RECOVERY STORIES: WHAT DO PEOPLE'S ACCOUNTS OF THEIR RECOVERY FROM PSYCHOSIS TELL US, AND WHICH THEORETICAL MODELS HELP US TO UNDERSTAND WHAT WE HEAR?

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MAIN AIMS AND OUTLINES

The main aims of this paper are as follows:

- To explain the recovery approach to psychosis.
- To suggest how transliminality[1] and spirituality[2] can be involved in psychosis onset and recovery.
- To suggest some resources for recovery work with people with psychosis.
- To outline approaches to working with people's life stories, and to explain how this is an important part of recovery from psychosis.

This paper is in two parts. Part A, begins with some definitions, and is followed by a historical outline of the Recovery approach, before getting to the heart of the matter: What is Recovery? After the heart, some soul, as part A explores transliminarity and spirituality in onset and recovery from psychosis. Part B contains resources for taking theory into practice in working for recovery from psychosis- it is the how to do part of the paper. This section promotes the message that it is important to work with people's life stories as part of the process of recovery and a procedure of how to do this will be presented.

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[1] Thalabourne et al (1997) in "Transliminarity: its nature and correlates" defined "transliminal" as a term that includes the experiences of psychosis, but without the pejorative connotations of psychosis, and it situates psychotic experiences in a wider context of human experiences. Transliminality is linked to strong beliefs in and reporting paranormal phenomenon, enhanced creativity, magical thinking, mystical experiences and susceptibility to psychotic experiences.

[2] Jackson (2001) provides a definition of spiritual experiences that can be summarised as follows. A spiritual experience, states Jackson, is one that is special for the individual, it has profound meaning for them and involves them going beyond the every-day consensual reality; examples of this include sensing a spiritual presence, or feeling that they are outside of time, or of having a radically altered sense of self.

PART A

DEFINITION OF RECOVERY[3]

In a seminal paper “Recovery from Mental Illness: the guiding vision of the Mental Health Service System in the 1990’s” (1993), Anthony states: “Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness.” Recovery involves the development of new meanings and purposes in one’s life as one grows beyond the catastrophic effects of mental illness”. Anthony stresses that recovery is about the individual’s own meanings; that it is about living within limitations, that it is about hope, and that it about continuing to contribute to society. In addition, he stated that: “Recovery is what people with disabilities do. Treatment, case-management, and rehabilitation are what the helpers do to facilitate recovery.” In the recovery approach the professionals of mental health services do not do to people, they do not cure people; they facilitate recovery and enable the people to cure themselves.

Defining “Recovery” in this way has come in for some criticism. Oyebode (2004) in an invited commentary on “The rediscovery of recovery: open to all” by Roberts and Wolfson (2004), expressed concern that the labelling of these changes as “Recovery” is a misappropriation of a term whose more accepted meaning in Medicine is a restoration to the former state of health prior to pathology, not an ability to live well with ongoing symptoms remaining. So an acceptance of the concept of Recovery may not mean an acceptance of the medical model of recovery, but may in fact be a challenge to it. And that a purely medical approach may not lead to recovery in the sense defined by the Recovery approach? As an alternative, in transpersonal therapy, there is a concept of a sense of wounding and recovery through this to a more integrated sense of personal meaning and functioning (Wellings, 2000).

An associated term to Recovery in the literature is “Recovery style”; this represents the psychological adjustment to psychosis. According to Tait et al. (2003) the two styles of adjustment, sealing-over or integration, have a strong relationship to service engagement. As the names suggests, in sealing over the person puts a lid on that part of their life that contained psychosis, and there is little or no interest in what information about themselves the psychosis offered. When they are not experiencing psychosis, their past experiences of psychosis are not something that they want to discuss with clinicians. Therefore, relapse prevention work with people who seal over is difficult. In contrast, people who integrate seek to find the meanings in their psychosis experiences, potentially to understand it more, and out of this knowledge to

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[3] The Recovery approach is concerned with the wide grouping of experiences that are classified as mental illness, not just psychosis; however the focus of this paper is recovery from psychosis.

have more control over their future lives and the psychosis that it may contain. This paper suggests that integration is the more likely path for recovery as defined by the Recovery approach to psychosis.

HISTORY OF RECOVERY APPROACHES

Figure 1 below summarises the main events in the development of the recovery approach to mental illness. The figure demonstrates that it has been an approach driven by service users, and that they have retained ownership of it. However, professionals together with their representative bodies have also been involved, and governments have begun to take the approach seriously.

Figure 1: The recovery approach 1813 to 2003

1813 Samuel Tuke establishes the York Retreat

1937 Recovery Incorporated, a four step recovery group system is set up in Chicago by Low, a psychiatrist, at the Illinois State Psychiatric Institute.

1960s onwards the Civil Rights Movement extends to Mental health Service users in the USA (See Chamberlin, 1990).

1978 Chamberlin, a service user in the USA publishes “On our own: patient controlled alternatives to the mental health system”. It recounts the stories of the lives of mental health service users.

1988 Deegan in “The lived experience of rehabilitation” emphasises recovery as a process.

1989 “The Well being Project” is produced by USA service users, Campbell and Schraiber.

1992 Davidson & Straus publish “Sense of self in recovery from severe mental illness”.

1993 Anthony in the USA publishes “Recovery form mental illness: the guiding vision for the 1990s” and brings together the main ideas of the approach.

1994 Warner in “Recovery from Schizophrenia” makes the distinction between “Social recovery” and “Complete recovery”.

1997 Topor, Svenson, Bjerke, Borg & Kufus in Sweden, publish a study into “turning points”. They conceptualise that recovery involves turning points; that there is descent before ascent, and the importance of a significant person in the recovery process.

1997 Copeland (1997) in the USA produces “The Wellness Recovery Action Plan”. This remains a highly popular self-management system.

1998 Weaver publishes a list of eleven items for providers to guide them in how to help a service user to recover: e.g. “I will stop trying to control the consumer’s life”.

1998 The Personal Visions of Recovery Questionnaire is published by Ensfield, Steffen, Borkin & Schafer.

1998 “Modernising Mental Health Services: safe, sound and supportive” and **1999** “The National Service Framework for Mental Health: modern standards and service models” are published by the UK’s Department of Health: Service users and their carers are to be at the centre of service provision.

2000 “Strategies for Living” is published by the Mental Health Foundation in the UK.

2000 “Can we measure Recovery” a compendium of outcome measurement tools is published in USA by Ralph, Kidder & Philips.

2001 New Zealand health and social services incorporate “Recovery practices” as part of policy, and assessed services accordingly.

2001 Topor in “Managing the contradictions: Recovery from severe mental disorders” challenges that the belief of chronicity in “schizophrenia” is a self-fulfilling prophecy.

2001 In the UK the Department of Health publish “Journey to Recovery”; National Institute for Mental Illness (England) appoints “Recovery fellows”; and MIND publishes “Routes to Recovery”.

2003 In the UK Rethink begins a research and development programme into self- management.

The figure above presents developments in the USA, New Zealand, Sweden and the UK in work on Recovery approaches to psychosis. However, there remains something to be learned from other cultures from the rest of the world about the processes of psychosis and recovery (Tobert, 2001; Raguram et al, 2002).

WHAT ARE THE THEMES OF RECOVERY, AND CAN IT BE OPERATIONALISED?

A number of authors, people who have experienced psychosis and recovered, together with clinicians who have worked with them, have sought to locate the main themes of recovery from psychosis.

Rufus May (2004), someone who has recovered from psychosis and became a clinical psychologist, put forward his recovery themes in “Making sense of psychotic experience and working towards recovery”, and are presented in figure 2 below.

Figure 2: May’s Recovery themes

1) Recovering and building a positive personal and social identity: Being psychotic is taboo, this has to be overcome, the old identity has to be mourned and adaptive responses have to be found. It is important to have access to conversations and activities that make a person feel good about themselves.
2) Narratives of possibility: Developing enabling narratives from the experience- using the wisdom and expertise that people have about their own lives.
3) The importance of supportive others: A supportive network shares the burden and helps enhance confidence and social skills.
4) Hope: Traditionally this has been lacking in mental health services. One way to bring hope is through a “Recovery library” of people’s positive accounts of their recovery.
5) A coherent account of experience: there is no one correct way, the medical way, to understand experiences of psychosis; people have to develop their own which may incorporate voices and unusual beliefs in a way that allows them to function.
6) Spiritual beliefs: spirituality is often cited as being important by people who recover from psychosis.
7) Becoming active: Traditional services encouraged passive adjustment to “illness”, the recovery approach encourages people to be active participants, sharing decision making, negotiating care, making advanced directives, taking informed risks.
8 Emotional recovery: Emotionally validating experiences and giving space for them to express emotions. This may include work on recovery from trauma work.
9) Living and coping with alternative beliefs: Understanding persecutory frameworks as adaptive to past experiences, focusing on ways that people cope with their ideas and presenting a range of options.
10 Medication partnerships: Informed decisions of whether to continue medication or not, in order that they can best get on with life.

The themes that May presents resonate with the findings of other experiencer-researchers. The Personal Visions of Recovery Questionnaire was developed by Ensfield et al. (1998) through interviews with people who experienced psychosis and who had recovered. They found that the five main themes, or factors, in recovery were as follows:

1 Support
2 Personal challenges
3 Professional assistance
4 Action and help-seeking
5 Affirmation.

The Recovery Advisory Group model of recovery (Ralph, 1999) again drew upon the experiences of people who have experienced psychosis and recovered. This model emphasised the process model of recovery; according to this model recovery from psychosis progresses through the following six stages:

1 Anguish
2 Awakening
3 Insight
4 Action plan
5 Determination commitment to become well
6 Well-being empowerment

An extension to this model, from a psychoanalytic perspective, would be for an explicit phase of mourning to be incorporated; a mourning of the parts of selfhood and opportunities that have been lost. It is suggested that this phase would be most likely to occur during the first half of recovery, a time when the person recovering and clinicians need to be aware of the risk of despair overpowering hopefulness.

It has also been suggested to the author, by an ex service-user (personal communication, 2004), that some of the action plans created may not be the best of plans and may contain knee-jerk reactions in response to misunderstandings. An action plan remains an important decision making area where people could use practical help and support, but recriminations and misunderstandings need to be avoided.

The evidence issue: can recovery be operationalised?

One current dominant ideology in the UK National Health Service is that of Evidence Based Practice (EBP). How do recovery approaches measure up when evaluated against EBP? Can recovery be operationalised, measured and evaluated? How difficult is the task, given that the recovery approach stresses that recovery from psychosis is not just the cessation of symptoms? In addition, some people prefer the term “Discovery” to “Recovery” in order to emphasise that it is a process without end- so what exactly would we measure for them, the amount of personal territory discovered?

Attempts have been made to find ways to assess and measure recovery; notable examples being the compendium of assessment tools of Ralph et al. (2000) in “Can we measure recovery?” However, some clinicians remain sceptical about such attempts, as the clinical psychologist James Plaistow (personal communication, 2004) stated:“ I’m still uncomfortable with the idea that we can define and operationalise recovery as something with definite outcomes as I feel this is still something that should be defined individually.”

As a complementary approach to EBP, other clinicians, Fullford (2004) have proposed Value-Based Practice (VBP)[4].

VBP, as the name suggest, focuses on the values that are involved in clinical decision-making. According to Allott et al. (2003) VBP shares a number of themes with the recovery approach, these are as follows:

- Respect the values of the individual.
- Focus on strengths and positive values.
- Processes are as important as outcomes.
- Provide options in care that draw on the resources available.
- Decision making rests with those directly involved, the service user and those providing their care.

The search for the evidence base for recovery approaches continues, and quite rightly so. However there is a danger that EBP can focus clinicians onto their professional knowledge base, for example their ability to understand the outcomes of randomised controlled trials, reinforcing their sense of expertise and focusing them on nomeothetic arguments. To complement these clinicians need to value the expertise of people who have experienced psychosis and recovered through the accounts that they produce, and to embrace idiographic arguments. VBP may assist in this process, by highlighting the value bases that underpin decision-making and how different forms of evidence are valued differently, not always for the best of reasons.

SPIRITUALITY AND THE TRANSLIMINAL IN ONSET OF PSYCHOSIS AND RECOVERY

People who have experienced psychosis have long spoken of spirituality and transliminal experiences as part of psychosis onset and recovery. However, except for notable exceptions, notably Jung (1968), clinicians have been slow to recognise this. Psychiatry and psychology have tended to enhance their credibility by allying themselves with the materialist schools of thought that were dominant in science through much of the last century. However, times have changed.

Isabel Clarke's model

As an attempt to make sense of the linkage between the experiences of psychosis and those of spirituality, via the concept of the transliminal, Clarke (2001) has proposed a model that draws upon the work of Kelly's personal construct theory (Bannister & Fransella, 1971) and the Interacting Cognitive Subsystems model of Teasdale & Barnard (1993). Clarke states

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[4] In 2001 The National Institute for Mental Health England launched Values Project Group to study VBP further

that there are two modes of experiencing the world. Firstly, there is the ordinary consciousness: the propositional higher order sub system of the logical mind in seamless communication with the other higher order subsystem, the, implicational subsystem. Secondly, there is the transliminal: the implicational mind that perceives the whole and emotional meaning operating partially disconnected from the filtering influence of the propositional. The latter state is associated with both the experiences of psychosis and spirituality.

Some accounts of people who experience psychosis

"Psychosispirituality" is an Internet Yahoo web-group that is jointly run by Isabel and Chris Clarke. The group is for people who have an interest in the relationship between psychosis and spirituality. Its membership comes from around the world- predominantly the UK and the USA. In 2003 the author posted an enquiry on this Yahoo group asking group members to offer their stories of recovery from psychosis, and whether it contained a transliminal or spiritual component. Responses from six people, who have experienced psychosis and consider that they have recovered, are presented below; these highlight some of the important issues in this area. Respondents gave their consent for their quotes to be used; and for confidentiality they are referred to as persons A to F.

Person A: Transliminality in recovery: longer but stronger

Person A spoke of how they valued the transliminal experiences that they had, but that they had made recovery a longer process: "I think that having some conviction that something REAL happened during my transliminal experiences may have made my recovery take longer but in the end made it more authentic". The authenticity of the experience is important to them. This highlights May's (2004) point that validation of the person's experience is important. Person A went on to quote Joseph Campbell the author of "Hero of a thousand faces", that quote being: "I do not need faith, I have experience".

Person A: The need to be grounded

Person A considered her experiences to be mystical ones, but that if we are not prepared for them, psychological harm may follow: "I think that mystical experiences uncover our unconscious weaknesses, if we have important ones. Maybe this is what the mystics meant when they said that 'purification' was needed first; maybe this is a major reason why there are warnings about 'messing with the occult". Person A then cites the work of the transpersonal psychologist, Ken Wilber, by stating that if a person is not grounded well enough when they have this form of experience, then they will regress to a pre-personal stage of development, but if they are grounded well enough then

they will have positive transliminal experiences. Person A reminds us that there are both helpful and unhelpful aspects to the transliminal.

Person B: The task of balancing the two ways of experiencing the world

Person B gives an account that fits with the two ways of experiencing the world as expressed by Clarke (2001), when they state that: " Sometimes when my heart and soul were open to Spirit, a sensitivity emerges that makes functioning in some parts of mainstream culture become very difficult. For example, going to malls or watching television become impossible. Violence in watching or reading the news is just too excruciatingly painful. How do we open and close ways that help us remain functional in our world? How do we tenderly honour the openness and sensitivity? When do we need to close? How? " For them, navigating between these two ways of experiencing the world remained a challenge.

Person C: Concerns about losing spiritual experiences- reconciling medication with faith

Person C believes that her transliminal experiences are gifts from God, and yet also considered part of a mental illness, advice from a friend enabled person C to reconcile these two positions: " I have seen a couple of references in recent posts to people feeling that their God-mediated experiences might be over due to their medications. I had that concern too, when I first went on medication. However, as I have written before, a wise friend reminded me that our God is omnipotent, capable of engaging with us in spite of any medication." Person C has been able to integrate her beliefs about psychosis in an embodied way into her life, through her vocational activities, which she believes has enabled her recovery, in conjunction with the social and personal resources that she possesses: "I am thankfully fully 'recovered' in that I have a wonderful job in pharmaceutical sales, can pursue my passion for Christian Education as director of the Education dept in my church, have a happy ,stable marriage and rewarding friendships, am free of the depression that preceded my initial experience of psychosis, and have the emotional balance and Biblical grounding to now experience and interpret transliminal events without confusion and disruption to my daily life."

Person C: Continuing to experience, and find value in, Transliminal experiences -the grounding that following a religion can give in this process

In addition, Person C believes that their transliminal experiences are gifts from God that have enhanced their life: "I would even go so far as to say that God allows 'psychosis' as a way of expanding our mental capacity for exploring things that are beyond our usual sensory experiences so that He can relate to us on a more intimate and personal basis. I have a wonderful personal relationship with the Lord, solidly grounded in Biblical doctrine and

experience. Those in Scriptures who are referred to as God's friend, like Abraham, Elijah, David etc., I believe had experiences that freed them from the limitations of their normal five senses." The experience of being grounded is important for people who continue to have transliminal experiences, and for person C that grounding is in the Bible; this allows person C to have transliminal experiences with greater safety than might have been the case without such a solid reference point. This grounding normalises the experience and reduces potential distress. Person C believes she is fortunate in this: "Sadly, too few people will find resolution of their psychotic "crises" by having them interwoven into a meaningful expansion of their faith life". But for person C these ongoing experiences are valued as God-given important experiences in the journey through life: "They are defining moments for me, often abruptly revealing new insights about life and faith that have transformed me. Though at the time some of them were quite confusing, God has been faithful to the gradually bring about understanding and show me how these insights mesh together in a more coherent theology that is solidly Biblically bound."

Person D: Get that spirituality out of here!

Person D takes a different perspective to the same issue, for them religion, and spiritual experiences, were something that they felt that they needed to be rid of in order to recover. They put forward the following biologically orientated explanation: "My paranoid schizophrenia began with an elevated chemical imbalance in my brain that convinced my mind to believe that I was experiencing a spiritual awakening. I took this belief to an extreme convincing myself that I was the fourth part of the trinity along with Jesus Christ. My obsession with my so called spiritual awakening forced me to crash my car against another oncoming car in order to kill myself and bring Jesus back to earth in my dead body. Since my arrest, I have been serving a two year probation in which medication is mandatory. What I have recently concluded it that if the pill can remove the 'spiritual' sensations that I've experienced for three years, then it must all be chemically related and not spiritually enhanced. In my recovery, I'd like to leave the spiritual world to the dead and the sanity to the living." Given their negative experiences of what religion and spirituality lead them to do, the position taken by person D is understandable. It must be noted, that in subsequent emails person D admitted that in this initial email they were being somewhat polemical. However, they make the valid point that transliminarity, spirituality and religion do have negative sides to them.

In a later correspondence to the author, person D summarised his understanding of the potential redundancy of the concept of Spirituality, and that is a by-product of cosmologies that predate the Enlightenment: "Since we assume that the Chemistry in our brains and bodies is Spirituality; mostly because we have accepted old world views from thousands of years when an electron microscope was nowhere to be found, it hinders the idea and perspective that this sensation is nothing more than and electron and proton

or molecule feels like. Why does a vegetable state exist if our spirits have their own minds? Why do we need a brain now, if a spirit can live without on in the afterlife?"

Person E: Creativity and recovery: a controlled and grounded way to experience the Transliminal?

Person E wrote of how creative activity, particularly creative writing, has enabled them to recover from psychosis, and to successfully navigate between the two ways of experiencing the world". The process of artistic creativity has healed most of my wounds. When I am at my most creative I often get a glimpse of the Second Sight I experienced before; the patterns and coincidences- unseen by my normal eye. It inspires me and captivates me. It makes me feel alive and become entranced in this new paradigm. But it is different now. I have learned to tame the wild madness. I let it lift me gently off the ground. I soar with it to great burning blue heights. But I have learnt to land, to ease the throttles and find the runway." For person E creative activity is a way for them to make sense of their experiences, it offers containment for their spiritual and alternative beliefs, to tip the balance in their transliminal experiences making them helpful, rather than harmful. In addition, creative activity allows them to be to be an active participant in their recovery; they are at the controls. Finally, it is a way for them to maintain a positive personal and social identity through the role of artist as part of their identity.

Person E: Medication partnerships and friendly boundaries

In response to the question of how he tamed the "Wild madness" that the author put to him, Person E offered medication and boundaries as both of having value. "The technical answer, I suppose, is the fact that for the past ten years I've started every day with a little orange pill called Fluanxol (0.5mg)- apparently an antisychotic. But I like to think that there is more to it than that. I believe that I've also extended the boundaries of my personal conception of what divides 'reality' and madness. Instead of a barbed wire fence with snipers either side, I've set up a bridge that can be crossed from time to time. I honestly believe that a big part of psychosis is 'losing your nerve' and this occurs a lot more easily when you 're in the sights of sniper fire." Person E is less fearful of the experiences that troubled them; so, it has not been a case of removing those experiences, but of learning to cope and to live with them.

Person F: How services need to change

Person F puts forward the case of how mental health services need to change to offer genuine support through increased understanding and validation: "I think that the mental health centres can be made more supportive and loving once madness is seen within a perspective that encompasses respect for the message madness gives of another 'reality'. The world of the madman is not without form and structure. It is the world of

mythical thinking. The madman is telling us something about ourselves and we need to hear what he is saying. Once we adopt a perspective that can respect the necessity of madness, we no longer have to approach madness as something that does not have a home. Its home is in the mythical world of the psyche and that is where it can best be understood and its value found. So we start by recognising that the madman we are treating is also treating us. Our world of rational thought and the world of the mythical complement one another."

The above accounts give testimony that suggests that both an understanding of transliminarity and the role of spirituality in psychosis may be important to help people recover from psychosis. They also suggest that spiritual and transliminal dimensions can sometimes be harmful to a person on their path to recovery. As a consequence resources to aid recovery need to assist the person in grounding themselves in material world activity and experiences.

PART B

RESOURCES FOR RECOVERY WORK

This section contains a number of resources that can help service users and clinicians work together in a partnership for recovery. These resources represent maps to navigate the territory of recovery from severe and enduring mental illness, including psychosis. Only one of these, the "Wellness Recovery Action Plan", Copeland (1997), is a tool devised specifically for recovery, the others are from other areas of psychological work, and have been adapted by the author for recovery work.

Wellness Recovery Action Plans

The Wellness Recovery Action Plan (WRAP) was devised by Mary Ellen Copeland in 1997 with a group of service users as a workbook that enables service users to workout their own plan of recovery. The service user together with a supporter (a friend, carer or professional) complete the workbook when the service user's mental health is at their best, and it is then potentially available to be shared with any professional team involved in their care and to become part of the Care Programming Approach process. The main areas of the WRAP are as follows:

- A wellness toolbox
- A daily maintenance plan to help the person stay well.
- A list of triggers and early warning signs for relapse.
- A plan for if things break down. This includes reminders of what not feeling well is like, a personal crisis plan, what to do if they are in danger and a way to deactivate the plan.

- A list of supporters, helpers and people to call on before or during a crisis.
- Statements of the service-users views on various treatments that they might be offered, which include alternatives to medical treatments and safe places other than hospital. And if it should come to hospital, what they would like a hospital experience to be like.
- A post crisis plan.

Strategies such as the WRAP clearly put the service-user at the centre of service delivery and so fit neatly with the National Service Framework (NSF) for Mental Heath. However, the approach does require local services to recognise the plan as having validity, and being in accordance with the NSF does not mean that it can override the Mental Health Act. In addition, what a person may hope their hospital admission will be like, with every good intention of their care-team, resources may not make it unattainable.

The WRAP is atheoretical in assumptions about the aetiology of psychosis, and WRAPs could be produced that are strongly biomedical, social and political, spiritual, psychodynamic or cognitive behavioural in orientation. The WRAP is an organisational framework to hold the person's understanding of their psychosis.

Albee's model applied to recovery

The work of psychologist George W Albee has not focused on recovery, or psychosis, but on the primary prevention of mental health problems in general, however his model is applicable to this area. Albee's (1985) model is presented below, after Davis & Burdett (2004).

$$\text{Incidence of Emotional illness} = \frac{\text{organic factors} + \text{stress} + \text{exploitation}}{\text{coping skills} + \text{self esteem} + \text{support groups}}$$

Davis & Burdett (2004) summarise the implications of Albee's work as follows:" To reduce the incidence of madness, we must increase the size of the denominator and decrease the size of the numerator. This requires reducing our exposure to stressful or traumatic events and increasing our capacity to participate in the world by creating a more just society. At the same time, it involves increasing our ability to cope with trauma and inequality by learning better coping skills, enhancing our self-esteem, and developing better formal and informal social support systems."

Albee's model could help clinicians to appreciate the weighting of factors for and against recovery for a particular person. It could be a guide, and reminder, to clinicians of the range of areas in which they can be intervening. It could be used with a client in therapeutic work to indicate their current weighting with the suggestions of where change is required and the strong

areas that need to be maintained. Suggestions of interventions from each factor are given below:

Factor [5]	Intervention
Organic factors:	Medication Improve nutrition Reducing substance use (alcohol, nicotine, caffeine and street and drugs) Increase exercise
Stress:	Identify sources of stress and address (Clarify what can be removed, and what has to be lived with)
Exploitation:	Identify sources of exploitation and address them
Coping skills:	Build on coping skills for life stress and anomalous experiences. Identify maladaptive coping styles and replace.
Self esteem:	Encourage self esteem boosting activities and conversations Promote participation in work, relationships and leisure
Support groups:	Develop support groups for solidarity, comfort and understanding.

Many, if not all of the items above are often included in care plans, but are presented as discrete items, without the links to the promotion of recovery being made explicit. The promotion of recovery needs clear, simple models that make the rational for intervening in certain areas of a person's life clear. Albee's model is one such model, another is that of Hagan & Smail (1998).

Hagan & Smail's Power-mapping

Hagan & Smail advocate for a Community Psychology approach to Clinical psychology; this approach is concerned with the operation of social power and political issues in relation to psychological distress. As Hagan & Smail (1997) state: "individuals distress is the outcome of social origins whose origins- whether in time, space, or both- may lie far beyond the individual's ability to identify them". To assist identification, Hagan and Smail developed a method called "Power-mapping". This they describe as:" a flexible method for representing important aspects of his/her social environment, in terms both the powers and resources available to him/ her (assets) and the extent to

[5] In Rehabilitation, or Psychosis, complex mental heath and recovery services, one suggestion would be for a staff member in collaboration with a service user to develop initiatives for each of these factors for users of that service.

which s/he is subjected adversely to the proximal powers of other (liabilities)". This enables clinicians to map the clients' circumstances, target areas for action, monitor progress and measure outcomes in a way that provides a visual summary for the client. Power-mapping covers the following areas:

Material resources:
1 Employment
2 Money
3 Education
4 Physical environment

Home and family life
1 Parents
2 Relations
3 Spouse and partner
4Children
5 Love life

Social life
1 Friends
2 Leisure
3 Associations

Personal resources
1 Confidence
2 Understanding of past
3 Development of desire
4 Embodiment
5 Intelligence

The author is of the opinion that one does not have to fully concur with their assessment of the causes of psychological distress to find Power-mapping a useful clinical tool. Power-mapping could be a useful resource for recovery work in mapping the terrain of the assets and liabilities of resources and how these impact on the person's recovery.

Isabel Clarke's model

The use of approaches to recovery in accordance with Clarke's model would be recommended if a person's psychosis had spiritual or transliminal features. According to Clarke, there are two ways of experiencing the world- the ordinary consciousness and the transliminal. From this model, recovery work involves working to assist people have more control over moving between the two modes of experience; the person being able to choose when to enter the transliminal, rather than shut it down completely. As Clarke stated in a personal communication (2004): "I see it as coming in at various different levels. Taking the spiritual dimension seriously helps to orientate the person towards recovery by allowing them to feel more comfortable with themselves. There might be learning for their life in the experience, or it might be some

sort of wrong turn. At the fine-grained level, it is a matter of giving the person skills to ground themselves in the present so that they have more control over experiences that might be intrusive, persecutory, or otherwise disruptive of their lives. I teach grounding, mindfulness etc. for this purpose. Re-connecting with ordinary emotion and relationships can be a factor at this level. It can also be useful in healing relationships with the services- finding a way they can talk to each other while preserving the person's ownership of their experiences, and this can further Recovery."

Clarke's approach shares features of other approaches that are less spirituality orientated when stressing the need to help a person focus in the here and now and not become lost in their transliminal/ psychotic experiences. What is special to this approach is that it values those experiences as having meaning[6] and that the person could choose to regain them at certain times should they wish to do so. Rather than asking them to ignore or to cut off part of their experiences, which they may not be able to do, it accepts them as part of the person's current identity, which helps with personal integration and a developing a coherent account of their life.

WORKING WITH PEOPLE'S LIFE STORIES

McAdams's model for life story work

A crucial part of recovery work is assisting a person to develop a coherent account of their life that includes their psychosis (as a past or ongoing experiences), and encourages their life story onward to a more positive future. Working with people's life stories is at the core of narrative approaches to therapy typified by the work of family and systems therapists, most notably, H. Anderson & Gooloishian (1988), White & Epston (1990), and T. Anderson (1990) However, the approach outlined here is that of McAdams (1998, 2001). One reason for this is that it is not a "therapy" approach and therefore requires fewer "therapist" skills from the mental health worker putting it into practice with a service user; secondly, because the themes of this approach, such as "journey", "turning point" and "redemption", resonate so strongly with the idea of recovery. These terms resonate with stories of a Hero's Journey, as expounded in the work of Joseph Cambell (1968) and in so doing situate recovery from psychosis in the wider context of the human journey through life as potentially heroic.

Dan McAdams research programme into life stories at The Foley Centre for the study of lives at Northwestern University, Illinois developed a dramaturgical and literary discourse approaches to the story of ordinary and

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[6] The Clinical psychologist, Dorothy Rowe, (in Masson 1992, p.17) stated that: "whenever our own truth is denied, ignored or invalidated, we experience the greatest fear we can ever know: the threat of the annihilation of our self". This is particularly notable for people who experience psychosis, for whom, according to the psychodynamic model, fears of the annihilation of the self are at the core of this condition.

some times extraordinary lives. McAdams believes that the narratives that we tell about ourselves create personal integration and coherence; we discover the story in the discourses with others, but the definitive audience is ourselves: "In modern societies, adults typically provide their lives with some sense of unity and purpose constructing self-defining life stories that serve as their identities. Such stories are told to others and to an internalised audience or listener who serves as the ultimate judge and interpreter of the narrative" Mc Adams (1998). Telling stories about ourselves, to discover ourselves is normal.

Work with the normal process of self-narrative development with people who experience psychosis may enable recovery. The experience of psychosis can dislocate the person in the narrative of their lives; their journey through life has taken an unexpected or unwanted route. In addition, for some people who experience psychosis, the lack of a coherent narrative for their lives or of having taken an unexpected or wrong turning in their life's journey may have played a role in the onset of their psychosis. Therefore, to work collaboratively with a person on their life-story may enable them to integrate their experiences and rejoin their life's journey in a way that is acceptable to them, rather than remaining static at the psychotic crossroads wondering: well how did I get here?

To enable work with life stories McAdams developed the life story interview. The interview protocol is presented in figure 3 below:

Figure 3 The life story interview (After Mc Adams & Bowman, 2001)

1 **Life chapters:** participant divides his or her life into main "chapters" and provides a plot summary of each chapter.
2 **Significant scenes:** For each of the eight scenes below, the participant describes exactly what happened, who was there, what he or she was thinking and feeling in the scene, and what he or she thinks the scene says about who or she is, or might be.
High point: a scene of great joy, happiness, positive affect. The best scene in the story.
Low point: A scene of great misery, fear, negative affect. The worst scene in the story.
Turning point: A scene in which the participant experienced a significant life change.
Earliest memory
Important childhood scene
Important adolescent scene
Important adulthood scene
Any other important scene
3 Life challenge: Participant describes single greatest challenge in life.
4 Characters:
Most important **Positive influence:** Describe the person or institution who has had the most positive impact on the story.

Most important **Negative influence:** Describe the person or institution who has had the most negative impact on the story.
5 Favourite stories: Describe favourite stories seen, read, or heard.
6 Future plot: Where is the story going? What happens next? Goals for the future.
7 Personal ideology: A series of questions about fundamental values, religious and political beliefs, and how values have changed over time.
8 Life theme: Identify single integrative theme of life story.

In using this protocol with people who experience psychosis care needs to be taken to deal with the distress that it may create, given the relationship between trauma experiences and psychotic experiences (Romme & Escher 1993; Calcott et al. 2004). However, the need for care and caution does not mean that this is something not to be done, as the potential gains for recovery make it worthwhile.

Simply to enable people to find at least some positive messages in their psychosis experiences, is not just about making them feel happier, it could have knock on benefits on the overall process of recovery. According to McAdams (2001): " The take home message from the empirical literature on benefit-finding is that people who perceive benefits in adversity tend to show better recovery from and adjustment to the negative events that brought them into adversity in the first place…survivors of illness and trauma often report increased self-reliance and broader self-understanding, enhanced self-disclosure and emotional expressiveness in relationships and a changed philosophy of life (Tedeschi & Calhoun,1995)." In addition, Mc Adams work with people experiencing challenge and change in their lives has generated concepts that could be useful in recovery work with people who experience psychosis: the concepts of turning points, contamination and redemption[7]. Using these concepts as part of a life story approach could be part of the process of the recovery of the sense of self.

Recovery of the sense of self

According to Hemsley (1998) "schizophrenic" disruption is linked to disruption to the sense of self. For recovery to occur that disruption needs to be addressed and the sense of self recovered. The recovery of self in psychosis has been researched by Davidson & Strauss (1992); they interviewed sixty-six people who are recovering from severe mental illness: twenty-five were diagnosed with Schizophrenia; seventeen were diagnosed with Schizoaffective disorder; twenty-four were diagnosed with Major affective disorder. They discovered the following themes in the recovery of self:

[7] McAdams (2001) defines a contamination sequence in a person's life as one where an emotionally positive event goes suddenly bad; and such a sequence is associated with depression, reduced life satisfaction, self-esteem and sense of life coherence. In contrast, a redemption sequence is about the transformation of a bad event into a good one; and is associated with increased life-satisfaction, self-esteem, sense of coherence and reduced depression.

1 Discovering a more active self;
2 Taking stock of the self;
3 Putting the self into action;
4 Appealing to the self.

The findings of Davidson & Straus suggest that this process of self recovery can occur even whilst the person continues to experience symptoms; they do not have to be "cured" first. This fits with Tudor's (1996) two continua model: a mental disorder/ cure continuum and a mental health/ healing continuum. What is suggested by Davidson & Straus fits with the latter continuum. This is not to suggest that the former continuum should not be a focus for clinical work, obviously symptoms should still be addressed, but it is suggesting the need for the second continuum to be addressed within the psychiatric system to enable improved recovery of self.

In addition, Davidson & Straus suggest that for recovery of self to occur, the person needs to be an active participant: "This process of developing a functioning sense of self in the midst of persistent psychotic symptoms and dysfunction…will need to allow for, and encourage, a more active and collaborative role for the person with the disorder." Symptoms of a mental disorder may be removed by a clinician treating the more passive body and mind of the patient, but for recovery to occur the person who recovers needs to participate.

For people who continue to experience symptoms, despite the best efforts of clinicians to treat them, either by medication or Cognitive Behavioural Therapy, the recovery of a stable sense of self is a vital resource for them in their self management of psychotic symptomology: "a stable sense of self may be utilised by a person in coping with some of the ravages of the illness and be employed in coping with it's symptoms." This echoes the position of Pat Deegan (1988) who stated that recovery is about becoming one's true self in spite of the illness.

Recovery for people who have experienced, or who continue to experience, psychosis

Recovery for a person who has experienced, or who continues to experience psychosis, is about regaining a coherent sense of self. It is about finding redemption in, and from, the experience of psychosis. It is about the development of a life-story in which they are an active participant: they do not exclude, or allow themselves to be excluded by others, from the social world; it is they who recover, as they are not a passive body and mind that is cured and treated by others. In addition, they are open to experiencing the universe in ways that are different from the everyday; but with the capacity to do so within the control of the self- there is no more slipping into the transliminal to the detriment of functioning in the everyday world of work and relationships. The person who recovers understands the thread that leads from their past, through their present and into the future, with hope that that future will be positive.

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To do:

1 Put in The 4 stage model of Recovery from the NIMHE (2004) doc
2 DREEM is a measure of how Recovery Orientated a care environment is- measured by users- for “The evidence issue section “Attempts have been made…”
3 Possibly worked case examples for each of the resources