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LESSONS FROM THE RECOVERY TRAINING PROGRAMME FOR SERVICE USERS EMPOWERMENT

Abstract

There is no single definition for recovery. The personal recovery is driven by people's lives, subjective experiences of psychotic crisis and challenges the notion of permanent, chronic mental illness. Several types of activities have an impact on recovery. This paper presents the preliminary results of the twelve hours training focused on the following topics: recovery – individual experiences, barriers in the process of recovery, social and internalised stigma, empowerment, personal strengths, problem solving, personal recovery plan, life narrative story. The participants found it to be a positive experience: helpful and supportive. They agreed that talking of their strengths was much useful and made them feel good. In their opinions' the most important exercise was personal recovery plan which has given them the opportunity to establish individual, meaningful life goals, provide them with hope and self-determination. These results need replication and further work to identify what were the preconditions for making the training such a valuable experience and how this could be replicated on a wider basis.

Introduction

Persons with mental illness may suffer from self-stigma and diminished self-esteem and self-efficacy as a result (Corrigan & Watson, 2002). Illness identity, defined as the set of roles and attitudes that a person has developed in relation to his or her understanding of having a mental illness, may lead to the negative assumption that mental illness means incompetence, inadequacy and powerlessness (Yanos et al., 2010). This usually starts a process in which the persons become at risk of social exclusion.

The recovery applies to persons who live outside the mental illness. There is no single definition for this phenomenon. It is indicated that this is because recovery is a journey shaped by an individual's own experiences and stages. It occurs through ongoing transactions between an individual and his or her world (Davidson, 2007; Onken et al., 2007), as a continuing process of change which is not illness focused. What this means is that mental health professionals should be prepared to relinquish power and control and work in meaningful hope-inspiring relationships with people who use their services (Slade, 2009).

Ongoing debate about the recovery forms two groups of definitions which are suggested to be in tension with each other: service-based recovery and user-based recovery. The medical model drives the clinical view of the process – recovery is objective and understood to be a return to a former state of health. Outcomes include reduced symptomatology, no psychiatric hospitalisation, pharmacotherapy compliance and adherence (when needed), full- or part-time involvement in work or

school (increases a person's self-worth, stabilizes living circumstances and facilitates integration with the community), life independent of supervision, not fully dependent on financial support from disability insurance, relations with friends. The personal view of recovery is driven by people's lived, subjective experiences of psychotic crisis and challenges the notion of permanent, chronic mental illness (Leamy et al., 2011). Outcomes include empowerment, hope, choice, self-defined goals, meaningful life, hopefulness and self-determination, healing, wellbeing and control of symptoms (Andresen et al., 2011; Adame & Knudson, 2008; Schrank & Slade, 2007). This dynamic process may involve great suffering and unpleasant flash-backs, but it can also lead to self-discovery, self-renewal, and transformation.

The following personal accounts of coping, healing and consideration, however published many years ago, still form stirring examples of users' recovery and social inclusion perspective:

> *Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.*
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> Deegan, 1988, p. 15.

> *Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort. I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us.*
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> Leete, 1988, p. 52.

> *When we are first diagnosed, we must come to terms with the prevailing ideologies regarding people with mental illness. These ideologies segregate people with mental illness from the rest of the population through the enforcement of an 'us-them' mentality. Consequently, our identity is challenged as we are placed in the 'them' category by virtue of diagnosis.*
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> Schiff, 2004, p. 217.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation organized by SAMHSA (The Substance Abuse and Mental Health Services Administration), patients, health care professionals and researchers agreed on ten core principles of recovery orientation: self-direction, individualised and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, hope (http://www.apa.org/monitor/2012/01/recovery-principles.aspx).

Types of recovery activities

Several types of activities have an impact on recovery (Ralph, 2000). There is writing of personal accounts – courageous narratives about the struggle with and overcoming of mental illness and accompanying social challenges, writing

describing an evolving sense of self. They often include information about how to recover and how to continue to be well. These may be presented at conferences and workshops, exchanged on the internet, printed in service users' newsletters or included in peer-reviewed journals.

There are workshops and training in how to recover, run by service providers or / and service users (Anczewska & Ryan, 2009) or the implementation of self management training, based on psychological theory of self-determination (Ryan & Deci, 2000), in a lifelong learning strategy (Cook et al., 2009; Cook et al., 2012; Lucksted et al., 2009). In this framework, lasting health behavior change occurs through autonomous motivation in which actors experience a sense of volition, self-initiation, and endorsement of their behavior.

Allott (et al., 2002) suggests that service users should be supported in their own personal development by helping them to build their self-esteem, to discover identity and to become active participants – as opposed to passive recipients – of their mental health care and regain their role in society.

Other recovery activity is research focusing on recovery. These include a wide variety of methods including consumer surveys, qualitative studies, outcome studies, development and testing of specific interventions, both quantitative and qualitative instrument development, and model development and testing.

The aim of this paper is to share with educators and mental health providers some ideas on life long learning approach which helps service users achieve social stability and inclusion in their everyday lives. The authors present the preliminary results of training program for service users in recovery.

The training process and structure

The learning element of the training is based on learner-centred, team work on issues of common concerns to find solutions for diverse contexts. The workshops prioritise a "three-fold concept" of competence development: developing sensitivity and awareness, knowledge and understanding, individual practice.

Theoretical background of the training is based on empowerment (Linhorst & Eckert, 2003; Zimmerman, 1995) to learn how to gain control over one's own life; on personal recovery (Adame & Knudson, 2008; Andresen et al., 2011; Cohen, 2005) how to acquire hopefulness and self-determination, rebuilt self-esteem and challenge the notion of permanent, chronic mental illness, on cognitive behavioural theory (Alford & Beck, 1997) how to fight self-stigma, on narrative theories (Pennebaker & Seagal, 1999; Thornhillet al., 2004; Wisdom et al., 2008) how to encouragingly analyse life experiences to establish new meaningful life goals, on illness identity (Yanos et al., 2010) how to overcome the notion that mental illness means incompetence and powerlessness.

The authors of the training follow the concept that if recovery is a journey then the role of trainers is to provide some guidance and sign posts on that journey – moving from alienation to a sense of meaning and purpose it is not to accomplished alone – the journey involves support, empowerment and learning.

The twelve hours training is designed to be delivered by two psychologists and one psychiatrist in maximum ten persons groups. The length of it arrived as a result of evaluation made after the former experience – in 2007 and 2008 the ten hours training "Empowering people in recovery" was run in the Institute.

The content of the training consists of the following topics: recovery – individual experience, internalised stigma, empowerment, personal strengths, problem solving, personal recovery plan, life narrative story (Roszczyńska-Michta et al., 2009), with exercises: *working out recovery definition, individual stop over recovery journey, barriers in recovery, personal values and strengths in opposition to stereotypes, identity and social roles, situation-thought-emotion, what makes you feel strong?, being controlled and control others, individual recovery plan, how to manage the problem in regard psychotic crisis, my life is like "a book"*.

Each teaching session lasts two hours with short breaks, taught over six weeks, organised in the afternoon in order to not interfere with participants daily duties. People are provided with educational materials to make homework which are discussed during the subsequent sessions. After the module is concluded the participants evaluate the program in regards its usefulness, strengths and weaknesses, peoples needs and expectations, opinions on recovery and ways to accomplish it.

Participants

The service users were contacted through clinical services in the Institute of Psychiatry and Neurology. The announcement titled "Recovery Workshops" was put on the Institute official web side with general training information, a contact person and a telephone number. Service users were invited for an evaluation session during the week after the first contact was made. The decision to participate in the training was strictly voluntary. Inclusion criteria were as follows: aged 18 and over, suffering from schizophrenia or delusional disorders. Patients with active drug or alcohol dependence and severe cognitive deficits were excluded. We decided to train schizophrenia or delusional disorders sufferers since these illnesses are ranked among the leading causes of disability worldwide (Prince et al., 2007).

The recruitment process proved some difficulties namely how to motivate people with psychotic crisis experience to participate in the training. The trainers used some elements of motivational interviewing (Barkhof et al., 2006): a non-judgemental and empathetic attitude and directed conversation about people recovery problems.

The subsequent workshops were run within 24 months (from October 2011 till October 2013). The trainers noticed that the participants usually dropped out from the last training session. In their opinion it might be explained as a form of "overstimulation" and should be taken into consideration when planning the next intervention structure.

70 service users concluded the training. Participants age varied from 20 to 50 years, the women were in majority (67%), as well as people with higher education (61%), unemployed (71%), using mental health services not longer than five years (56%).

Participants' opinions on recovery

In general the service users' opinions on recovery represent four dimensions: satisfaction of life – e.g. *recovery means better living, accomplish life goals, coping with life challenges*; well-being – e.g. *recovery it is soma and psyche balance*; *recovery means accept myself – my failures*; social support – e.g. *recovery means*

having close friends; to recover is to have friendly people around and supportive family; personhood – e.g. *recovery means to be a person not a case, to acknowledge that mental illness has no relation to me as a person*. These opinions support the notion of personal recovery rather than medical one. Among all the participants there was no single opinion on illness symptoms reduction, medication use or employment in terms of recovery.

Participants' recommendation on concluding recovery journey

In general the trainees' recommendations were in accordance with Personal Assistance in Community Existence A recovery guide (Ahern & Fisher, 1999): recovery beliefs – e.g. *it is useful to think of the future instead of the past unpleasant experiences*; recovery relationships – e.g. *a person should have supportive friends and trust in God, it is helpful to talk with people with the same experience*; recovery skills – e.g. *a person should found new goals, it is helpful to know that everyone may fail and should forgive himself*; recovery identity – e.g. *think of you as a husband not a psychiatric patient*. In their recommendations the participants didn't refer to recovery community, namely work or helping others.

Participants' reactions to the training

All of the participants, who took part in the sessions showed full engagement with the training, however not all of them did homework completely and carefully. They underlined that talking of their strengths was much helpful and made them feel good. In their opinions' the most useful exercise was personal recovery plan which has given them the opportunity to establish individual, meaningful life goals, provide them with hope and self-determination. During the following sessions the group shared: friendliness and gratitude to each other and facilitators.

The current study supports the ongoing debate about the two groups of recovery definitions: service-based recovery and user-based recovery. Among all the participants of the training there was no single opinion on service-based recovery namely illness symptoms reduction, medication use or employment. They focused on dimensions of personal recovery: life satisfaction, well-being, social support, personhood. The participants didn't also refer to recovery community, this can be explained by organizational factors – there are hardly any recovery-promoting initiatives in Polish mental health system.

Conclusions

There is no single definition for the recovery. It is suggested that this is because recovery is a journey shaped by an individual's own experiences and stages. The twelve hours training focused on the principles of recovery orientation was positively judged by service users suffering from schizophrenia – they found it helpful and supportive. The participants highly rated the session on personal strengths and on personal recovery plan which have given them the opportunity to establish individual, meaningful life goals, provide them with hope and self-determination. These results need replication and further work to identify what were the preconditions for making the training such a valuable experience and how this could be replicated on a wider basis.

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