

Recovery from Psychiatric Disability: Implications for Rehabilitation Counseling Education

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***Abstract.** People with psychiatric disabilities have been viewed historically as incapable of recovery. However, recent data suggest that many people do recover and go on to fulfilling and contributing lives in their communities. These new data have important implications for teaching students who will be working with people with psychiatric disabilities.*

Introduction

For most of the past century, schizophrenia and other serious psychiatric disabilities have been viewed as irreversible illnesses with increasing disability over time (Harding & Keller, 1998; Harding, Zubin, & Strauss, 1992). Individuals with psychiatric disabilities were viewed as having no future, unable to enter the world of work, unable to sustain relationships, unable to manage their symptoms, and unable to assume common roles in their personal life and in the community (Harding & Zahniser, 1994). They were viewed as hopeless and their illnesses were viewed as unyielding.

Mental health program planning, policies, and practices were developed and implemented to support this uncompromisingly negative view of the predicted outcome for people with psychiatric disabilities. For example, people were routinely housed in large holding environments with little or no treatment or rehabilitation, and most were expected to remain in these facilities for the rest of their existence. Family members were told to forget about them and go on with their own lives. In addition, values, attitudes, and beliefs associated with this negative view of outcome became imbedded in people with psychiatric disabilities, their family members, professionals, the general public, and the media (Borinstein, 1992; Deegan, 1990; Minkoff, 1987).

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Early outcome studies were often biased, focusing solely on hospitalized patients and neglecting to follow up on those individuals who did recover (Harding et al., 1992). Even today's professionals are biased because they generally see only individuals who are seriously struggling with their illnesses and have lost contact with others as they improved. However, numerous recent studies have demonstrated that one half to two thirds of people with severe mental illnesses significantly recover over time (Harding & Keller, 1998; Harding & Zahniser, 1994; Harding, Zubin, & Strauss, 1992). This research evidence is widely supported by the self-help literature (Deegan, 1996; Houghton, 1982; O'Neal, 1984). Thus, there is no evidence to support the notion that people with psychiatric disabilities follow a specific, inflexible, and negative natural history. While the impact of serious mental illness is devastating to those who experience it and to their families, it does not appear that serious mental illness is necessarily a disease of slow and progressive deterioration, as was once widely believed (Harding & Zahniser, 1994). People with psychiatric disabilities can achieve partial or full recovery from the illness at any point during its course, even in the later stages of their life (Harding & Zahniser, 1994). A definition of recovery is

the process by which people with psychiatric disabilities rebuild and further develop their important personal, social, environmental and spiritual connections, and, confront the devastating effects of stigma through personal empowerment. Recovery is a process of adjusting one's attitudes, feelings, perceptions, beliefs, roles and goals in life. It is a process of self-discovery, self-renewal, and transformation. (Spaniol, Koehler, & Hutchinson, 1994, p. 1)

Implications for Rehabilitation Counseling Education

These dramatic findings related to recovering present a great challenge to rehabilitation counseling education. Implications include communicating hope for recovering, presenting personal models of people who are recovering, identifying the values that support recovering, discussing the importance of self-help in recovering, and providing information about its impact on family members. Further implications are covered in other articles in this Special Issue.

Hope for Recovering

Hope is an essential ingredient of the rehabilitation process (Rusinova, 1999). The recent information about the possibilities for recovering has strong implications for how we teach students who will be working with people with psychiatric disabilities. For example, students need to be aware of the limitations of the historical studies and become familiar with the findings of the recent studies and self-reports. Many rehabilitation professionals still do not believe that recovery happens; as a result, they feel hopeless and helpless in their rehabilitation work. Disseminating the new recovering information could alter these negative attitudes by teaching counseling students that it is possible for people

with psychiatric disabilities to (a) maintain friends and intimate relationships, (b) live in stable housing of their own choice, (c) work in a job that uses their skills and abilities, (d) contribute to their community, and (e) have reliable coping skills.

Recovering is a highly individualistic process and rehabilitation counseling professionals need to understand it from the perspective of the unique person they are assisting. While we are beginning to understand some of the generic aspects and longitudinal processes of recovering, we have to be cautious in applying them to the person we are working with (Strauss, Hafez, Liberman, & Harding, 1985). Each person needs to understand and validate his or her own journey toward recovering.

Recovering needs to be framed in a broader context than recovering from a mental illness. While the illness itself can cause a major disruption in a person's life, stigma and discrimination (negative personal, professional, and societal values; attitudes and practices) can further disconnect people and represent serious barriers to recovering (Harding & Zahniser, 1994; Kramer & Gagne, 1997; Spaniol, Gagne, & Koehler, 1997). For many people, the illness may be the least of their problems as they struggle to rebuild their lives. It is important for rehabilitation counselors to listen to the range of barriers that people encounter and to assist them with coping. Furthermore, people with psychiatric disabilities need to be taught the knowledge and skills they will need to build a life that is satisfying for them.

Personal Models of Recovery

It is important to include people with mental illness as presenters in rehabilitation counseling program classes. While reading about people with mental illnesses is helpful, it is more meaningful for students to see that people with psychiatric disabilities are functioning well, by listening to their stories of recovering and interacting with them in class. Furthermore, people with psychiatric disabilities could assist in developing the curriculum or even present an introductory class to students on psychosocial aspects of disability.

Another powerful way to affect attitudes is for people with psychiatric disabilities to participate as students in the rehabilitation counseling program. Although we are quite used to seeing people with physical disabilities in our classrooms, people with psychiatric disabilities usually attend as speakers, not as our peers. As students, people with psychiatric disabilities would be able to interact with other students as peers both academically and socially. Consequently, students without disabilities would view them as people and fellow students. Their illnesses would become less significant as other aspects of their selves became more visible and accessible.

Values that Support Recovering

The new vision of recovery requires communicating to rehabilitation counseling students a set of values that can form the basis of a more collaborative working relationship with people with psychiatric disabilities (see Table 1). Because people can recover and become agents in their own recovery, their relationships with rehabilitation counselors are best described as collaborative. People can act responsibly in making decisions about their

own life. They can work collaboratively with their rehabilitation counselors in the planning, implementation, and monitoring of their rehabilitation efforts.

Table 1
Values that Support Recovering

Value	Description
Empowerment	Creating a personal vision and having the confidence to move toward it. Feeling I can versus I can't.
Personal choice	People know how to lead their life better than someone else does.
Personal involvement	Participating in the processes by which decisions are made that affect one's life.
Community focus	Building on existing resources in the community.
Focus on strengths	Building on existing strengths in the person.
Connectedness	Enhancing relationship to self, others, environments, meaning/purpose.

Empowerment. Working collaboratively, from the point of view of the person with a psychiatric disability, is a step toward empowerment. Rehabilitation counselors can be taught that empowerment means that people believe they can, feel they can, and actually do act in their own interest. Both the illness itself and the manner in which helping professionals and society often treat people can severely injure this sense of personal potency. Treating people as equals helps them to feel their own unique sense of equality. Assuming that people can participate actively in their own interest helps them to believe this about themselves.

Choice. People with psychiatric disabilities have the right to make choices in their lives. They also can assume responsibility for the consequences of their choices. Even though, as rehabilitation counseling professionals, we are taught the knowledge and the skills to assist people in their rehabilitation, we cannot assume that we know how to lead someone's life better than they do. Rehabilitation counseling professionals may feel that their expertise puts them in charge of the rehabilitation process. However, the person alone maintains the right to make his or her own decisions regarding how to use the knowledge and skills imparted by the rehabilitation counselor.

Personal involvement. People have a right to participate in the decision-making process. In fact, it is essential that people be actively involved in their recovery. It may be necessary for the rehabilitation counselor to help people reach the point where they feel confident and safe enough to participate. They may have learned that active participation is unsafe and that expressing an opinion can evoke retaliation. As a result, people with psychiatric disabilities may distrust their own judgement and may require validation from

their rehabilitation counselor until their confidence, self-esteem, and trust are restored.

Community focus. People with psychiatric disabilities are often limited to resources provided by the mental health system so they do not feel a part of the larger community. However, when rehabilitation counselors help people with psychiatric disabilities to participate in the larger community, they can have access to its resources. Integrating people into the resources of the larger community, such as schools, jobs, housing, relationships, and recreation, helps them to find their place in the larger community. This integration enables them to identify themselves apart from their illnesses as people, students, workers, neighbors, friends, and people who can enjoy life. As these new identities gradually grow in importance, their own and others' focus on their disabilities becomes less dominant.

Focus on strengths. Historically, the focus in mental health has been on the illness. The mental health system provided treatment for the illness as the major intervention and did not focus on the needs of the person. Concomitant with the focus on the illness was the focus on what the person cannot do rather than what the person can do. While long-term drug treatment and attention to deficits are often helpful, they are rarely sufficient components of a rehabilitation intervention. The value of the rehabilitation counselor's focus on strengths means that people can build a life in their community that emphasizes their abilities and competencies, even when they are symptomatic. This value also assumes that people have abilities and competencies that either are currently present or can develop through the provision of knowledge, skills, and support by the rehabilitation counselor. This does not mean that we should ignore the illness or other deficits, but rather that they should not be the only focus—or even the major focus—as people recover from the initial trauma of the illness. It also means that we need not wait for the elimination of all symptoms before we begin our rehabilitation intervention. The primary focus of psychiatric rehabilitation is on improving the knowledge, skills, and supports of the person.

Connectedness. Many people with psychiatric disabilities experience frequent and intense periods of loneliness (Davidson & Stayner, 1997). They can easily lose a sense of being connected with themselves, with others, with their environments, and with larger meaning and purpose (Kehoe, 1999). This loss of connectedness often leads to self-alienation and loss of contact with life goals, values, and feelings in the present and in extreme situations may eliminate the ability to feel altogether. Self-alienation can also lead to a sense of hopelessness. The value of connectedness helps rehabilitation counselors assist people with psychiatric disabilities in rebuilding their connections to themselves, to others, to their environments, and to meaning and purpose in life.

Self-Help

A major impetus for the self-help movement has been the lack of helpful community services and programs available to meet the needs of people with psychiatric disabilities. Another impetus has been the realization on the part of people with psychiatric disabilities that they are often their own best helpers. Federal and state funding for some of these groups has also helped along this effort. Professionals have assisted some of these groups in their development, while people with psychiatric disabilities have developed many

of their own self-help groups.

Although self-help has become an important resource for people with psychiatric disabilities, many professionals are reluctant to refer to self-help groups (Lee, 1995). Students need to understand the value and benefits of self-help to the person (Chamberlin, Rogers, & Langer Ellison, 1996). It is humbling to acknowledge that people with psychiatric disabilities can often offer more help to one another than the professional. While self-help groups such as Recovery, Inc., Emotions Anonymous, and GROW have been around for some 50 years, the variety of self-help groups for people with psychiatric disabilities has been growing steadily during recent years. Some examples are presented below.

1. Social support groups, such as social clubs, that focus on social activities and building relationships;
2. Specialized groups such as the Depressive and Manic-Depressive Association, which has groups nationwide and focuses on education and support;
3. Independent living centers, which initially focused on people with physical disabilities and have now become much more cross-disability oriented. These are service delivery and advocacy centers that are controlled by, and largely run by, people with disabilities. They are also a national grassroots movement for social justice and civil rights for people with disabilities;
4. Groups for people with dual diagnosis such as *Double Trouble* (Vogel, Knight, Laudet, & Magura, 1988). These groups provide education and support for people with psychiatric disabilities and co-occurring substance disorder;
5. The Recovery Workshop, codeveloped by a professional and a person with a psychiatric disability at Boston University (Spaniol et al., 1994). This educational workshop helps people to acknowledge their own recovering process and teaches basic coping and life enrichment skills;
6. Advocacy groups, such as M-Power, the Massachusetts statewide advocacy group, are available in many states and advocate policy and legislative changes;
7. Groups that focus on the human process of healing and transformation, such as National Artists for Mental Health and A.R.T.S. Anonymous, which uses the 12 steps (Spaniol, 2000).

To make an appropriate referral, students need to become familiar with the self-help movements in their own community and their distinct foci. It is often useful to have another person with a psychiatric disability assist the person in making the first contacts.

The Role of the Family

The onset of mental illness triggers a major crisis in family members much like that experienced by family members of people with other major disabilities. Few family members are prepared to deal with a traumatic crisis and the resulting caretaking that frequently continues for many years. One key to improving collaboration between family members and rehabilitation counselors is helping rehabilitation counselors understand the experience of the family members when they deal with this crisis in their family. Interestingly, rehabilitation counselors are often as unprepared as family members are in their response to this profound crisis. In fact, we can frequently see a parallel process in the responses of the rehabilitation counselor and family members: both feel helpless, angry,

despairing, and anxious.

The training rehabilitation counselors receive often fails to provide them with the information, attitudes, skills, and competent supervision necessary to assist family members to cope and adapt. On the contrary, counselors are often taught that parents are the cause of the mental illness or the decompensation of their family member (Marsh, 1998; Marsh et al., 1996). Their professional beliefs, lack of helping skills, and sense of inadequacy due to the lack of known "cures" for these illnesses often compound the burden of guilt for newly traumatized family members.

Understanding the family's complex and highly charged emotional experience can give rehabilitation counselors new beliefs and attitudes that foster more helpful approaches with the family members (Spaniol, Zipple, Finley, & Marsh, 2000). Rehabilitation counselors can help family members view their experience as a natural result of a traumatic crisis, one that requires new coping and adaptation skills. Collaborating with the family helps the rehabilitation counselor to work more successfully with the person with a psychiatric disability (McFarlane et al., 2000).

Conclusions

The recent literature on recovery from psychiatric disabilities requires many system-wide policy, program, and people changes. The rehabilitation and mental health fields are currently in the throes of these many changes. Rehabilitation educators can teach rehabilitation counselors to assist people with psychiatric disabilities to live satisfying and contributing lives in the community by (a) understanding the recovery process, (b) communicating hope, (c) using mentors and models of people with psychiatric disabilities in their classes, (d) teaching values that support recovering, (e) understanding the benefits of self-help, and (f) understanding the role of the family in the psychiatric rehabilitation process.

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