“Recovery”

When we are talking about mental illness, we need to define what we mean.

BY KEVIN TURNQUIST, M.D.

Although “recovery” is a term that is widely used in psychiatry, it is still a relatively new concept in our field—one that many of us have had little or no exposure to in our training. So it’s no surprise there is confusion about what it means to recover from mental illness.

There are a number of competing models of recovery, each reflecting a different set of assumptions and beliefs. Knowing which assumptions and beliefs someone holds is important if we are to reach a common understanding.

The broken-leg model
This is the gold standard of recovery. The idea is that a person recovers from mental illness in the same way he or she recovers from a broken leg. After healing is complete, the limb is like it was before the break—perhaps even a little stronger. This model obviously appeals to mentally ill people and their families, and it frequently shapes their expectations about treatment.

One occasionally encounters people who have recovered in this way. They clearly suffered from schizophrenia or another major disorder yet now are symptom-free and manage to work in high-level jobs. Some of these folks work in the mental health field, educating professionals and the public about what is possible in terms of recovery from major mental illnesses.

There is no denying that this type of recovery exists. It represents an enormous human achievement. But the main problem with the broken-leg model is that it creates false expectations; it sets the bar so high that very few people will be able to achieve it.

The harsh reality is that very few people with schizophrenia and severe forms of other mental illnesses can go on to have the kind of lives and careers that they would have had they not had the illness. When family members compare their loved one with those few amazing individuals who seem to completely recover from a severe mental illness, they are usually sorely disappointed and may become angry with and blame the professionals charged with helping them.

The symptom-control model
This is the model almost universally embraced by psychiatrists. In fact, many of us never consider other possibilities. In this model, which grew out of the chemical imbalance theory of mental illness, control of symptoms is equated with recovery. Symptoms are seen as the result of ill-defined chemical imbalances. The psychiatrist’s job is to prescribe medications aimed at correcting the imbalance so that symptoms go away. If the symptoms are well-controlled, then we’ve done our job.

Other mental health professionals are then charged with trying to make sure patients continue to take those medicines—often against their will. When symptoms do recur, it’s assumed that the patient has stopped taking his medications or that he needs more of them. A flare-up of symptoms is almost always met with a trip to the psychiatrist’s office or a psychiatric hospital so that adjustments to medications can be made.

There is certainly nothing wrong with focusing on symptom control. Psychosis, mania and depression can be disabling, and people usually function better when their symptoms are relieved. The problem comes when people believe that the control of symptoms will lead to recovery from the underlying illness.

When looking at patients’ lives, one finds there is more to recovery than controlling symptoms. Millions of patients are given medications that help alleviate symptoms, but not all of them go on to become happier or more productive or functional. And many who have had their symptoms reduced through medications stop taking them at the first chance that they get. It turns out that having a sense of control over one’s life is far more important than having symptoms reduced, especially given that many mentally ill people never believe they are experiencing the symptoms of a mental illness in the first place.

“The client costs the system less money” model
This is the model favored by administrators, politicians and policy makers. The goal of recovery is to move the client toward utilizing less-expensive services. If the person is hospitalized, the goal is to have him or her live in the community. If he or she requires services in order to get by in the community, the goal is for that person to function more independently. The ultimate goal is to have the individual working in a job that allows him or her to be self-sufficient. In this model, it’s the client who no longer costs the system money who represents the ideal.

The farther one is removed from actual clients, the easier it is to assume that such a goal makes sense. We all assume that everyone else’s mind works just like our own, so we tend to believe that approaches that would work for us will work for everyone else. As a result, our system now pushes to
have everyone working toward recovery in a linear fashion. “Achievable goals” are set. Problems are broken down into small pieces. Progress is measured at each step along the way so administrators will know which programs and approaches are moving clients toward self-sufficiency. Any treatment that has not been subjected to the necessary research to be considered a “best practice” or “evidence-based treatment” is looked upon with skepticism.

This approach is understandable, given the financial realities that health care system planners must deal with every day. Business models that emphasize cost-certainty and proven outcomes are awfully attractive to those responsible for a care system whose costs could spiral out of control at any moment. The problem is that recovery is not a commodity that can be regularly produced using proven formulas.

The clinical reality is that patients do not respond well to an approach that’s intended to make them less burdensome to the system. Many will flee at the first glimpse of a workbook that is to be used to break their problems down into simplistic components. Others won’t buy into any relationship in which a professional determines what’s best for them. And some are able to smell when the goal of treatment is to make a professional look better and reject it right away.

The “get a life back that I can feel OK about” model
This is a new model of recovery that is beginning to catch on. Although it has been held up by patients for some time, we mental health professionals have been slow to adopt it. This model simply defines recovery in terms of quality of life. For many patients, feeling good about their life again is the only goal that makes sense.

This model recognizes that many severe mental illnesses stem from changes in the way the brain is structured. Implicit in that understanding is awareness that most mentally ill people will not become “normal” after having their brain chemistry readjusted. In addition, it acknowledges that symptom control alone does not equal recovery. Controlling symptoms may be very helpful—even essential—to leading a satisfying life after the onset of mental illness, but it’s never enough. The work of accepting that life probably won’t turn out as one originally dreamed must be done. Residual symptoms such as reduced stress tolerance, difficulties with motivation or reduced cognitive abilities have to be recognized and planned around. Use of medications must be weighed in terms of their positive versus their unwanted effects. Oftentimes a new social network must be established.

In this model, recovery is seen as a process, one that is different for each person. There is no expectation that progress will be linear or that its pace will be determined by the help of a professional. Becoming truly responsible for one’s own life and the direction it takes is an enormous task for any human, so it’s not surprising that this sort of recovery is not easy to accomplish.

The building blocks of recovery
The sad truth is that our current health care and social service systems are not set up to promote recovery from mental illness. For recovery to happen, some very basic things must be in place, and we don’t yet do a very good job of providing them.

Foremost among them is the need to ensure that people with mental illnesses have a place they can call home. Almost no one can make significant progress toward recovery if they don’t have a stable living environment. But in our system, mentally ill people are transferred from place to place depending on their symptoms or behavior at any given time. Frequent transfers between group homes, hospitals, apartments and halfway houses are common. Many clients live in several places throughout the course of a year. It’s easy to forget that very few people without a mental illness could function well if they were never in one place long enough to get grounded.

To promote recovery, housing should be long-term and designed with supports to see people through various stages of their clinical condition. The living environment also must be safe enough so that the individual isn’t under constant stress. Mentally ill people often live in situations that would make anyone anxious. High-crime neighborhoods and overcrowded housing are all too common. No brain functions well when the fight or flight response is constantly activated.

Even with safe, long-term housing, there is no guarantee that a person will “recover” from their illness. For life to be satisfying, an individual must find something or someone outside of themselves to which they can become connected. Without a connection to the real world—a sense of belonging to the greater human community—it’s all too easy to become isolated in one’s own mind. Hobbies, friendships, work, and pets are just a few of the things that can provide someone with a sense of connection and having something to love.

Setting the bar too high?
People may find themselves uneasy as they contemplate the new model of recovery, as it raises the question “What makes any life satisfying and meaningful?” We Americans are at a stage where clear answers to that question seem elusive. The simple directives supplied by religion no longer feel adequate for many of us, but little has been offered up to replace them. Although we’re preoccupied with status, sexuality and possessions, they don’t make our lives feel complete. So defining recovery as having a life that one can feel good about may seem like setting the bar impossibly high.

But would any of us be willing to settle for anything less? Does any other model make sense for people with mental illnesses? These are questions of more than intellectual importance. The beliefs that we hold about recovery from mental illness affect every aspect of our mental health care system. More importantly, they shape the expectations, behaviors and lives of the people who suffer from these disorders.

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