide and have recognized hopelessness as a reliable predictor for risk of suicide (Beck, Brown, Berchick, Stewart, & Steer, 1990; Drake & Cotton, 1986). At the same time, hope-inspiring interventions have been recommended as a powerful treatment for suicide prevention (Kaplan & Schwartz, 1993). In the context of life threatening situations, hope functions as a life-saving force for individuals who have been overwhelmed by despair.

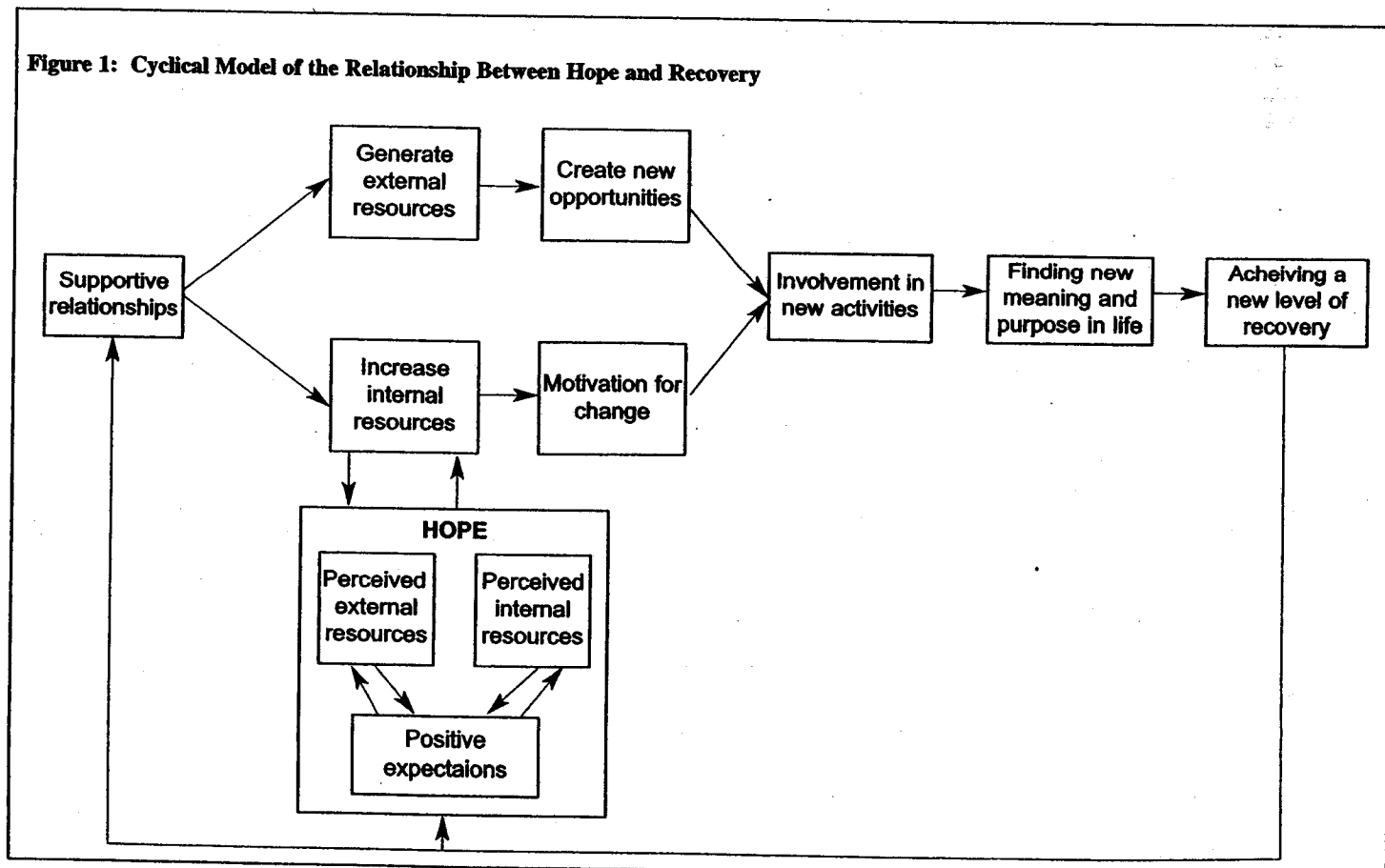
A Conceptual Model of the Relationship Between Hope and Recovery

The essential role which hopeful expectations play in overcoming despair and promoting positive changes in mental health consumers' lives requires not only the simple recognition of the existing relationship between hope and recovery from a serious mental illness but also a more thorough analysis and modeling of this relationship. The operationalization of this relationship becomes an important prerequisite for the effective utilization of the healing potential of hope. The model presented below (Figure 1) is an attempt to conceptualize the mechanism relating hope and recovery from a serious mental illness (Russsinova, 1998).

Recovery is a prolonged process of gradual positive change in the social and psychological functioning of a person who has been affected by a disabling mental illness. Hope and recovery are deeply interconnected, as hope is often the starting point of the recovery process. However, it is important to distinguish between consumer's hope for his/her own recovery and the hope other supporting people have regarding this person's future improvement. Often, the hope of supportive others is the initial source of consumers' own hope for recovery (Orrin, 1996; Fisher, 1997). The following is a description of the dialectical relationship between hope and recovery.

A supportive relationship is a key element contributing to the recovery process because, as discussed earlier, hope manifests itself in the context of a relationship. There is a need for a caring and supportive individual who would bring the "spark" of hope in the despairing heart of a person overwhelmed by a devastating mental illness (Deegan, 1988; Byrne, et al., 1994). The presence of a supportive other is particularly important at the early stages of recovery, when people with psychiatric disabilities tend to feel more hopeless and discouraged. Ironically, consumers often hear the most despairing and discouraging messages from mental health providers when first diagnosed with a serious mental illness. A supportive relationship instilling hope slowly breaks the closed circle of despair that tends to stagnate the person and limit involvement in recovery-promoting activities. Supportive relationships are also important when consumers experience temporary setbacks, as relationships provide the emotional stability and encouragement which could restore the person's hope for a better future. The hope generated in supportive relationships provides the containment of the person's fears, doubts, and despair and

Figure 1: Cyclical Model of the Relationship Between Hope and Recovery



allows their gradual transformation into confidence, strength, and new opportunities for change.

Hopeful support can be provided by friends, peers, family members, as well as mental health and rehabilitation professionals. For the purposes of this article, the analysis of the relationship between hope and recovery will focus only on practitioners' role in maintaining supportive relationships and instilling hope in clients with psychiatric disabilities. Caregivers' ongoing hope in the person's ability to overcome or at least minimize the disabling effects of a serious mental illness creates "the holding environment" (Winnicott, 1965) that allows the recovery process to unfold. Providers' capacity to tolerate despair and still maintain hope even when the consumer's personal circumstances in a given period of time tend to be discouraging, prevents the person from giving up and feeling devastated by the disability. In this way, the practitioners' ability to tolerate and contain the vicissitudes of hope and despair provides the elasticity of the relational holding environment, permits new risks to be taken, and, thus, new opportunities to be explored by mental health consumers.

Mental health and rehabilitation practitioners are in a position not only to keep hope alive in their clients through the general positive belief about the potential for recovery but also to provide the external and internal resources necessary to facilitate the recovery process. Depending on professional qualifications and job requirements, mental health and rehabilitation practitioners should focus on the provision of a variety of external or internal resources promoting recovery, such as adequate housing, job training, and supported education services, as well as resilience, coping skills, and self-acceptance. The more internal and external recovery related resources that are available to consumers, the greater the potential for recovery. Mental health and rehabilitation professionals have the responsibility not only to develop and provide such resources but also to help consumers become aware that such resources are available. Despair often prevents the latter from acknowledging the strengths and opportunities that would facilitate change. The development of consumers' awareness about the availability of recovery-promoting resources is the mechanism that generates hope and metabolizes despair. Thus, in the context of the presented model, the person's hope for recovery is a reflection of his/her perceptions of the available internal and external resources necessary for overcoming the disabling effects of the illness. The suggested operationalization of hope based on the availability of internal and external resources for recovery from a disabling mental illness is relevant to the mechanism describing the generation and maintenance of hopefulness in both providers and consumers. *The extent to which practitioners can identify internal resources in a given client and can secure external resources for this person determines how hopeful they feel about his/her process in recovery.* In turn, providers' expressions of hope and confidence regarding recovery through the identification and provision of relevant internal and external resources are gradually internalized by clients and transformed into a new internal resource determining the unfolding of the recovery process.

The operationalization of hope through the perception of the available resources necessary for the recovery of people with psychiatric disabilities allows the question about the adequacy of hope to be approached in a new way. Many providers are often

afraid of giving "false hope" to clients and thus, typically imply and maintain a less hopeful treatment perspective. The presence of recovery-relevant internal and external resources eliminates the danger of giving "false hope" to consumers. The adequacy of providers' hope is determined by their accurate perception and estimation of the external and internal resources available to a person to achieve desired future outcomes. It is of crucial importance that mental health and rehabilitation practitioners are able to evaluate adequately not only the resources currently available to a given client, but particularly the potential for additional resources to be developed in the future.

Once hope is instilled in consumers, it begins to function as an internal resource and becomes a major source of the person's motivation for positive change. When combined with favorable external resources and opportunities for rehabilitation, it determines the individual's involvement in new activities that pave the person's journey in rebuilding a wounded self and finding new meaning and purpose in life. Each new achievement and accomplishment promotes the recovery process while bringing more hope in both consumers and supportive others. Thus, the dialectical relationship between hope and recovery implies that hope functions as both a source and an outcome of the recovery process. The process of recovery includes numerous cycles similar to the one presented schematically on Figure 1. The increase of consumers' hopefulness as a result of specific meaningful personal achievements and relationships closes the loop of a given circle through positive feedback and thus, initiates a new stage or segment of the recovery process. Based on this dynamic, the presented model is described as a cyclical model outlining the dialectical relationship between hope and recovery from psychiatric disabilities. In this context, hope is identified as the primary motivational force both initiating the recovery process and allowing its gradual unfolding.

Serious Mental Illness as a Challenge to Practitioners' Professional Competence

Although hope is recognized as the initiating point of recovery and providers are considered to play a crucial role in conveying and maintaining it in their clients, often serious mental illness presents a major challenge to the professional skills of mental health and rehabilitation practitioners. It is easy to develop negative attitudes when working with people with chronic mental illness.

Evidence about the prevalence of such attitudes is provided by reports of mental health professionals themselves, as well as reports of mental health consumers. Menninger (1959) warned the mental health community about the dangerous effect practitioners' hopelessness can have on the professional beliefs of young professionals in training: "I perceived vividly how hopelessness breeds hopelessness, how the non-expectant, hope-lacking or 'unimaginative' teacher can bequeath to his student a sense of impotence and futility, utterly out of keeping with facts known to both of them" (p. 489). However, various authors have pointed out the presence of negative attitudes among mental health professionals and students toward people with psychiatric disabilities (Lefley & Cutler, 1988; Minkoff, 1987; Degen & Nasper, 1996).

Working with people with serious mental illness is considered to be unrewarding, non-prestigious, and hopeless. Thus, feelings of hopelessness, helplessness, and dislike of such patients become the major affective barriers that interfere with the treatment of this population. According to Minkoff (1987) these barriers are very closely related to the personal development of the practitioner, and particularly with his/her way of processing feelings of hope and despair. Clinicians, faced with chronicity, generally tend to experience unbearable feelings of despair which prevent them from bringing a more hopeful perspective to the treatment of their clients and might further deepen consumers' hopelessness. Degen and Nasper (1996) noted that when clinicians working with people with schizophrenia are not able to contain feelings of frustration, hopelessness, and helplessness, they often react with annoyance, avoidance, neglect, and rudeness.

There are numerous accounts of consumers about initial interactions with mental health professionals that have left them feeling disrespected, discouraged, and hopeless. Deegan (1990) named this phenomenon "spirit breaking." She specified that "the experience of spirit breaking occurs as a result of those cumulative experiences in which we are humiliated and made to feel less than human, in which our will to live is deeply shaken or broken, in which our hopes are shattered and in which 'giving up,' apathy, and indifference become a way of surviving and protecting the last vestiges of the wounded self" (p. 306). The phenomenon of "spirit breaking" identifies some of the manifestations and factors contributing to the development of the secondary negative symptoms of serious and persistent mental illness. This phenomenon also explains the mechanisms leading to the development of learned helplessness among people with psychiatric disabilities which has been identified as one of the major barriers to recovery (Deegan, 1992; Flannery, Penk, & Addo, 1996; Weingarten, 1994a).

Practitioners' Hope-Inspiring Competence

The manifestations of practitioners' hope for recovery can be conceived as a continuum with a high level of hopefulness as its upper end, and a low level of hopefulness as its lower end. The concept of hope-inspiring competence is introduced to denote a relatively high level of the practitioner's ability to instill and maintain hope for recovery in people with psychiatric disabilities. From this perspective, hope-inspiring competence is defined as a creative and flexible integration of practitioners' hopeful stance about the client's potential for recovery with the practitioner's skills to utilize various hope-inspiring strategies. Hope-inspiring competence requires more than simply having a positive attitude about recovery and focuses on the practitioner's ability to use various hope-inspiring strategies in the process of service delivery. Based on the review of the literature addressing hope and its characteristics, the following dimensions of practitioners' hope-inspiring competence (Russonova, 1996) are identified:

1) *Beliefs about the potential for recovery (better future outcomes) from a disabling mental illness.* This dimension reflects practitioner's attitudes and expectations about positive outcome and recovery of people with a disabling mental illness. It is consistent with dimensions identified empirically through the analysis of the factorial structure of instruments measuring generalized

hope such as "anticipation of the future" (Miller & Powers, 1988), "temporariness and future" (Herth, 1991), and "future is possible" (Nowotny, 1989). The set of generalized beliefs about the potential of mental health consumers to recover substantially or completely represents practitioner's hope for recovery of people who have experienced a serious mental illness. This is a specific type of hope that is relatively independent from practitioners' level of hopefulness as an overall attitude toward life, other people, and themselves. Providers' hope for recovery from a disabling mental illness develops in the process of their professional training and personal experience of working with people with psychiatric disabilities. It is grounded in existing knowledge about recovery from serious mental illness. However, it also requires a deep conviction and confidence that this knowledge could be personally implemented in one's own professional practice.

2) *Capacity to tolerate uncertainty regarding future outcomes from a disabling mental illness.* Although recent studies show that a significant percentage of people diagnosed with a serious mental illness do improve and recover, many continue to struggle. Since the factors determining successful vs. unsuccessful recovery are not completely known, practitioners still have to provide services without knowing for certain the outcome or speed of recovery for their clients. Yet, it is important for practitioners to be able to convey hopefulness to all people with a disabling mental illness. This requires practitioners to maintain a high level of tolerance of uncertainty regarding the recovery outcomes. Tolerating this kind of uncertainty becomes a prerequisite for practitioners' ability to convey hope to their clients with psychiatric disabilities, to contain consumers' despair, and to metabolize it into a more hopeful perspective.

3) *Motivation of the practitioner for promoting better outcomes for people with a disabling mental illness.* This dimension reflects practitioners' determination and persistence in providing a more hopeful perspective about the future. It is consistent with the first component of the theoretical and empirical model of generalized hope developed by Snyder and his colleagues (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, & Harney, 1991), who describe this component as "agency" and define it as "a sense of successful determination in achieving goals" (p. 570). Maintaining a generalized but stable belief that there is potential for a person struggling with a disabling mental illness to recover requires the practitioner to be able to contain his/her own feelings of helplessness, despair, and frustration with the slow improvement of clients. Providers' persistence and patience in keeping hope alive, even when a client decompensates, is closely related to their ability to identify, remember, and acknowledge small achievements of the person. Such positive encouragement is considered to bring more hope in clients and, thus, to be one of the crucial factors determining continuance of treatment and its outcomes (Ripple, Alexander, & Polemis, 1964).

4) *Hope-inspiring resourcefulness of the provider.* This dimension reflects practitioners' ability to utilize various techniques and approaches that generate higher levels of hope in clients. Such techniques represent the broad spectrum of various hope-inspiring strategies that have been implemented in medical practice for the treatment of people with a terminal, critical or

chronic illness (Miller, 1989; Herth, 1990; Kirkpatrick et al., 1995). This dimension is consistent with the second "pathways" component identified by Snyder and his colleagues (Snyder et al., 1991) in their model of hope. They describe this component as "a sense of being able to generate successful plans to meet goals" (p. 570).

From the point of view of the cyclical model outlining the relationship between hope and recovery discussed earlier, three types of mental health and rehabilitation practitioners' hope-inspiring strategies can be identified: hope inspiring strategies utilizing or mobilizing respectively interpersonal resources, internal resources, and external resources. The utilization of different strategies allows the development and mobilization of these three types of resources which, in turn, generate hope and promote recovery. A comprehensive perspective of the three types of hope-inspiring strategies is presented in Table 1. These strategies have been identified and grouped based on: 1) the review of the relevant medical and mental health treatment outcome literature; 2) the author's clinical experience in working with people with psychiatric disabilities; and 3) the implications of the presented conceptual model of the dialectical relationship between hope and recovery.

The first type of hope-inspiring strategies reflects the healing potential of supportive relationships. One of the most powerful hope-inspiring strategies included in this group is the ability of the practitioner to promote the person's potential and strengths through maintaining a strong belief in the individual, even during times of crisis and temporary deterioration. These hope-inspiring strategies are relevant to any helping relationship independently of the practitioner's professional discipline. The second group of hope-inspiring strategies focuses on increasing the person's coping skills, self-esteem, and confidence in their personal strengths. The third group of hope-inspiring strategies facilitates the individual's ability to recognize and use a variety of external resources

that can have a positive impact on the process of recovery. Because of the different nature of mental health and rehabilitation services, the last two groups of hope-inspiring strategies may have a different priority in the professional activities of mental health and rehabilitation providers. While mental health practitioners typically focus on the development of the person's inner resources, rehabilitation practitioners may place an emphasis on the effective utilization of external resources that will facilitate the process of healing and personal growth.

Various hope-inspiring strategies are routinely implemented by mental health and rehabilitation practitioners, though often, these interventions are not connected with the goal of instilling and maintaining hope in the client. It is important to integrate hope-inspiring strategies with practitioners' understanding of the dynamics of hope and despair and with their own beliefs regarding the potential for recovery from a disabling mental illness.

Conclusion

The recognition of the crucial role of hope in promoting the recovery process of people with psychiatric disabilities presents new demands regarding the professional competence of mental health and rehabilitation practitioners working with this population. Both practitioners' awareness of the complex dynamics of the interconnectedness between hope and recovery, and their competence to inspire and maintain hope in mental health consumers, become critical factors in determining treatment and rehabilitation outcomes. From this perspective, the training of mental health and rehabilitation professionals to utilize more effectively the healing potential of hope in the process of service delivery to people with psychiatric disabilities will provide a new avenue to improve the recovery outcomes. The implementation of such training requires further operationalization and empirical validation of the concept of practitioners' hope-inspiring competence, as

Table 1: Types of Hope-Inspiring Strategies

Hope-Inspiring Strategies for Utilizing Interpersonal Resources for Recovery	Hope-Inspiring Strategies for Mobilizing Internal Resources for Recovery	Hope-Inspiring Strategies for Utilizing External Resources for Recovery
Believing in the person's potential and strength.	Helping the person to set and reach concrete goals.	Helping the person to connect to successful role models (i.e., persons at a more advanced stage of recovery).
Valuing the person as a unique human being.	Helping the person to develop better coping skills.	Being available when the person is in crisis.
Accepting the person for who he/she is.	Helping the person to recall previous achievements and positive experiences.	Helping the person to manage the illness through medication.
Listening non-judgmentally to the person's experiences.	Using techniques for changing the person's negative perceptions of events and self.	Supporting the person's involvement in educational programs.
Tolerating the uncertainty about the future developments in the person's life.	Helping the person to accept limitations.	Educating consumers regarding their illness.
Accepting the person's decompensations and failures as part of the recovery process.	Helping the person to accept failures and learn from them.	Helping the person to join self-help groups.
Tolerating the person's challenges and defeats.	Helping the person to grieve for the losses experienced because of the mental illness.	Facilitating the family support for the person.
Trusting the authenticity of the person's experiences.	Helping the person to make sense of the suffering related to his/her mental illness.	Providing support regarding the person's housing situation.
Expressing a genuine concern for the person's well-being.	Helping the person to find personal meaning and purpose in life.	Supporting consumers to obtain and maintain employment.
Using humor appropriately.	Supporting the person's spiritual beliefs.	

well as the development of relevant in-service and pre-service training curricula.

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