Recovery into Practice

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Promoting Recovery: What's Love Got to Do With It?

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One of the key ways in which recovery-oriented practice has been distinguished from traditional approaches is that it attends first and foremost to the ***person*** with the mental health condition, rather than, say, to the symptoms of the illness or to the diagnosis. The importance of this shift from illness or diagnosis to person permeates first-person accounts of recovery, in which people consistently identify "having someone who believed in me" as one of the most important factors in their recovery. While medications and other treatments may also be useful in addressing illness, having a foundation of social support in trusting, accepting relationships in which the person feels valued as a human being appears to offer a necessary basis for the person to take up "the work of recovery" (Davidson & Strauss, 1992).
The need for recovery-oriented care to attend first to the person has been a longstanding and well-accepted principle of the recovery movement. It was highlighted as early as 1992 by Pat Deegan, when she suggested that "the concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with a mental illness are human beings" (15). Of the 10 components of recovery articulated by a 2004 consensus development conference convened by the Substance Abuse and Mental Health Services Administration (SAMHSA), the first two speak directly to this issue. The first is that recovery is a "self-directed" process; the second is that mental health care that is recovery-oriented is "individualized and person-centred" (SAMHSA, 2007).

Another leading figure in the articulation of recovery-oriented practice, Bill Anthony (2004), argued that the transcendent principle of recovery is the attention it draws to the fundamental "personhood" of those with mental illnesses. What does it mean, though, to realize and attend to someone's "personhood"? This means the person with the illness is to be respected as the primary decision-maker in—and author of—his or her own life (O'Connell & Davidson, 2010). For the practitioner, in addition to honouring each person's autonomy, this requires a rethinking of the traditional therapeutic stance of abstinence or neutrality, inherited from psychoanalysis, in favour of a more engaged, compassionate stance that we suggest falls under the broad rubric of "love." Obviously, we do not mean "love" in a romantic sense. There are many different kinds of love, and several play important roles in promoting recovery, whether the love is received from mental health practitioners or others in the person's life. At bottom, though, we agree with certain philosophical/ethical (e.g., Plato and Aristotle) and theological/spiritual (e.g., Jewish, Christian, Muslim, Buddhist, Hindu) traditions that suggest that recognizing and attending to a person's "personhood" is fundamentally a ***loving*** act.

Why is this necessarily a key, if perhaps controversial, dimension to recovery-oriented practice? Because serious mental illnesses pose a threat to a person's basic sense of self as a person. One man with schizophrenia with whom I worked for more than a decade told me that the worst aspect of this condition was the times

when it made him forget that he was a person. Other people have described similar experiences, in which the illness robbed them of their sense of being human and relegated them to the status of an object or a machine.

People appear to lose themselves to the illness in two interrelated ways. One is through the cognitive intrusions and disruptions that are core symptoms of the illness. We derive our sense of being a person from our own ability to make decisions and act on them, from the very basic act of intentionally directing our attention and focus on something to the more sophisticated actions of deciding how to spend our time or whom to marry. Cognitive intrusions and disruptions can challenge this sense of personhood at its most basic level. Meanwhile, the prejudice that has been associated with mental illness for the past two centuries can challenge this sense of personhood at the higher levels. We know that we are people by seeing how we can affect the world—and by seeing how others view and treat us. If we seem unable to affect ourselves or the world—and are viewed and treated as "nobodies, nowhere" by others (Weingarten, 1994)—it can become exceedingly difficult to hold onto any sense of being a person, and the illness rushes in to fill the emptiness.

As Deegan has described: Once a person comes to believe that he or she is an illness, there is no one left inside to take a stand toward the illness. Once you and the illness become one, then there is no one left inside of you to take on the work of recovering, of healing, of rebuilding the life you want to live (1993, 9). Helping to separate the person from the illness and to restore his or her sense of personhood thus become two of the first major tasks of recovery-oriented care (Davidson & Strauss, 1992). This is why recovery-oriented practices—practices that are aimed at helping to restore the person's basic sense of personhood—can no longer perpetuate the neutral stance advocated by Freud.

Mental health consumers have suggested that the dispassionate stance taken by mental health practitioners has contributed to, rather than lessened, their sense of no longer being a person. One-directional relationships, in which one party does all the giving and the other party does all the taking, leaves the second party feeling diminished, rather than enhanced (Davidson, Haglund, & Stayner, 1996). Understanding the limitations of therapeutic abstinence has led recovery-oriented practitioners to adopt a more passionate and engaged—yet still professional—stance, in which a core part of their role is to validate the person's fundamental personhood and assist the person in reconstructing a self, and a life, in the wake of the illness and the effects of prejudice.

In referring to this stance as one of "love," we are returning to our cultural and spiritual roots in both Western and Eastern traditions (as well as to psychotherapeutic pioneers such as Frieda Fromm Reichmann and Harry Stack Sullivan). In the Eastern tradition, for example, we can refer to the concept of "Karuna," which refers to a form of compassion that aims to reduce the suffering of others. People with psychotic disorders are deserving of our compassion, not in the sense of charity or pity, but in the more fundamental sense of showing respect for their dignity and shared humanity.

In Ancient Greece, a similar concept was that of “Agape.” Agape refers to unconditional acceptance, the high regard in which one person holds another simply because he or she is a fellow human being. People with psychotic disorders are deserving of practitioners who hold them in such high regard, as it is the regard of others that provides a key foundation for the person’s efforts to reclaim his or her personhood from out of the ravages of the illness and the social consequences of discrimination. The work involved in establishing this foundation in the face of psychosis is thus best understood as a labour of love.

To clarify this point, I offer the following contrast. The following passage represents the picture that has too often resulted from a lack of compassion on the part of people observing the effects of mental illnesses from the “outside” (i.e., from the stance of a neutral observer). This prominent American psychiatrist once described the effects of schizophrenia, understood as a “broken brain,” as follows: Delusions, hallucinations, and disorganized speech tend to occur early in the illness. As it progresses, these symptoms sometimes “burn out.” The patient is then left only with prominent negative or defect symptoms… The ‘burned out’ schizophrenic [sic] is an empty shell—[she or he] cannot think, feel, or act… She or he has lost the capacity both to suffer and to hope—and, at present, medicine has no good remedy to offer for this loss. (Andreasen, 1984, 62–63)

Compare this sentiment with that of two people with mental illnesses who address this issue from the “inside.” They remind us that it is, after all, still people (rather than empty shells) who suffer from the effects of the illness, regardless of whether or not they convey their suffering to others (Davidson & Stayner, 1997). The first is Pat Deegan, who describes her experiences of sitting motionless on her grandmother’s couch for several years early in the course of her own recovery from psychosis. She writes: The professionals called it apathy and lack of motivation. They blamed it on our illness. But they don’t understand that giving up is a highly motivated and goal-directed behaviour. For us, giving up was a way of surviving. Giving up, refusing to hope, not trying, not caring; all of these were ways of trying to protect the last fragile traces of our spirit and our selfhood from undergoing another crushing. (1994, 19)

The second is Vincent Van Gogh, who succumbed to the effects of bipolar disorder, compounded by social alienation and rejection, while exploring new ways to paint. Van Gogh wrote to his brother, his main supporter (both financially and emotionally), in 1878: Like everyone else, I feel the need of relations and friendship, of affection, of friendly intercourse, and I am not made of stone or iron, so I cannot miss these things without feeling, as does any other intelligent and honest man, a void and deep need… Do you know what frees one from this captivity? It is every deep serious affection. Being friends… love, these open the prison by supreme power, by some magic force. Where sympathy is renewed, life is restored. (1937, 41, 48)

It requires the loving compassion of Karuna or Agape to see beyond the “empty shell” made of “stone or iron” to engage the person struggling underneath the weight of the illness and prejudice, to collect back up the “last fragile traces” of that person’s selfhood, and to invite him or her back into the human race. Stopping short of that leaves the person locked inside of the illness, to suffer alone. As one participant in a

supported socialization study concluded: “I’m nobody till somebody loves me” (Davidson, 2003, 159). While the basic validation that people receive through love is certainly not limited to that offered by practitioners, this fact does not diminish the importance of mental health care being grounded in such a loving and empathic stance as a basic condition of its efficacy. Only in this way are we able to address adequately the effects of an illness that cuts to the very core of what makes us human.

How can practitioners demonstrate this kind of love in their relationships with their patients or clients? How can practitioners show that they believe in someone, even when that person may have lost all faith in him or herself? By conveying a genuine sense of compassion to the person, by remembering—as suggested by Pat Deegan— that, no matter what the diagnosis or the severity of the illness, the person remains a human being. By providing a safe space in which the person can feel welcomed, supported, and valued, in which the person is invited to talk about the things that matter to him or her, and in which the practitioner can take the time to listen. Agape also discourages practitioners from making decisions for the person, doing things to the person, and doing things for the person without asking for the person’s input or agreement, or at least without explaining what is being done and why (when emergency measures are required). Additional strategies that demonstrate a loving stance include finding out where the person’s passions or interests, sense of meaning and purpose, and ability to derive pleasure reside, and offering to connect the person to those activities, people, or places of interest.

Finally, practitioners can take care to show common human concern for a person’s everyday life. As Juanita, a woman who had formerly been homeless, explained at the end: When you carry something, let me see, when you carry like a television, you know, that’s heavy, you have something heavy, and you put it down, you feel better. That’s how I feel today. You don’t see me crying no more, you know. I need somebody to, to understand me and help me. Like I say, if you’re going to go to my house or you’re going to call me, or you need to see me, please ask me how I am… ’cause I got my problems. I need somebody to come and help me talk. Don’t give me nothing. I don’t want nothing from nobody. I just want you to sit with me. “Juanita, how are you today?” That’s all. (quoted in Styron, Janoff–Bulman, & Davidson, 2000).

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